ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

BENEFIT OPTIONS
High Deductible Health Plan with Health Savings Account (HDHP with HSA) Summary Plan Description

EFFECTIVE JANUARY 1, 2018

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ARTICLE 1

PLAN MODIFICATION, AMENDMENT AND TERMINATION

The Plan Sponsor reserves the right to, at any time, amend, change or terminate benefits under the Plan, to amend, change or terminate the eligibility of classes of Employees to be covered by the Plan, to amend, change, or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it.

No consent of any Member is required to terminate, modify, amend or change the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any covered medical expenses incurred prior to the termination date of the Plan.

This document is effective January 1, 2018 and supersedes all Plan Descriptions and all enrollment guides previously issued by the Plan Sponsor.

ARTICLE 2

ESTABLISHMENT OF PLAN

2.1 Purpose

The Plan Sponsor established this Plan to provide for the payment or reimbursement of covered medical expenses incurred by Plan Members.

2.2 Exclusive Benefit

This Plan is established and shall be maintained for the exclusive Benefit of Eligible Members.

2.3 Compliance

This Plan is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. Should any part of this Plan Description for any reason be declared invalid, such decision shall not affect the validity of any remaining portion, which remaining portion shall remain in effect as if this Description has been executed with the invalid portion thereof eliminated.

2.4 Legal Enforceability

The Plan Sponsor intends that terms of this Plan, including those relating to coverage and Benefits provided, are legally enforceable by the Members, subject to the Employer's retention of rights to amend or terminate this Plan as provided elsewhere in this Plan Description.

2.5 Note to Members

This Plan Description describes the circumstances when this Plan pays for medical care. All decisions regarding medical care are up to a Member and his Physician. There may be circumstances when a Member and his Physician determine that medical care, which is not covered by this Plan, is appropriate. The Plan Sponsor and the Third Party Claim Administrator do not provide or ensure quality of care.

Each network contracts with the in-network providers under this Plan. These providers are affiliated with the PPO Networks and the Travel Network and do not have a contract with the Plan Sponsor or Third Party Claim Administrator.

ARTICLE 3

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility

The Plan is administered in accordance with Section 125 Regulations of the Internal Revenue Code and the Arizona Administrative Code. Benefit Services will provide potential Members reasonable notification of their eligibility to participate in the Plan as well as the terms of participation.

Both Benefit Services and the Third Party Claim Administrator have the right to request information needed to determine an individual's eligibility for participation in the Plan.

Please see ARTICLE 16 for definitions of the terms used below.

3.2 Member Eligibility

Eligible Employees, Eligible Retirees, and Eligible Former Elected Officials may participate in the Plan.

Members' legal Spouse and Eligible Children under the age of 26 may participate in the Plan. An Eligible Dependent may not participate in the Plan unless an Eligible Employee, Eligible Retiree, or Eligible Former Elected Official is also enrolled.

If you and your Spouse are both covered under the Plan, you may each be enrolled as a Member or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll their Child as a Dependent.

3.3 Continuing Eligibility through COBRA

See Section 3.13 of this article.

3.4 Non-COBRA Continuing Eligibility

The following individuals are Eligible for continuing coverage under the Plan.

Eligible Employee on Leave without Pay

An Employee who is on leave without pay for a health-related reason that is not an industrial illness or injury, may continue to participate in the Plan by paying both the state and Employee contribution. Eligibility shall terminate on the earliest of the Employee:

- Receiving long-term disability benefits that include the benefit of continued participation;
- Becoming eligible for Medicare coverage; or
- Completing 30 months of leave without pay.

An Employee who is on leave without pay for other than a health-related reason may continue to participate in the Plan for a maximum of six months by paying both the state and Employee contributions.

Surviving Dependent(s) of Insured Retiree

Upon the death of a Retiree insured under the Plan, the Surviving Dependents are Eligible to continue coverage under the Plan, provided each was insured at the time of the Member's death, by payment of the Retiree premium.

If the Spouse survives, he/she, for purposes of Plan administration, will be reclassified as a Member. As such, he/she may enroll Dependents as allowed under Section 3.2. Coverage for the Surviving Spouse may be continued indefinitely.

In the case where Children, who are Eligible Dependents of the Surviving Spouse, survive, they may continue participation in the Plan if enrolled by the Surviving Spouse as allowed under Section 3.2.

In the case where Children survive but no Spouse survives or the Children are Eligible Dependents of the Spouse, each Child, for purposes of Plan administration, will be reclassified as a Member. As such, each Child may enroll Dependents as allowed under Section 3.2. In this circumstance, coverage for each Surviving Child may be continued indefinitely.

Please note that a Dependent not enrolled at the time of the Member's death may not enroll as a Surviving Dependent.

Surviving Spouse/Child of Insured Employee Eligible for Retirement under the Arizona State Retirement System (ASRS)

Upon the death of an insured Employee meeting the criteria for retirement under the ASRS, the Surviving Spouse and Children, provided each was enrolled at the time of the Member's death, are Eligible to continue participation in the Plan by payment of the Retiree premium.

If the insured Spouse survives, he/she, for purposes of Plan administration, will be reclassified as a Member. As such, he/she may enroll Dependents as allowed under Section 3.2. Coverage for the Surviving Spouse may be continued indefinitely.

In the case where insured Children, who are Eligible Dependents of the Surviving Spouse, survive, they may continue participation in the Plan if enrolled by the Surviving Spouse as allowed under Section 3.2.

In the case where insured Children survive but no Spouse survives, each Child, for purposes of Plan administration, will be reclassified as a Member. As such, each Child may enroll Dependents as allowed under Section 3.2. In this circumstance, coverage for each Surviving Child may be continued indefinitely.

Please note that a Child/Spouse not enrolled as a Dependent at the time of the Member's death may not enroll as a Surviving Child/Spouse.

Surviving Spouse of Elected Official or Insured Former Elected Official (EORP)
Upon the death of a Former Elected Official insured under the Plan, the Surviving Spouse may continue participation in the Plan, provided that he/she was enrolled at the time of the Member's death, by payment of the Retiree premium. The Surviving Spouse, for purposes of Plan administration, will be reclassified as a Member. As such, he/she may enroll Dependents as allowed under Section 3.2. Coverage for the Surviving Spouse may be continued indefinitely.

Please note that a Spouse not enrolled at the time of the Former Elected Official's death may not enroll as a Surviving Spouse.

Upon the death of an elected official who would have become Eligible for coverage upon completion of his/her term, the Surviving Spouse may continue participation in the Plan, provided that he/she was enrolled at the time of the elected official's death, by payment of the Retiree premium. The Surviving Spouse, for purposes of Plan administration, will be reclassified as a Member. As such, he/she may enroll Dependents as allowed under Section 3.2. Coverage for the Surviving Spouse may be continued indefinitely.

Please note that a Spouse not enrolled at the time of the elected official's death may not enroll as a Surviving Spouse.

Surviving Spouse or Dependent of a Law Enforcement Officer Killed in the Line of Duty
Upon the death of an insured Employee meeting the criteria under A.R.S. § 38-1114, the Surviving Spouse and/or Dependent, are Eligible to participate in the Plan.

3.5 Eligibility Audit
Benefit Services may audit a Member's documentation to determine whether an enrolled Dependent is Eligible according to the Plan requirements. This audit may occur either randomly or in response to uncertainty concerning Dependent eligibility.

Both Benefit Services and the Third Party Claim Administrator have the right to request information needed to determine an individual's eligibility for participation in the Plan.

3.6 Grievances Related to Eligibility
Individuals may file a grievance with the Director of the Benefit Services Division regarding issues related to eligibility. To file a grievance, the individual should submit a letter to the Director that contains the following information:

- Name and contact information of the individual filing the grievance;
- Nature of the grievance;
- Nature of the resolution requested; and
- Supporting Documentation

The Director will provide a written response to a grievance within 60 days.

3.7 Enrollment Procedures and Commencement of Coverage

New enrollments or coverage changes will only be processed in certain circumstances. Those circumstances are described below.

3.8 Initial Enrollment

Once Eligible for coverage, potential Members have 31 days to enroll and provide required documentation for themselves and their Dependents in the Plan.

It should be emphasized that coverage begins only after an individual has successfully completed the enrollment process by submitting a completed election and providing any required documentation within 31 days. Benefits will be effective as referenced on the following table. Documentation may be required.

The table below lists pertinent information related to the initial enrollment process.

Category	**Must enroll within 31 days**	**Enrollment contact**	**Coverage begins on the**[1]
Eligible state Employee	Date of hire	Agency liaison	first day of first pay period after completion of enrollment process
Eligible university Employee	Date of hire	Human Resources Office	first day of first pay period after completion of enrollment process
Eligible participating political subdivision Employee	Date of hire	Human Resources Office	*Please contact the appropriate Human Resources Office*
Eligible Retiree	Date of retirement	Benefit Services	first day of first month after completion of enrollment process[2]
Eligible Former Elected Official	Date of leaving office or retiring	Benefit Services	first day of first month after completion of enrollment process[3]

[1] Under no circumstance will coverage for a dependent become effective prior to the Member's coverage becoming effective.
[2] For state employees entering retirement and their dependents, coverage begins the first day of the first pay period following the end of coverage as a state employee. This results in no lapse in coverage.
[3] Eligibility is subject to A.R.S. § 38-802.

3.9 Open Enrollment

Before the start of a new Plan Year, Members are given a certain amount of time during which they may change coverage options. Potential Members may also elect coverage at this time. This period is called Open Enrollment.

In general, Open Enrollment for Eligible Employees, Retirees and Former Elected Officials is held in October or November.

At the beginning of each year's Open Enrollment period, enrollment information is made available to those Eligible for coverage under the Plan. This information provides details regarding changes in benefits as well as whether a current Member is required to re-elect his/her coverage during Open Enrollment (called a "positive" Open Enrollment).

Elections must be made before the end of Open Enrollment. Those elections – or the current elections, if no changes were made and it was not a positive Open Enrollment – will be in effect during the subsequent Plan Year.

Coverage for all groups begins on the first day of the new Plan Year.

It should be emphasized that coverage options change only after an individual has successfully completed the enrollment process by submitting a completed election form and providing any required documentation within 31 days of the end of the Open Enrollment period.

3.10 Qualified Life Event Enrollment

If a qualified life event occurs, Members have 31[4] days to enroll or change coverage options.

Changes made as a result of a qualified life event must be consistent with the event itself, except in the case of HIPAA Special Enrollment.

It should be emphasized that coverage options change only after an individual has successfully completed the enrollment process by submitting a completed election form and providing any required documentation within 31 days of qualifying event.

State Employees should contact the appropriate agency liaison when they choose to change coverage options as a result of a qualified life event. University and political subdivision Employees should contact the appropriate human resources office. Retirees and Former Elected Officials should contact Benefit Services.

For state Employees, most coverage changes become effective on the first day of the first pay period after completion of the enrollment process. For Retirees and Former Elected Officials, most coverage changes become effective on the first day of the first month after completion of the enrollment process. University and political subdivision Employees should contact the

[4] Pursuant to the Children's Health Insurance Program (CHIP) Reauthorization Act, individuals who lose Medicaid or CHIP coverage due to ineligibility have 60 days to request enrollment.

appropriate human resources office for information regarding the effective date of coverage changes.

A Surviving Spouse/Dependent must submit a completed election form and provide any required documentation within six months of the death of the insured Retiree or insured Employee eligible for retirement under the ASRS. A Surviving Spouse/Dependent of an Elected Official or Formal Elected Official has 31 days to complete the election form and provide required documentation.

The table below lists pertinent information related to the qualified life event enrollment process. It should be noted that not all qualified life events are listed below.

Type of event	**Must enroll/change coverage within 31 days of:**	**Coverage/change in coverage begins on the[5]:**
Marriage	date of the event	See above
Death of Dependent	date of the event	See above
Divorce, annulment, or legal separation	date of the event	See above
Employment status change (beginning employment, termination, strike, lockout, beginning/ ending FMLA, full-time to part-time)	date of the event	See above
Change in residence	date of the event	See above
Loss/gain of Dependent eligibility (other than listed below)	date of the event	See above
Newborn[6]	date of birth	date of birth[7]
Adopted Child	date of placement for adoption	date of adoption[8]
Child placed under legal guardianship	date Member granted legal guardianship	date Member granted legal guardianship[8]
Child placed in foster care	date of placement in foster care	See above

3.11 Change in Cost of Coverage

If the cost of benefits increases or decreases during a Plan Year, Benefit Services may, in accordance with Plan terms, automatically change your elective contribution.

[5] University and political subdivision employees should contact the appropriate human resources office for information regarding effective date of coverage changes.
[6] Born to Member or Member's legal Spouse.
[7] Coverage ends on 31st day after date of birth if Member does not enroll newborn in the Plan.
[8] A Child adopted, placed under legal guardianship, or placed in foster care covered from date of adoption only if Member subsequently enrolls Child in the Plan.

When Benefit Services determines that a change in cost is significant, a Member may either increase his/her contribution or elect less-costly coverage.

3.12 Termination of Coverage

Coverage for all Members/Dependents ends at 11:59 p.m. on the date the Plan is terminated. Termination of coverage prior to that time is described in the table below.

Category	**Coverage ends at 11:59 p.m. on the earliest of:**
Eligible state/university Employee	• last day of the pay period for/in which the Member: ➢ makes last contribution; ➢ fails to meet the requirements for eligibility; or ➢ becomes an active Member of the armed forces of a foreign country; or • last day Member is Eligible for extension of coverage.
Eligible participating political subdivision Employee	*Please contact the appropriate human resources office*
Eligible Retiree[9]/Former Elected Official	• last day of the month for/in which the Member: ➢ makes last premium payment; or ➢ fails to meet the requirements for eligibility.
Eligible long-term disability recipient	• last day of the month in which the disability benefit ends.
Eligible Dependent	• the last day of the month in which the Dependent Child reaches the limiting age of 26; • day the Dependent: ➢ dies; ➢ loses eligibility for reason other than limiting age; or ➢ becomes an active Member of the armed forces of a foreign country; or • day the Member: ➢ is relieved of a court-ordered obligation to furnish coverage for a Dependent Child; or ➢ is no longer covered.
Eligible Employee on leave without pay	• last day of period in which Member becomes Eligible for: ➢ long-term disability benefits for which there is eligibility to continue coverage under the Plan; or ➢ coverage under Medicare; or • 30 months after the leave-without-pay period began. • Last day of the period for which the Member makes last payment.
Surviving Child/Spouse of Eligible Retiree	• last day of the period for which the Member makes last payment; or

[9] Excluding long-term disability recipient.

Category	Coverage ends at 11:59 p.m. on the earliest of:
	• day the Surviving Child fails to be Eligible as a Child.
Surviving Spouse of elected official or Eligible Former Elected Official	• last day of the period for which the Member makes last payment.

3.13 Continuing Eligibility through COBRA

Eligibility of enrolled Members/Dependents

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a Member/Dependent who has had a loss of coverage due to a qualifying event may extend his/her coverage under the Plan for a limited period of time.

To be Eligible for COBRA coverage, a Member/Dependent must be covered under the Plan on the day before the qualifying event. Each covered individual may elect COBRA coverage separately. For example, a Dependent Child may continue coverage even if the Member does not.

Members and Dependents would be Eligible for COBRA coverage in the event that the state of Arizona files bankruptcy under Title 11 of the U.S. Code.

The table below lists individuals who would be Eligible for COBRA coverage if one of the corresponding qualifying events were to occur.

Category	Duration of COBRA coverage	Qualifying event
Eligible Employee, Dependent	Up to 18 months[10]	• Voluntary or involuntary termination of Member's employment for any reason other than "gross misconduct"; or • Reduction in the number of hours worked by Member (including retirement)[11].
Dependent	Up to 36 months	• Member dies; or Member and Dependent Spouse divorce or legally separate.
Dependent Child	Up to 36 months	• Dependent Child no longer meets eligibility requirements.

[10] If the Member and/or Dependent has a disability when he/she becomes eligible for COBRA or within the first 60 days of COBRA coverage, duration of coverage may be extended to 29 months. See section 3.16 for Special Rules Regarding Disability.

[11] If the Member takes a leave of absence qualifying under the Family and Medical Leave Act (FMLA) and does not return to work, the COBRA qualifying event occurs on the date the Member notifies ADOA that he/she will not return, or the last day of the FMLA leave period, whichever is earlier.

3.14 Subsequent Qualifying Events

An 18-month COBRA period may be extended to 36 months for a Dependent if:

- Member dies; or
- Member and Dependent Spouse divorce or legally separate; or
- Dependent Child no longer meets eligibility requirements.

This clause applies only if the second qualifying event would have caused the Dependent to lose coverage under the Plan had the first qualifying event not occurred.

3.15 Eligibility of Newly Acquired Eligible Dependents

If the Member gains an Eligible Dependent during COBRA coverage, the Dependent may be enrolled in the Plan through COBRA. The Member should provide written notification to Benefit Services within 31 days of the qualifying life event. Newly acquired Dependents may not enroll in the COBRA coverage after 31 days.

3.16 Special Rules Regarding Disability

The 18 months of COBRA coverage may be extended to 29 months if a Member is determined by the Social Security Administration to have a disability at the time of the first qualifying event or during the first 60 days of an 18-month COBRA coverage period. This extension is available to all family members who elected COBRA coverage after a qualifying event.

To receive this extension, the Member must provide Benefit Services with documentation supporting the disability determination within 60 days after the latest of the:

- Social Security Administration disability determination;
- Qualifying event; or
- Date coverage is/would be lost because of the qualifying event.

3.17 Payment for COBRA Coverage

Participants who extend coverage under the Plan due to a COBRA qualifying event must pay 102% of the active premium. Participants whose coverage is extended from 18 months to 29 months due to disability may be required to pay up to 150% of the active premium beginning with the 19th month of COBRA coverage.

COBRA coverage does not begin until payment is made to the COBRA administrator. A participant has 45 days from submission of his/her application to make the first payment. Failure to comply will result in loss of COBRA eligibility.

3.18 Notification by the Member/Dependent

COBRA coverage cannot be elected if proper notification is not made. Under the law, the Plan must receive written notification of a divorce, legal separation, dissolution of partnership, or Child's loss of Dependent status, within 60 days of the later of the:

- Date of the event; or
- Date coverage would be lost because of the event.

Notification must include information related to the Member and/or Dependent(s) requesting COBRA coverage. Documentation may be required.

Written notification should be directed to:

ADOA Benefits Services Division
100 N. 15th Avenue, Suite 260
Phoenix, AZ 85007

3.19 Notification by the Plan

The Plan is obligated to notify each participant of his/her right to elect COBRA coverage when a qualifying event occurs and the Plan is notified in accordance with Section 3.18.

3.20 Electing COBRA Coverage

Information related to COBRA coverage and enrollment may be obtained through an agency liaison or by calling ADOA Benefit Services Division at 602-542-5008 or 1-800-304-3687 or by writing to the address provided Article 15.

3.21 Early Termination of COBRA Coverage

The law provides that COBRA coverage may, for the reasons listed below, be terminated prior to the 18-, 29-, or 36-month period:

- The Plan is terminated and/or no longer provides coverage for Eligible Employees;
- The premium is not received within the required timeframe;
- The Member enrolls in another group health plan; or
- The Member becomes eligible for Medicare.

For Members whose coverage was extended to 29 months due to disability, COBRA coverage will terminate after 18 months or when the Social Security Administration determines that the Member no longer has a disability.

3.22 Contact Information for the COBRA Administrator

COBRA-related questions or notifications should be directed to ADOA Benefit Services Division at 602-542-5008 or 1-800-304-3687 or by writing to the address provided in Section 3.18.

3.23 Certificate of Creditable Coverage

When COBRA coverage ends, the Third Party Claim Administrator will send a certificate of creditable coverage. This certificate confirms that each participant was covered under the Plan and for what length of time. The certificate may be used as credit against a new plan's pre-existing condition limitation.

ARTICLE 4

PRE-CERTIFICATION/PRIOR AUTHORIZATION AND NOTIFICATION FOR MEDICAL SERVICES AND PRESCRIPTION MEDICATION

4.1 Pre-Certification/Prior Authorization and Notification

Pre-Certification/Prior Authorization is the process of determining the Medical Necessity of services before the services are incurred. This ensures that any medical care a Member receives meets the Medical Necessity requirements of the Plan. The definition and requirements of Medical Necessity are identified in Article 16. Pre-Certification/Prior Authorization is required if the Plan is considered primary as defined in Article 10 Pre-Certification/Prior Authorization is initiated by calling the toll-free Pre-Certification/Prior Authorization phone number shown of your ID card and providing information on the planned medical services. Pre-Certification/Prior Authorization may be requested by you, your Dependent or your Physician. However, the Member is ultimately responsible to ensure Pre-Certification/Prior Authorization is obtained.

All decisions regarding medical care are up to a Patient and his/her Physician. There may be circumstances when a Patient and his/her Physician determine that medical care, which is not covered by this Plan, is appropriate. The Plan Sponsor and the Third Party Claim Administrator do not provide or ensure quality of care.

Pre-Certification/Prior Authorization should be initiated for specific services noted in the Plan Description by calling the Third Party Claim Administrator Customer Service Center and providing information on the planned medical services. The patient or the physician/facility may request Pre-Certification/Prior Authorization; however, the Member is ultimately responsible to ensure Pre-Certification/Prior Authorization is obtained.

If Pre-Certification/Prior Authorization is not obtained before planned medical services are incurred, the submitted claim will pend and a letter will be issued notifying you and the provider that Pre-Certification/Prior Authorization is required before claim processing can continue. This must be initiated by calling the Third Party Claim Administrator and providing information on the incurred medical services. If Pre-Certification/Prior Authorization is not initiated within 60 days of the first pend letter, the claim will be denied.

4.2 Medical Services Inpatient Admissions

Pre-Certification/Prior Authorization for Inpatient admissions refers to the process used to certify the Medical Necessity and length of any hospital confinement as a registered bed patient. Pre-Certification/Prior Authorization is performed through a utilization review program by a Third Party Claim Administrator with which the State of Arizona has contracted. Pre-Certification/Prior Authorization should be requested by you, your Dependent or an attending physician by calling the Pre-Certification/Prior Authorization phone number shown on your ID card prior to each inpatient hospital admission. Pre-Certification/Prior Authorization should be requested, prior to the end of the certified length of stay, for continued inpatient hospital confinement.

You should start the Pre-Certification/Prior Authorization process by calling the Third Party Claim Administrator prior to an elective admission, prior to the last day approved for a current admission, or in the case of an emergency admission, by the end of the second scheduled business day after the admission. The Third Party Claim Administrator will continue to monitor the confinement until you are discharged from the hospital. The results of the review will be communicated to the Member, the attending Physician, and the Third Party Claim Administrator.

The Third Party Claim Administrator is an organization with a staff of Registered Nurses and other trained staff members who perform the Pre-Certification/Prior Authorization process in conjunction with consultant Physicians.

4.3 Notification of Maternity Services

While Pre-Certification/Prior Authorization is not required for maternity services in the physician's office, outpatient, and inpatient within federally mandated stay limits, we encourage you to contact the Third Party Claim Administrator if you will be receiving any maternity services. This will assist in the Pre-Certification/Prior Authorization process should inpatient services be required that exceed 48 hours for a normal delivery and 96 hours for a cesarean section. Notification also enables the Third Party Claim Administrator staff to assist you with education and/or resources to maintain your health during your pregnancy.

4.4 Notification of 23-Hour Observation Admissions

While Pre-Certification/Prior Authorization is not required for 23-hour observation admissions, we encourage you to contact the Third Party Claim Administrator if you will be receiving these services. This will assist in the Pre-Certification/Prior Authorization process should the admission exceed 23 hours.

4.5 Other Services and Supplies

Pre-Certification/Prior Authorization should be requested for those services that require Pre-Certification/Prior Authorization. Pre-Certification/Prior Authorization should be requested by you, your Dependent or your physician by calling the toll-free phone number shown on the back of your ID card prior to receiving services. Services that should be pre-certified include, but are not limited to:

1. Inpatient services in a hospital or other facility (such as hospice or skilled nursing facility);
2. Inpatient maternity services in a hospital or birthing center exceeding the federally mandated stay limit of 48 hours for a normal delivery or 96 hours for a cesarean section;
3. A separate Pre-Certification/Prior Authorization is required for a newborn in cases where the infant has been diagnosed with a medical condition requiring in-patient services independent of the maternity stay.
4. Outpatient surgery in a hospital or ambulatory surgery center as required by the Third Party Claim Administrator.
5. Accidental dental services;
6. Dental confinements/anesthesia required due to a hazardous medical condition;
7. Inpatient mental/nervous and substance abuse services;

8. Outpatient and ambulatory magnetic resonance imaging (MRI/MRA), PET Scans, BEAM (Brain Electrical Activity Mapping);
9. Non-emergency ambulance transportation;
10. Organ transplant services;
11. Cancer clinical trials;
12. Epidural and facet injection, radio frequency ablation and biofeedback;
13. Infusion/IV Therapy in an Outpatient setting as required by the Third Party Claim Administrator;
14. Injectable medication in the Physician's office as required by the Third Party Claim Administrator;
15. Home health including parenteral;
16. Outpatient and ambulatory cardiac testing, angiography, sleep testing (including sleep studies and polysomnography), video EEG;
17. All purchase or rental of Durable Medical Equipment and prosthetics as required by the Third Party Claim Administrator;
18. Coverage for repair or replacement equipment;
19. Foot Orthotic devices and inserts (covered only for diabetes mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.);
20. Repair or replacement of prosthetics;
21. End Stage Renal Disease services (including dialysis);
22. Services not available through an in-network provider;
23. Services which have a potential for a cosmetic component, including but not limited to, blepharoplasty (upper lid), breast reduction, breast reconstruction, ligation (vein stripping), and sclerotherapy.
24. CAT/CT imagery
25. Injections given during an office visit as required by the Third Party Claim Administrator;
26. Cochlear Implants, and hearing aids.
27. Treatment for Autism Spectrum Disorder;
28. Medical foods, metabolic supplements and Gastric Disorder Formula;
29. Orthognathic treatment or surgery.

4.6 Services not Available from a Participating Provider

If you require non-emergency or urgent services which are not available from a Participating Provider, approval may be requested to allow the Member to receive services at a non-Participating Provider under the In-Network benefit level. To obtain Pre-Certification/Prior Authorization for these services, contact the Third Party Claim Administrator.

4.7 Prescription Medications

Medicare Part D participants have dual drug coverage. For drugs covered under Medicare Part D, the following does not apply, please refer to www.medicaregenerationrx.com/stateofaz. For drugs not covered under Medicare Part D the following applies.

For purposes of Member safety, certain prescriptions require "prior authorization" or approval before they will be covered, including but not limited to an amount/quantity that can be used within a set timeframe, an age limitation has been reached and/or exceeded or appropriate utilization must be determined. The Pharmacy Benefit Management Vendor (PBM), in their capacity as pharmacy benefit manager, administers the prior authorization process for prescription medications.

Prior Authorization (PA) may be initiated by the pharmacy, the physician, you, and/or your covered family members by calling the PBM. The pharmacy may call after being prompted by a medication denial stating *"Prior Authorization Required."* The pharmacy may also pass the information on to you and require you to follow-up.

After the initial call is placed, the Clinical Services Representative obtains information and verifies that the Plan participates in a PA program for the particular drug category. The Clinical Services Representative generates a drug specific form and faxes it to the prescribing physician. Once the fax form is received by the Clinical Call Center, a pharmacist reviews the information and approves or denies the request based on established protocols. Determinations may take up to 48 hours from the PBM's receipt of the completed form, not including weekends and holidays.

If the prior authorization request is APPROVED, the PBM Clinical Services Representative calls the person who initiated the request and enters an override into the WHI processing system for a limited period of time. The pharmacy will then process your prescription.

If the PA request is DENIED, the PBM Clinical Call Center pharmacist calls the person who initiated the request and sends a denial letter explaining the denial reason. The letter will include instructions for appealing the denial. For more information, see the "Appeals Procedures" section of this document.

The criteria for the PA program are based on nationally recognized guidelines; FDA approved indications and accepted standards of practice. Each specific guideline has been reviewed and approved by the PBM Pharmacy and Therapeutics (P&T) Committee for appropriateness. Types of prescription medications that require PA prior to dispensing include, but are not limited to:

1. Oncology Medications;
2. Multiple Sclerosis Medications;
3. Rheumatoid Arthritis Medications;
4. Lipid Lowering Medications;
5. Testosterone Replacement Medications.

Medication(s) included in medication management programs, including but not limited to, an amount or quantity that can be used within a set timeframe or an age limitation, may be subject to PA. Medication Management programs are subject to change and are maintained and updated as medications are FDA approved within the defined therapeutic class and as clinical

evidence requires. Medications subjected to quantity limits include, but are not limited to certain medications listed below:

1. Asthma/COPD Agents beyond defined quantity limitations;
2. Oral Antiemetics beyond defined quantity limitations;
3. Medications to treat insomnia beyond defined quantity limitations;
4. Medications used to treat migraine headaches beyond defined quantity limitations.

A certain class of medications will be managed through the PBM's Specialty Pharmacy Program. For more information, on what is covered see the "Specialty Pharmacy" section of this document. Medications that may be included in this program are used to treat chronic or complex health conditions, may be difficult to administer, may have limited availability, and/or may require special storage and handling. A subset of the medications included in the PBM Specialty Pharmacy program requires a PA.

To confirm whether you need a PA and/or to request a PA, you may call the Pharmacy Benefit Management Vendor listed on your ID card or visit the PBM website to review the formulary. Please have the information listed below when initiating your request for PA:

- Name of Medication
- Physician's Name
- Physician's Phone Number
- Physician's Fax Number, if available
- Member ID number (from ID card)
- Rx Group ID number (from ID card)

ARTICLE 5

CASE MANAGEMENT / DISEASE MANAGEMENT AND INDEPENDENT MEDICAL ASSESSMENT

5.1 Case Management

Case Management is a service provided by the Third Party Claim Administrator, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, some trained in a clinical specialty area such as high risk pregnancy or mental health, and others who work as generalists dealing with a wide range of conditions in general medicine and surgery. In addition, Case Managers are supported by physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager may recommend alternate treatment programs and help coordinate needed resources, the patient's attending physician remains responsible for ordering and guiding the actual medical care.

You, your Dependent or an attending physician may request Case Management services by calling the toll-free phone number shown on your ID card during normal business hours, Monday through Friday. In addition, the Third Party Claim Administrator or a utilization review program may refer an individual for Case Management.

Each case is accessed to determine whether Case Management is appropriate. You or your Dependent will be contacted by an assigned Case Manager who explains in detail how the program works.

Following an initial assessment, the Case Manager works with you, your family and physician to determine the needs of the patient and to identify what alternate treatment programs are available. (For example, in-home medical care in lieu of extended hospital convalescence.) You are not penalized if the alternate treatment program is not followed.

The Case Manager arranges for alternate treatment services and supplies, as needed. (For example, nursing services or a hospital bed and other durable medical equipment for the home.) The Case Manager also acts as a liaison between the patient, his or her family, and physician as needed. (For example, by helping you to understand a complex medical diagnosis or treatment plan.)

Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

Case Management professionals may offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

5.2 Disease Management

Disease Management is a service provided by the Third Party Claim Administrator, which assists Members with treatment needs for chronic conditions. If you are being treated for certain conditions which have been initiated under this program, you will be contacted by the Disease Management staff with further information on the program. The goal of Disease Management is identification of areas in which the staff may assist you with education and/or resources to maintain your health.

5.3 Independent Medical Assessment

The Plan reserves the right to require independent medical assessments to review appropriateness of treatment and possible alternative treatment options for any Member participating in the Plan. The individual medical assessments may take place on site or via medical record review and will be carried out by a licensed/board certified medical doctor specializing in the area of treatment rendered to the Member. Independent medical assessments may be utilized in instances where current treatment is atypical for the diagnosis, where the current treatment is complex and involves many different providers, and/or the current treatment is of high cost to the Plan. If an independent medical assessment is required, the enrolled person will be notified in writing.

ARTICLE 6

TRANSITION OF CARE

6.1 Transition of Care

If you are a new Member, upon written request to the Third Party Claim Administrator, you may continue an active course of treatment with your current health care provider who is a Non-Participating Provider and receive in-network benefit levels during a transitional period after the effective date of coverage if one of the following applies:

1. You have a life threatening disease or condition;
2. If you have been receiving care and a continued course of covered treatment is Medically Necessary, you may be eligible to receive "transitional care" from the Non-Participating Provider;
3. Entered the third trimester of pregnancy on the effective date of enrollment; or
4. If you are in your second trimester of pregnancy and your doctor agrees to accept our reimbursement rate and to abide by the Plan's policies and procedures and quality assurance requirements.

There may be additional circumstances where continued care by a provider no longer participating in the network will not be available, such as when the provider loses his license to practice or retires.

Transitions of Care request forms are available by contacting the Third Party Claim Administrator Customer Service Center or by visiting their Website.

ARTICLE 7

SCHEDULE OF MEDICAL BENEFITS
COVERED SERVICES AND SUPPLIES

7.1 Schedule of Medical Benefits Covered Services and Supplies Chart

It is important to note that all inpatient services and certain prescription medications require Pre-Certification/Prior Authorization. Please refer to Article 3 of this document for details.

HSA Contribution	
	Annual IRS Contribution Maximum[12]
Employee Only	$3,450
Employee plus Adult	$6,900
Employee plus Child	$6,900
Family	$6,900

	In-Network	Out-of-Network
Deductible[13] per Plan Year		
Employee Only	$1,350	$2,700
Employee plus Adult	$2,700	$5,400
Employee plus Child	$2,700	$5,400
Family	$2,700	$5,400
Out-of-Pocket Maximum [13] per Plan Year		
Employee Only	$2,000	$5,000
Employee plus Adult	$4,000	$10,000
Employee plus Child	$4,000	$10,000
Family	$4,000	$10,000

	Coinsurance[13]	
	In-Network	**Out-of-Network**
PREVENTIVE/WELLNESS SERVICES Refer to Section 7.53 for more information		
Well Child	No Copayment	50% after deductible

[12] Subject to effective date of enrollment and remaining pay periods. If Member is an eligible individual who is age 55 or older, the contribution limit is increased by $1,000.

[13] The Deductible must be met before the coinsurance will apply. There are separate In-Network and Out-of-Network Deductibles for the Plan. Deductibles or Coinsurance accumulate toward the Out-of-Pocket maximum. Refer to Section 7.5 for more information

	Coinsurance[13]	
	In-Network	**Out-of-Network**
Well Adult	No Copayment	50% after deductible
Immunizations	No Copayment	50% after deductible
Preventive Laboratory, Radiology, or Other Tests	No Copayment	50% after deductible
OUTPATIENT SERVICES Coinsurance is subject to one per day per provider		
Physician Visit General Practice, Family Practice, Obstetrics & Gynecology, Internal Medicine, and Pediatrician	10% after deductible	50% after deductible
Specialist Visit	10% after deductible	50% after deductible
Urgent Care	10% after deductible	50% after deductible
Chiropractic & Osteopathic Services	10% after deductible	50% after deductible
Minor Diagnostic and Therapeutic Laboratory and X-Ray Services Refer to Section 7.21 for more information	10% after deductible	50% after deductible
Major Diagnostic Radiology Services Refer to Section 7.21 for more information	10% after deductible	50% after deductible
Maternity Care Services Includes initial diagnosis, prenatal visits, and delivery	10% after deductible	50% after deductible
Freestanding Ambulatory Facility	10% after deductible	50% after deductible
Outpatient Surgical Facility	10% after deductible	50% after deductible
Therapy Services Refer to Short-term Rehabilitative Therapy Section 7.57	10% after deductible	50% after deductible
Allergy Testing, Treatment, or Injections	10% after deductible	50% after deductible
INPATIENT SERVICES		
Ambulance Services For medical emergency or required interfacility transport. Non-emergency transportation requires pre-certification.	10% after deductible	10% after deductible
Hospital Admission Including Intensive Care Unit and private rooms when Medically Necessary. Excludes Subacute Care, Post-Acute Care, Hospice, Bariatric Surgery, and Maternity Admission. Subacute Care includes but is not limited to long-term care, hospital based skilled nursing facilities (SNFs), and free-standing SNFs.	10% after deductible	50% after deductible

	Coinsurance[13]	
	In-Network	**Out-of-Network**
Emergency Room Must be a medical emergency as defined by the Plan. Copayment waived if admitted but subject to hospital admission copayment	10% after deductible	10% after deductible
Bariatric Surgery	20% Coinsurance	No coverage
Hospice Care	10% after deductible	50% after deductible
Skilled Nursing Facility	10% after deductible	50% after deductible
Rehabilitation and Subacute Care Facility	10% after deductible	50% after deductible
MENTAL HEALTH SERVICES		
Office Visit	10% after deductible	50% after deductible
Inpatient and Residential	10% after deductible	50% after deductible
OTHER		
Durable Medical Equipment	10% after deductible	50% after deductible
Home Health / Home Infusion Care	10% after deductible	50% after deductible
Mammography Screening	No Copayment	50% after deductible
Nutritional Evaluation	10% after deductible	50% after deductible
Organ and Tissue Transplant Services	10% after deductible	50% after deductible
Ostomy Supplies	10% after deductible	50% after deductible
Prostate Screening	No Copayment	50% after deductible

7.2 Determination of Eligible Expenses

Subject to the exclusions, conditions, and limitations stated in this document, the Plan will pay Benefits to, or on behalf of, a Member for covered Medical Expenses described in this section, up to the amounts stated in the Schedule of Benefits.

The Plan will pay Benefits for the Reasonable and Customary Charges or the contracted fee as determined by the Provider's contract with the Network for services and supplies which are ordered by a Physician. Services and supplies must be furnished by an Eligible Provider and be Medically Necessary.

The obligation of the Plan shall be fully satisfied by the payment of allowable expenses in accordance with the Schedule of Benefits. Benefits will be paid for the reimbursement of medical expenses incurred by the Member if all provisions mentioned in this document are satisfied.

All payments made under this Plan for allowable charges will be limited to Reasonable and Customary Charges or the contracted fee as determined by the Provider's contract with the Network minus all deductibles, copays and coinsurance stated in the Schedule of Benefits.

7.3 Notification, Proof of a Claim, and Payment

Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and Pre-Certification/Prior Authorization by the Third Party Claim Administrator.

Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than the second business day after admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to the Third Party Claim Administrator as soon as reasonably possible.

Coverage for Emergency Services received through Non-Participating Providers at an Inpatient or Emergency Room Facilities shall be limited to covered services to which you would have been entitled under the Plan, and shall be reimbursed at billed charges in cases where no discounts are achieved through the Third Party Claim Administrator.

Claims and supporting documentation submitted for reimbursement must meet the Timely Filing requirements and be received within one (1) year from the date the services were rendered. Claim forms are available on the Third Party Claim Administrator website at or by calling the Customer Service Center.

Foreign Claims: Request for reimbursement of foreign claims must include the following information: Employee name, Member identification number, patient name, date of service, provider name and address, detailed description of the services rendered, charges, and the currency in which the charges are being reported. Foreign travel guidelines are available on the Third Party Claim Administrator website.

7.4 Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person, if they are incurred after he becomes insured for these benefits and prior to the date coverage ends. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of a non-occupational injury or a sickness and outlined below.

The Covered Expenses available to a Member under this Plan are described below. Any applicable copayments and other limits are identified in the Schedule of Benefits. Unless otherwise authorized in writing by the Plan, Covered Expenses are available to Participants only if:

1. They are Medically Appropriate and not specifically excluded in this Article or any other Article; and
2. Pre-Certification/Prior Authorization is obtained from the Plan by the Member or provider, for those services that require Pre-Certification/Prior Authorization. To obtain Pre-Certification/Prior Authorization call the number on the back of your ID card.

If a Member uses Participating Providers for facility and physician services for a given procedure, any assistant surgeon, anesthesiologist, radiologist, and pathologist charges in connection with that procedure will be payable at the in-network level of benefits even if rendered by Non-Participating Providers. During an inpatient admission, if a consultation is required by a specialist on call at the facility causing the Member to have no control over the provider chosen, charges

in connection with the consult will be payable at the in-network level of benefits even if rendered by non-Participating Providers. Covered charges will be reimbursed at in-network benefit levels subject to Reasonable and Customary rates. Any remaining balance may be subject to billing by Non-Participating Providers and will be the responsibility of the Member.

7.5 Out-of-Pocket Maximum Provider Expenses

Out-of-Pocket Expenses are a portion of the covered expense for which the participant is financially responsible. The Plan year deductible and coinsurance paid by the Member applies to the Out-of-Pocket Maximum. The following do not apply to the accumulation of the out-of-pocket maximum:

1. Out-of-Network prescription drug costs
2. Charges in excess of Reasonable and Customary; and
3. All charges associated with a non-covered service.

For Members under the Employee Only tier:
When a Member enrolled in the HSA Plan has paid the Out-of-Pocket Maximum Expenses of $2,000 in a Plan Year for Participating Provider claims, benefits for Covered In-Network Expenses incurred during the rest of the Plan Year will be payable by the Plan at the rate of 100% of the Reasonable and Customary Charge or the contracted fee as determined by the Provider's contract with the Network. Services for Out-of-Network claims must meet a $5,000 maximum before the Plan pays 100% of the Reasonable and Customary Charge.

For Members under the Employee plus Adult, Employee plus Child, and Family Only tiers:
When a single Member enrolled in the HSA Plan has paid $2,000 of the $4,000 Out-of-Pocket Maximum Expenses in a Plan Year for Participating Provider claims, benefits for Covered In-Network Expenses incurred during the rest of the Plan Year will be payable by the Plan at the rate of 100% of the Reasonable and Customary Charge or the contracted fee as determined by the Provider's contract with the Network for that Member.

When two or more Members enrolled in the HSA Plan have paid a combined amount of the Out-of-Pocket Maximum Expenses of $4,000 in a Plan Year for Participating Provider claims in-network, benefits for Covered Expenses for the Employee and all Eligible Dependents incurred during the rest of the Plan Year will be payable at the rate of 100% of the Reasonable and Customary Charge or the contracted fee as determined by the Provider's contract with the Network. Services for Out-of-Network claims must meet a $10,000 maximum before the Plan pays 100% of the Reasonable and Customary Charge.

7.6 Autism Spectrum Disorder Services

Behavioral therapy is only covered for the treatment of Autism Spectrum Disorder as defined in Article 16.

Short-term rehabilitative therapy included in an outpatient facility or physician's office that is part of a rehabilitation program for treatment of Autism Spectrum Disorder, including physical,

speech, and occupational therapy is subject to the 60 visit benefit limitations described under Section 7.57 Short-Term Rehabilitative Therapy. The following services are excluded: Sensory Integration, LOVAAS Therapy and Music Therapy.

If multiple services are provided on the same day by different Providers, a separate copayment will apply to each Provider.

7.7 Physician Services

Physician Services are diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, virtual visits, periodic health assessments, well-child care and routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures.

7.8 Inpatient Hospital Services

Inpatient hospital services are services provided for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in another Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; admit kit; and other services which are customarily provided in acute care hospitals. Inpatient hospital services also include Birthing Centers.

7.9 Outpatient Facility Services

Outpatient facility services are services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

7.10 Emergency Services and Urgent Care

In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a referral from your Physician for emergency services, but you should call your Physician as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, contact the Third Party Claim Administrator to obtain the necessary authorizations for care or hospitalization.

If you receive emergency services outside the service area, you must notify the Third Party Claim Administrator as soon as reasonably possible. We may arrange to have you transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so in order to continue benefits at the in-network benefit level.

"Emergency Services" are defined as a medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. You are covered for at least a screening examination to determine whether an emergency exists. Care up and through stabilization for an emergency situation is covered without prior authorization.

For urgent care services, you should take all reasonable steps to contact your Physician for direction and you should receive care from a Participating Provider, unless otherwise authorized by the Plan. If you are traveling outside of the network's service area in which you are enrolled, you should, whenever possible, contact the Plan or your Physician for direction and authorization prior to receiving services.

"Urgent Care" is defined as medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are determined by the Plan in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or are scheduled to receive services. Such care includes but is not limited to: dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that you should not travel due to any medical condition.

7.11 Ambulance Service

Ambulance services to/from an appropriate provider or facility are covered for emergencies. Pre-Certification/Prior Authorization for non-emergency ambulance services may be obtained from the Third Party Claim Administrator by a provider that is treating the Member.

Covered Expenses include charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.

7.12 Bariatric Surgery

The Plan covers the following bariatric surgery procedures open roux-en-y gastric bypass (RYGBP), laparoscopic roux-en-y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), open biliopancreatic diversion with duodenal switch (BPD/DS), laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS), and laparoscopic sleeve gastrectomy (LSG) if all the following criteria are met:

1. The patient must have a body-mass index (BMI) ≥35.
2. Have at least one co-morbidity related to obesity.
3. Previously unsuccessful with medical treatment for obesity. The following medical information must be documented in the patient's medical record:

   Active participation within the last two years in one physician –supervised weight-management program for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of all of the following components:

   a. Weight
   b. Current dietary program
   c. Physical activity (e.g., exercise program)

4. In addition, the procedure must be performed at an approved Center of Excellence facility that is credentialed by your health network to perform bariatric surgery.
5. The Member must be 18 years or older, or have reached full expected skeletal growth.

If treatment was directly paid or covered by another plan Medically Necessary adjustments will be covered.

The following bariatric procedures are excluded:

1. Open vertical banded gastroplasty.
2. Laparoscopic vertical banded gastroplasty.
3. Open sleeve gastrectomy
4. Open adjustable gastric banding.

7.13 Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following services and supplies are covered:

1. Surgical services for reconstruction of the breast on which the mastectomy was performed;
2. Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
3. Post-operative breast prostheses; and

4. Mastectomy bras/camisoles and external prosthetics that meet external prosthetic placement needs.

During all stages of mastectomy, treatments of physical complications, including lymphedema, are covered.

7.14 Cancer Clinical Trials

Coverage shall be provided for Medically Necessary covered patient costs that are directly associated with a cancer clinical trial that is offered in the State of Arizona and in which the Member participates voluntarily. A cancer clinical trial is a course of treatment in which all of the following apply:

1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in the State of Arizona, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific directions for administering the therapy and monitoring patients; (e) definition of quantitative measures for determining treatment response; and (f) methods for documenting and treating adverse reactions;
2. The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial;
3. The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: (a) One of the National Institutes of Health; (b) A National Institutes of Health Cooperative Group or Center; (c) The United States Food and Drug Administration in the form of an investigational new drug application;(d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; (f) a qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility; or (g) a panel of qualified recognized experts in clinical research within academic health institutions in the State of Arizona;
4. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in the State of Arizona;
5. The personnel providing the treatment or conducting the study (a) are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise;(b) agree to accept reimbursement as payment in full from the Plan at the rates that are established by the Plan and that are not more than the level of reimbursement applicable to other similar services provided by the health care providers with the Plan's network;
6. There is no clearly superior, non-investigational treatment alternative;
7. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative;

For the purposes of this specific covered service and benefit, coverage outside the State of Arizona will be provided under the following conditions: (a) The clinical trial treatment is curative in nature; (b) The treatment is not available through a clinical trial in the State of Arizona; (c) There is no other non-investigational treatment alternative;

For the purposes of this specific covered service and benefit, the following definitions apply:

1. "Cooperative Group" – means a formal network of facilities that collaborates on research projects and that has an established national institutes of health approved peer review program operating within the group, including the National Cancer Institute Clinical Cooperative Group and The National Cancer Institute Community Clinical Oncology Program.
2. "Institutional Review Board" – means any board, committee or other group that is both: (a) formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit; and (b) approved by the National Institutes of Health Office for Protection From Research Risks.
3. "Multiple Project Assurance Contract" – means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and that sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.
4. "Patient Cost" – means any fee or expense that is covered under the Plan and that is for a service or treatment that would be required if the patient were receiving reasonable and customary care. Patient cost does not include the cost: (a) of any drug or device provided in a phase I cancer clinical trial; (b) of any investigational drug or device; (c) of non-health services that might be required for a person to receive treatment or intervention; (d) of managing the research of the clinical trial; (e) that would not be covered under the Plan; and (f) of treatment or services provided outside the State of Arizona.

7.15 Chiropractic Care Services

Chiropractic care services include diagnostic and treatment services utilized in an office setting by chiropractic Physicians and Osteopaths. Chiropractic treatment includes the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

The following are specifically excluded from chiropractic care and osteopathic services:

1. Services of a chiropractor or osteopath which are not within his scope of practice, as defined by state law;
2. Charges for care not provided in an office setting;

3. Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent reoccurrences or to maintain the patient's current status; and
4. Vitamin therapy.

Services are limited to twenty (20) visits per Member per Plan year.

7.16 Compression Garments

Compression garments for treatment of lymphedema and burns are limited to one set upon diagnosis. Coverage of up to four (4) replacements per Plan Year. When determined to Medically Necessary by the Third Party Claim Administrator and the compression stocking cannot be repaired or when required due to a change in the Member's physical condition.

7.17 Cosmetic Surgery

Cosmetic Surgery is covered for reconstructive surgery that constitutes necessary care and treatment of medically diagnosed services required for the prompt repair of accidental injury. Congenital defects and birth abnormalities are covered for Eligible Dependent Children.

7.18 Dental Confinements/Anesthesia

Facility and anesthesia services for hospitalization in connection with dental or oral surgery will be covered, provided that the confinement has been Pre-Certified because of a hazardous medical condition. Such conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer related conditions, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia). All facility services must be provided by a contracted network provider.

7.19 Dental Services – Accident only

Dental services are covered for the treatment of a fractured jaw or an Injury to sound natural teeth. Benefits are payable for the services of a Physician, dentist, or dental surgeon, provided the services are rendered for treatment of an accidental injury to sound natural teeth where the continuous course of treatment is started within six (6) months of the accident.

Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch.

7.20 Diabetic Service and Supplies

Coverage will be provided for the following Medically Necessary supplies, devices, and appliances prescribed by a health care provider for the treatment of diabetes:

1. Podiatric appliances for prevention of complications associated with diabetes; foot orthotic devices and inserts (therapeutic shoes: including Depth shoes or Custom Molded shoes.) Custom molded shoes will only be covered when the Member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and any of the following complications involving the foot:

Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. Definitions of Depth shoes and custom molded shoes are as follows:

  - Depth Shoes shall mean the shoe has a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.
  - Custom-molded shoes shall mean constructed over a positive model of the Member's foot; made from leather or other suitable material of equal quality; have removable inserts that can be altered or replaced as the Member's condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

2. Any other device, medication, equipment or supply for which coverage is required under Medicare guidelines pertaining to diabetes management; and
3. Disease Self-Management Training from a Participating Provider is covered when it has a therapeutic role in the care of diabetes.

7.21 Diagnostic and Therapeutic Services

The following outlines the benefits for outpatient major diagnostics, minor diagnostics, therapeutic treatments and scopic procedures:

The following are examples of major diagnostic services:

- Computed tomography (CT) scans
- Positron emission tomography (PET) scans
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Combination CT/PET Scans
- Nuclear medicine
- Any other diagnostic services that would be classified as a major diagnostic service as determined by the Third Party Claims Administrator.

The following are examples of minor diagnostic procedures:

- Laboratory services
- X-ray
- Ultrasounds
- Mammography

The following are examples of therapeutic procedures:

- Radiation therapy
- Chemotherapy

- Dialysis
- IV infusion therapy

Coverage is provided for diagnostic and therapeutic scopic procedures. This includes but is not limited to colonoscopy, sigmoidoscopy and upper gastrointestinal endoscopy.

Diagnostic and therapeutic scopic procedures are those scopic procedures that are done for visualization, biopsy and polyp removal. Those scopic procedures that are surgical would be covered under the Outpatient Surgical benefit.

Scopic procedures when performed in a physician office are covered under the Physician Services benefit. When performed outpatient in a hospital or alternate facility the Outpatient Surgical benefit applies.

7.22 Durable Medical Equipment

Purchase or rental of durable medical equipment and prosthetics is covered when ordered or prescribed by a Physician and provided by a vendor approved by the Plan. The determination to either purchase or rent equipment will be made by the Plan. Repair or replacement equipment is covered when approved as Medically Necessary by the Third Party Claim Administrator.

Durable medical equipment is defined as:

1. Generally for the medical or surgical treatment of an illness or injury, as certified in writing by the attending medical provider;
2. Serves a therapeutic purpose with respect to a particular illness or injury under treatment in accordance with accepted medical practice;
3. Items which are designed for and able to withstand repeated use by more than one person;
4. Is of a truly durable nature;
5. Appropriate for use in the home; and
6. Is not useful in the absence of illness or injury.

Such equipment includes, but is not limited to, breast pumps, crutches, hospital beds, wheel chairs, respirators, and dialysis machines.

Unless covered in connection with the services described in the "Inpatient Services at Other Health Care Facilities" or "Home Health Services" provisions, the following are specifically excluded:

1. Hygienic or self-help items or equipment;
2. Items or equipment primarily used for comfort or convenience such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;

3. Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
4. Institutional equipment, such as air fluidized beds and diathermy machines;
5. Elastic stockings and wigs (except where indicated for coverage);
6. Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and splints;
7. Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
8. Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars; and
9. Hearing aid batteries (except those for cochlear implants) and chargers.

7.23 External Prosthetic Appliances

The Plan covers the initial purchase and fitting of external prosthetic devices which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury, congenital defect or alopecia as a result of chemotherapy, radiation therapy, and second or third degree burns.

External prosthetic appliances shall include artificial arms and legs, wigs, hair pieces and terminal devices such as a hand or hook. Wigs and hair pieces are limited to one per Plan Year. Members must provide a valid prescription verifying diagnosis of alopecia as a result of chemotherapy, radiation therapy, second or third degree burns with a submitted claim for coverage. All other diagnosis are excluded.

Replacement of artificial arms and legs and terminal devices are covered only if necessitated by normal anatomical growth or as a result of wear and tear.

The following are specifically excluded:

1. Myoelectric prosthetic operated through or in conjunction with nerve or other electrical impulses;
2. Replacement of external prosthetic appliances due to loss or theft; and
3. Wigs or hairpieces (except where indicated for coverage above).

7.24 Family Planning Services (Contraception and Voluntary Sterilization)

Covered family planning services including:

1. Medical history;
2. Physical examination;
3. Related laboratory tests;
4. Medical supervision in accordance with generally accepted medical practice;
5. Information and counseling on contraception;
6. Implanted/injected contraceptives; and

7. After appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

7.25 Foot Orthotics

Foot Orthotic devices and inserts (covered only for diabetes mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.) See Section 7.20 Diabetic Services and Supplies:

Custom-molded shoes constructed over a positive model of the Member's foot made from leather or other suitable material of equal quality containing removable inserts that can be altered or replaced as the Member's condition warrants and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

7.26 Hearing Aids

Hearing aid devices limited to one per ear, per Plan Year when determined to be Medically Necessary by the Third Party Claim Administrator. The following services are covered:

- New or replacement hearing aids no longer under warranty (Pre-Certification/Prior Authorization required).
- Cleaning or repair
- Batteries for cochlear implants

7.27 Home Health Services

Home health services limited to a maximum of 42 visits per Member per Plan Year are covered when the following criteria are met:

1. The physician must have determined a medical need for home health care and developed a plan of care that is reviews at thirty day intervals by the physician.
2. The care described in the plan of care must be for intermittent skilled nursing, therapy, or speech services.
3. The patient must be homebound unless services are determined to be Medically Necessary by the Third Party Claim Administrator.
4. The home health agency delivering care must be certified within the state the care is received.
5. The care that is being provided is not custodial care.

A Home Health visit is considered to be up to four hours of services. Home health services do not include services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house. Physical, occupational, and speech therapy provided in the home are also subject to the 60 visit benefit limitations described under Section 7.57 Short-Term Rehabilitative Therapy.

7.28 Hospice Services

The Plan covers hospice care services which are provided under an approved hospice care program when provided to a Member who has been diagnosed by a Physician as having a terminal illness with a prognosis of six (6) months or less to live. Hospice care services include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; and home health services.

Hospice care services do not include the following:

1. Services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
2. Services and supplies for curative or life prolonging procedures;
3. Services and supplies for which any other benefits are payable under the Plan;
4. Services and supplies that are primarily to aid you or your dependent in daily living;
5. Services and supplies for respite (custodial) care; and
6. Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Hospice care services are services provided by a Hospital; a skilled nursing facility or a similar institution; a home health care agency; a hospice facility, or any other licensed facility or agency under a Medicare approved hospice care program.

A hospice care program is a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; a program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness; and a program for persons who have a terminal illness and for the families of those persons.

A hospice facility is an institution or portion of a facility which primarily provides care for terminally ill patients; is a Medicare approved hospice care facility; meets standards established by the Plan; and fulfills all licensing requirements of the state or locality in which it operates.

7.29 Immunizations

Immunizations are not subject to the annual routine visit limitation. Covered immunizations for adults and children over age 2 include:

1. Influenza, Trivalent inactivated influenza vaccine (TIV)
2. Influenza, Live attenuated influenza vaccine (LAIV)
3. Pneumococcal
4. Hepatitis A (Hep A)
5. Hepatitis B (Hep B)
6. Td/Tdap (Tetanus, diphtheria, pertussis)
7. Polio (IPV)
8. Varicella (Var)

9. Meningococcal Conjugate vaccine (MCV4)
10. MMR (Measles, mumps, rubella)
11. HPV Vaccine
12. Shingles Vaccine
13. DTap (diphtheria, tetanus, pertussis)
14. Other immunizations approved by the Plan.

Covered immunizations will be administered according to guidelines and recommendations from the Centers for Disease Control and Prevention (CDC).

7.30 Infertility Services

Diagnostic services rendered for infertility evaluation are covered. Any medical treatment and/or prescription related to infertility once diagnosed are excluded by the Plan.

7.31 Inpatient Services at Other Health Care Facilities

Inpatient services include semi-private room and board; skilled and general nursing services; Physician visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals and fluids.

Private rooms are only provided if deemed Medically Necessary by the Third Party Claim Administrator. The Plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.

7.32 Insulin Pumps and Supplies

Insulin pumps and insulin pump supplies are covered when ordered by a Physician and provided by a vendor approved by the Plan.

7.33 Internal Prosthetic/Medical Appliances

Internal prosthetic/medical appliances are prosthetics and appliances that are permanent or temporary internal aids and supports for non-functional body parts, including testicular implants following Medically Necessary surgical removal of the testicles. Medically Necessary repair, maintenance or replacement of a covered appliance is covered.

7.34 Mammograms

Mammograms are covered for routine and diagnostic breast cancer screening as follows:

1. A single baseline mammogram if you are age 35-39;
2. Once per Plan Year if you are age 40 and older.

Non-routine services covered more frequently based on recommendation of the Member's Physician if determined to be Medically Necessary by the Third Party Claim Administrator.

7.35 Maternity Care Services

Maternity care services include medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, cesarean section, spontaneous abortion (miscarriage), complications of pregnancy, and maternal risk.

Coverage for a mother and her newly born Child shall be available for a minimum of forty-eight (48) hours of inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

These maternity care benefits also apply to the natural mother of a newborn Child legally adopted by you in accordance with the Plan adoption policies.

These benefits do not apply to the newly born Child of an Eligible Dependent daughter unless placement with the Employee is confirmed through a court order or legal guardianship.

Charges incurred at the birth for the delivery of a Child only to the extent that they exceed the birth mother's coverage, if any, provided:

1. That Child is legally adopted by you within one year from date of birth;
2. You are legally obligated to pay the cost of the birth;
3. You notify the Plan of the adoption within 60 days after approval of the adoption or a change in the insurance policies, plans or company; and
4. You choose to file a claim for such expenses subject to all other terms of these medical benefits.

7.36 Medical Foods / Metabolic Supplements and Gastric Disorder Formula

Medical foods and metabolic supplements and gastric disorder formula to treat inherited metabolic disorders or a permanent disease/non-functioning condition in which a Member is unable to sustain weight and strength commensurate with the Member's overall health status are covered.

Inherited metabolic disorders triggering medical food coverage are:

1. Part of the newborn screening program as prescribed by Arizona statute; involve amino acid, carbohydrate or fat metabolism;
2. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and
3. Require specifically processed or treated medical foods that are generally available only under the supervision and direction of a physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

For non-inherited disorders, enteral nutrition is considered Medically Necessary when the Member has:

1. A permanent non-function or disease of the structures that normally permit food to reach the small bowel; or
2. A disease of the small bowel which impairs digestion and absorption of an oral diet consisting of solid or semi-solid foods.

For the purpose of this section, the following definitions apply:

"Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute. Medical Foods means modified low protein foods and metabolic formula.

"Metabolic Formula" means foods that are all of the following:

1. Formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy;
2. Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs;
3. Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and
4. Essential to a person's optimal growth, health and metabolic homeostasis.

"Modified Low Protein Foods" means foods that are all of the following:

1. Formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy.
2. Processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein;
3. Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and
4. Essential to a person's optimal growth, health and metabolic homeostasis.

For eosinophilic gastrointestinal disorder, amino acid-based formulas are considered Medically Necessary when:

1. The Member has been diagnosed with eosinophilic gastrointestinal disorder.
2. The Member is under the continuous supervision of a licensed physician.
3. There is a risk of a mental or physical impairment without the use of the formula.

The following are not considered Medically Appropriate and are not covered as a metabolic food/metabolic supplement and gastric disorder formula:

1. Standard oral infant formula;
2. Food thickeners, baby food, or other regular grocery products;
3. Nutrition for a diagnosis of anorexia; and
4. Nutrition for nausea associated with mood disorder, end-stage disease, etc.

7.37 Medical Supplies

Medical supplies include Medically Necessary supplies which may be considered disposable, however, are required for a Member in a course of treatment for a specific medical condition. Supplies must be obtained from a Participating Provider. Over the counter supplies, such as band-aids and gauze are not covered.

7.38 Mental Health and Substance Abuse Services

Mental Health Services are those services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any conditions of physiological instability requiring medical hospitalization will not be considered to be charges made for treatment of substance abuse.

The Third Party Claim Administrator will review level of care guidelines and determine whether Mental Health and Substance Abuse services will be provided in an inpatient or outpatient setting, based on the Medical Necessity of each situation.

7.39 Inpatient Mental Health Services

Inpatient Mental Health services are services that are provided by a hospital for the treatment and evaluation of mental health during an inpatient admission.

7.40 Outpatient Mental Health Services

Outpatient Mental Health Services are services by Providers who are qualified to treat mental health when treatment is provided on an outpatient basis in an individual, group or structured group therapy program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; neuropsychological testing; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health

conditions (crisis intervention and relapse prevention), outpatient testing/assessment, and medication management when provided in conjunction with a consultation.

7.41 Outpatient Substance Abuse Rehabilitation Services

Outpatient substance abuse services include services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, group, structured group or intensive outpatient structured therapy program. Intensive outpatient structured therapy programs consist of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive outpatient structured therapy programs provide nine or more hours of individual, family and/or group therapy in a week.

7.42 Mental Health and Substance Abuse Residential Treatment

Voluntary and court-ordered residential treatment for mental health and substance abuse treatment are covered.

7.43 Substance Abuse Detoxification Services

Substance abuse detoxification services include detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and medication management when provided in conjunction with a consultation. The Third Party Claim Administrator will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

7.44 Excluded Mental Health and Substance Abuse Services

The following are specifically excluded from mental health and substance abuse services:

1. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this Plan;
2. Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
3. Treatment of Chronic Conditions not subject to favorable modification according to generally accepted standards of medical practice;
4. Developmental disorders, including but not limited to:
    a. developmental reading disorders;
    b. developmental arithmetic disorders;
    c. developmental language disorders; or
    d. developmental articulation disorders.
5. Counseling for activities of an educational nature;
6. Counseling for borderline intellectual functioning;
7. Counseling for occupational problems;
8. Counseling related to consciousness raising;
9. Vocational or religious counseling;
10. I.Q. testing;
11. Marriage counseling;

12. Custodial care, including but not limited to geriatric day care;
13. Psychological testing on children requested by or for a school system;
14. Occupational/recreational therapy programs even if combined with supportive therapy forage-related cognitive decline; and
15. Biofeedback is not covered for reasons other than pain management.

7.45 Nutritional Evaluation

Nutritional evaluation and counseling from a Provider is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to:

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

All other services for the purpose of diet control and weight reduction are not covered unless required by a specifically identified condition of disease etiology. Services not covered include but not limited to: gastric surgery, intra oral wiring, gastric balloons, dietary formulae, hypnosis, cosmetics, and health and beauty aids.

7.46 Self-Management Training

Chronic Disease Self-Management Training from a Participating Provider is covered when it has a therapeutic role in the care of a diagnosed chronic disease/condition, including but not limited to:

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

7.47 Obstetrical and Gynecological Services

Obstetrical and gynecological services are covered when provided by qualified Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions.

7.48 Organ Transplant Services

Human organ and tissue transplant services are covered at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations. Due to the specialized medical care required for transplants, the Provider Network for this specific service may not be the same as the medical network in which you enrolled.

These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is an organ donor for a recipient other than a Member enrolled on the same family policy.

Organ transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform human to human organ or tissue transplants, such as:

1. Allogeneic bone marrow/stem cell;
2. Autologous bone marrow/stem cell;
3. Cornea;
4. Heart;
5. Heart/lung;
6. Kidney;
7. Kidney/pancreas;
8. Liver;
9. Lung;
10. Pancreas;
11. Small bowel/liver; or
12. Kidney/liver.

Organ transplant coverage will apply only to non-experimental transplants for the specific diagnosis. All organ transplant services other than cornea, kidney and autologous bone marrow/stem cell transplants must be received at a qualified organ transplant facility.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

7.49 Organ Transplant Travel Services

Travel expenses incurred by the Member in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Travel expenses are limited to $10,000. Organ transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available only for the recipient of a pre-approved

organ/tissue transplant from a transplant facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following:

1. Evaluation,
2. Candidacy,
3. Transplant event, or
4. Post-transplant care.

All claims filed for travel expenses must include detailed receipts, except for mileage. Transportation mileage will be calculated by the Third Party Claim Administrator based on the home address of the Member and the transplant site. Travel expenses for the Member receiving the transplant will include charges for:

1. Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
2. Transportation to and from the transplant site in a personal vehicle will be reimbursed at the standard IRS medical rate when the transplant site is more than 60 miles one way from the Member's home;
3. Lodging while at, or traveling to and from the transplant site;
4. Food while at, or traveling to and from the transplant site.

In addition to the Member being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany the Member. The term companion includes your Spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

Transplant Travel guidelines can be obtained by contacting your Third Party Claim Administrator.

7.50 Orthognathic Surgery

Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as Medically Necessary by the Third Party Claim Administrator.

7.51 Ostomy Supplies

Ostomy supplies are supplies which are Medically Necessary for care and cleaning of a temporary or permanent ostomy. Covered supplies include, but are not limited to pouches, face plates and belts, irrigation sleeves, bags and catheters, skin barriers, gauze, adhesive, adhesive remover, deodorant, pouch covers, and other supplies as appropriate.

7.52 Oxygen and the Oxygen Delivery System

Coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the service area. Oxygen services and supplies are not covered outside of the service area, except on an emergency basis.

7.53 Preventive Care Services

Preventive care services are provided on an outpatient basis at a Physician's office, an alternate facility or a hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care benefits defined under the Health Resources and Services Administration requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, benefits are available only for the most cost effective pump. The Third Party Claim Administrator will determine the following:

1. Which pump is the most cost effective;
2. Whether the pump should be purchased or rented;
3. Duration of a rental;
4. Timing of an acquisition.

Benefits are only available if breast pumps are obtained from an in-network DME provider or Physician.

For questions about preventive care benefits under this Plan contact the Third Party Claim Administrator.

7.54 Prostate Screening

Prostate specific antigen (PSA) screening and digital rectal examination (DRE) are covered annually if the following criteria is met:

1. If you are under 40 years of age and are at high risk because of any of the following:
   a. Family history (i.e., multiple first-degree relatives diagnosed at an early age)
   b. African-American race

   c. Previous borderline PSA levels
2. If you are age 40 and older.

7.55 Routine Physical

Periodic routine health examinations for Members age 4 and over by a physician are limited to one (1) visit per Member per Plan Year.

7.56 Radiation Therapy

Radiation therapy and other therapeutic radiological procedures are covered.

7.57 Short-Term Rehabilitative Therapy

Short-term rehabilitative therapy includes services in an outpatient facility or physician's office that is part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy. Covered expenses are limited to sixty (60) visits per Member per Plan Year, if deemed Medically Necessary by the Third Party Claim Administrator.

The following limitations apply to short-term rehabilitative therapy except as required for the treatment for Autism Spectrum Disorder:

1. Occupational therapy is provided only for purposes of training Members to perform the activities of daily living.
2. Speech therapy is not covered when:
   a. Used to improve speech skills that have not fully developed;
   b. Considered custodial or educational;
   c. Intended to maintain speech communication; or
   d. Not restorative in nature.
3. Phase 3 cardiac rehabilitation is not covered.

If multiple services are provided on the same day by different Providers, a separate copayment will apply to each Provider.

7.58 Surgical Procedures – Multiple/Bilateral

Multiple or Bilateral Surgical Procedures performed by one or more qualified physicians during the same operative session will be covered according to the following guidelines:

1. The lesser of the actual charges, Reasonable and Customary amount, or the contracted fee as determined by the Provider's contract with the Network will be allowed for the primary Surgical Procedure.
2. 50% of the lesser of the actual charges, Reasonable and Customary amount, or the contracted fee as determined by the Provider's contract with the Network (not to exceed the actual charge) will be allowed for the secondary Surgical Procedure.

7.59 Temporomandibular Joint (TMJ) Disorder

Benefits are payable for covered services and supplies which are necessary to treat TMJ disorder which is a result of:

1. An accident;
2. Trauma;
3. A congenital defect;
4. A developmental defect; or
5. A pathology.

Covered expenses include diagnosis and treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate treatment for TMJ, including intra-oral splints that stabilize the jaw joint.

7.60 Well Child Health Examinations

Well Child visits and immunizations are covered through 47 months as recommended by the American Academy of Pediatrics.

7.61 Well Adult Examinations

Well adult exams are covered in addition to periodic health exams. Limited to 1 visit per Member per Plan Year.

ARTICLE 8

PRESCRIPTION DRUG BENEFITS

Additional coverage of some prescription drugs not normally covered in a Medicare Part D prescription drug plan may be included in this Plan (enhanced drug coverage). To find out which drugs the Plan covers and any limitations, refer to your formulary. The amount you pay when you fill a prescription for these drugs does not count towards your total drug costs qualifying you for the Catastrophic Coverage Stage. In addition, if you are receiving Extra Help to pay for your prescriptions, you will not get any Extra Help to pay for these drugs. See your Medicare GenerationRx (Employer PDP) Evidence of Coverage booklet and formulary for more details. These documents are available at www.medicaregenerationrx.com/stateofaz.

8.1 Prescription Drug Benefits

If a Member incurs expenses for charges made by a Pharmacy for Covered Prescription Drugs, the Plan will pay a portion of the expense remaining after you have paid the required copayment shown in the Schedule of Benefits. The Prescription Drug Benefits are provided through the Plan Sponsor and administered by the Pharmacy Benefit Management vendor, an organization which has been contracted by the Plan Sponsor to perform these services.

Prescription drugs are covered In-Network only.	Co-Payment
Diabetic Supplies includes insulin, lancets, insulin syringes/needles, pre-filled cartridges, urine test strips, blood glucose testing machines, blood sugar test strips, and alcohol swabs.	Available through Mail Order and Retail Pharmacy at the Copayment outlined below.
Smoking cessation aids both prescribed and over-the counter will be covered. Member must have a prescription and present to an in-network pharmacy for the aid to be covered. Only FDA approved aids will be covered.	No charge
Prescribed preventive medication including certain aspirin, contraceptives, vitamins and other agents as recommended by the USPSTF and the CDC.	No charge

Prescription drugs are covered In-Network only.	Less than Deductible	More than Deductible less than Out-of-Pocket Maximum	Out-of-Pocket Maximum met
Retail Pharmacy (up to a 30-day supply)			
Preventive			
Generic	$15.00	$15.00	$0
Preferred Brand	$40.00	$40.00	$0
Non-Preferred Brand	$60.00	$60.00	$0

Prescription drugs are covered In-Network only.	Less than Deductible	More than Deductible less than Out-of-Pocket Maximum	Out-of-Pocket Maximum met
Non-Preventive Generic Preferred Brand Non-Preferred Brand	Member pays 100% of contracted rate.	 $15.00 $40.00 $60.00	 $0 $0 $0
Mail Order (up to a 90-day supply)			
Preventive Generic Preferred Brand Non-Preferred Brand	 $30.00 $80.00 $120.00	 $30.00 $80.00 $120.00	 $0 $0 $0
Non-Preventive Generic Preferred Brand Non-Preferred Brand	Member pays 100% of contracted rate.	 $30.00 $80.00 $120.00	 $0 $0 $0
Retail (up to a 90-day supply)			
Preventive Generic Preferred Brand Non-Preferred Brand	 $37.50 $100.00 $150.00	 $37.50 $100.00 $150.00	 $0 $0 $0
Non-Preventive Generic Preferred Brand Non-Preferred Brand	Member pays 100% of contracted rate.	 $37.50 $100.00 $150.00	 $0 $0 $0

The Member must pay a portion of Covered Prescription Drugs to receive Prescription Drug Benefits. A copayment is that portion of Covered Prescription Drugs which you are required to pay under this benefit. The Prescription Drug Co-payment is considered an Eligible Expense under the medical portion of this Plan and accumulates toward the medical Plan Out-of-Pocket Maximum.

In addition to the copayments, Members will be required to pay the Dispense as Written (DAW) penalty which is the difference in the medication cost of a generic medication versus a name-brand medication when the Member requests the brand name drug and the prescribing physician has indicated the generic equivalent substitution is allowable. The Plan will exclude Narrow Therapeutic Index drugs from the copay DAW penalties. Narrow Therapeutic Index (NTI) drugs are medications which can cause side-effects or be ineffective should the normal blood concentrations fall outside of the therapeutic window. These have been reviewed by the PBM Pharmacy and Therapeutic Committee for inclusion. NTI drugs may include transplant medications, thyroid hormones, and some seizure medications.

No payment will be made under any other section for expenses incurred to the extent that benefits are payable for those expenses under this section.

DISPENSE AS WRITTEN or "DAW" are the rules associated with how the Plan will pay for a name-brand prescription that has a generic equivalent.

DAW1 – The drug is available as a generic, but the physician has requested that the brand be dispensed to the Member. The Member will be responsible for a generic copay plus the difference in cost between the brand drug and the generic drug.

DAW2 – The drug is available as a generic, but the Member has requested that the brand be dispensed. The Member will be responsible for a generic copay plus the difference in cost between the brand drug and the generic drug.

DAW3 – The drug is available as a generic, but the pharmacist has selected that the brand be dispensed. The Member will be responsible for a generic Copay plus the difference in cost between the brand drug and the generic drug.

DAW4 – The drug is available as a generic, but the generic is not in stock and the pharmacy dispenses the brand drug. The Member will be responsible for a generic Copay plus the difference is cost between the brand drug and the generic drug.

To avoid additional cost above the copayment amounts Members should ask their doctor to prescribe any available generic equivalent medications.

The Preferred Medication List (PML), also known as a formulary, is a list of medications that will allow you to maximize the value of your prescription benefit. These medications, chosen by a committee of doctors and pharmacists, are lower-cost generics and brand names that are available at a lower cost than their more expensive brand-name counterparts. The PML is updated quarterly, and as needed throughout the year to add significant new medications as they become available. Medications that no longer offer the best therapeutic value for the Plan are deleted from the PML once a year, and a letter is sent to any Member affected by the change. To see what medications are on the PML, log on to the PBM website or contact the Customer Service Center listed on your ID card. You may also have a copy sent to you. Sharing this information with your doctor helps ensure that you are getting the medications you need, and saving money for both you and your Plan.

8.2 Covered Prescription Drugs

The term Covered Prescription Drugs means:

1. A Prescription Legend Drug for which a written prescription is required. A Legend Drug is one which has on its label "caution: federal law prohibits dispensing without a prescription";
2. Insulin; pre-filled insulin cartridges for the blind; oral blood sugar control agents;

3. Needles, syringes, glucose monitors, and machines, glucose test strips, visual reading ketone strips; urine test strips, lancets and alcohol swabs are all covered when dispensed by the mail order and retail pharmacy program
4. A compound medication of which at least one ingredient is a Prescription Legend Drug;
5. Tretinoin for individuals through age 24, without prior authorization;
6. Oral contraceptives or contraceptive devices, regardless of intended use, except that implantable contraceptive devices, such as Norplant, are not considered Covered Prescription Drugs;
7. Prenatal vitamins, upon written prescription;
8. Growth hormones (with prior-authorization); or
9. Self-Injectable drugs or medicines for which a prescription is required, except injectable infertility drugs.

8.3 Limitations

No payment will be made for expenses incurred for the following:

1. For non-legend drugs, other than those specified under ''Covered Prescription Drugs'';
2. To the extent that payment is unlawful where the person resides when expenses are incurred;
3. For charges which the person is not legally required to pay;
4. For charges which would not have been made if the person were not covered by these benefits;
5. For experimental drugs or for drugs labeled: ''Caution limited by federal law to investigational use'';
6. For drugs which are not considered essential for the necessary care and treatment of a non-occupational injury or sickness, as determined by the Third Party Claim Administrator;
7. For drugs obtained from a Non-Participating Pharmacy;
8. For any prescription filled in excess of the number specified by the Physician or dispensed more than one year from the date of the Physician's order;
9. For more than a 31-day supply when dispensed in any one Prescription Order through a Retail Pharmacy;
10. For more than a 90-day supply when dispensed in any one Prescription Order through a Participating Choice90 Retail Pharmacy or Mail-Order Pharmacy;
11. For indications not approved by the Food and Drug Administration;
12. For immunization agents, biological sera, blood or blood plasma;
13. For therapeutic devices or appliances, support garments and other non-medicinal substances, excluding insulin syringes;
14. For drugs for cosmetic purposes;
15. For tretinoin for individuals age 25 and over;
16. For administration of any drug;
17. For medication which is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution which operates, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

18. For prescriptions which an Eligible person is entitled to receive without charge from any workers' compensation or similar law or any public program other than Medicaid;
19. For non-Medically Necessary anabolic steroids;
20. For anorexients;
21. Implantable contraceptive devices;
22. For prescription vitamins not recommended for coverage by the USPSTF and CDC;
23. For all medications administered for the purpose of weight loss/obesity;
24. For treatment of erectile or sexual dysfunction (both male and female);
25. For all injectable infertility drugs; or
26. Prescription medications that have over-the-counter (OTC) equivalents, other than those drugs recommended by the USPSTF and CDC.

8.4 Specialty Pharmacy

Certain medications used for treating chronic or complex health conditions are handled through the PBM's Specialty Pharmacy Program.

The purpose of the Specialty Pharmacy Program is to assist you with monitoring your medication needs for conditions such as those listed below and providing patient education. The Program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods, special storage, handling, and delivery.

Medications for these conditions through this Specialty Pharmacy Program include but are not limited to the following:

1. Cystic Fibrosis;
2. Multiple Sclerosis;
3. Rheumatoid Arthritis;
4. Prostate Cancer;
5. Endometriosis;
6. Enzyme replacement;
7. Precocious puberty;
8. Osteoarthritis;
9. Viral Hepatitis; or
10. Asthma

Medications in the Specialty Pharmacy Program may only be obtained through contracted retail pharmacies or through the Specialty Vendor's home delivery service. You may contact the PBM to determine which retail pharmacies are contracted. Specialty medications are limited to a 30-day supply.

A Specialty Care Representative may contact you to facilitate your enrollment in the Specialty Program. Trained Specialty Care pharmacy staff is available 24 hours a day, 7 days a week to assist you or you may enroll directly into the program by calling the PBM's Customer Service Center.

8.5 Reimbursement/Filing a Claim

If you or your Dependent purchase Covered Prescription Drugs from a Participating Retail Pharmacy, you pay only the portion shown in the Schedule of Benefits at the time of purchase for covered medications. Should you need to obtain a Covered Prescription Drug prior to obtaining your Member ID card, you may file a claim form to obtain reimbursement. The claim form is available on the PBM's website.

If you or your Dependent purchases Covered Prescription Drugs from a Non-Participating Retail Pharmacy, you pay the full cost. These claims are considered not covered under any section of this Plan Description, unless the medication was obtained while traveling in a foreign country and was for an emergency. Claim forms and foreign travel guidelines are available on the PBM Vendor website.

8.6 Travel within the United States

Benefits are covered in-network. You may contact the PBM customer service center listed in your ID card to locate a pharmacy in the area in which you are traveling.

8.7 International Travel

Prescriptions cannot be mailed outside of the U.S. You may receive a one-year supply for certain prescriptions through mail-order service prior to leaving the U.S. Please call the PBM customer service center listed in your ID card to make arrangements. If you obtain non-emergency medications outside of the U.S., you will not be reimbursed.

8.8 Extended Vacation

Co-payments will be the same as you would normally pay times the number of refills you need.

If your medication is lost, stolen, or damaged, replacement medication is not covered.

ARTICLE 9

EXCLUSIONS AND GENERAL LIMITATIONS

9.1 Exclusions and General Limitations

In addition to any services and supplies specifically excluded in any other Article of this Plan Description, any services and supplies which are not described as covered are excluded.

In addition, the following are specifically excluded services and supplies:

1. Charges for services filed with the Third Party Claim Administrator beyond the Timely Filing period.
2. Care for health conditions that are required by state or local law to be treated in a public facility.
3. Care required by state or federal law to be supplied by a public school system or school district.
4. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
5. Treatment of an illness or injury which is due to war, declared or undeclared.
6. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Plan.
7. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
8. Any services and supplies which are experimental, investigational or unproven. These services may be related to medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan to be:
    a. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
    b. The subject of review or approval by an Institutional Review Board for the proposed use;
    c. The subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the Cancer Clinical Trials provision of this Plan under Covered Services and Supplies;) or

d. Not demonstrated, through existing peer reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

9. Cosmetic surgery or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis depilation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function such as surgery required to repair bodily damage a person receives from an injury.
10. Non-life threatening complications of a non-covered cosmetic surgery are not covered. This includes, but is not limited to, subsequent surgery for reversal, revision or repair related to the procedure.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics including braces, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies for a continuous course of dental treatment started within six months of an accidental injury to sound natural teeth are covered. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
12. The following bariatric procedures are excluded: open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy and open adjustable gastric banding.
13. Unless otherwise included as a covered expense, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Physician or otherwise covered under the Plan under Covered Services and Supplies.
15. Reversal of voluntary sterilization procedures and voluntary termination of pregnancy.
16. Gender reassignment surgery.
17. Treatment of erectile dysfunction and sexual dysfunction.
18. Medical and hospital care and costs for the infant child of a Dependent, unless this infant Child is otherwise Eligible under the Plan.
19. Non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, and intellectual disabilities.

20. Therapy to improve general physical condition including, but not limited to, routine long term care.
21. Consumable medical supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the Inpatient Hospital Services, Outpatient Facility Services, Home Health Services, Diabetic Services and Supplies, or Breast Reconstruction, Ostomy Supplies and Breast Prostheses.
22. Private hospital rooms and/or private duty nursing are only available during impatient stays and determined to be Medically Necessary by the Plan. Private duty nursing is available only in an inpatient setting when skilled nursing is not available from the facility. Custodial Nursing is not covered by the Plan.
23. Personal or comfort items such as television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
24. The following services are excluded: foot orthotics, corrective orthopedic shoes, and arch supports unless provided in the Diabetic Services and Supplies provision.
25. The following services and supplies are excluded: elastic/compression garments except for treatment of lymphedema and burns), garter belts, corsets, dentures, wigs/ hair pieces (except when indicated for coverage on Section 7.23), hair transplants, and treatment of alopecia or hair loss.
26. Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post-cataract surgery); routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
27. Treatment by acupuncture.
28. All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided by this Plan.
29. Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.
30. Membership costs or fees associated with health clubs, and weight loss programs.
31. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.
32. Services rendered by a midwife for the purpose of home delivery.
33. Genetic testing and therapy including germ line and somatic unless determined Medically Necessary by the Plan for the purpose of making treatment decisions.
34. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Plan's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
35. Blood administration for the purpose of general improvement in physical condition.
36. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks, except as otherwise referenced in this Plan Description. However, immunizations required for State of Arizona work related travel are covered by the Plan for all Members.

37. Cosmetics, dietary supplements, nutritional formula (except for treatment of malabsorption syndromes), and health and beauty aids.
38. Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
39. Phase 3 Cardiac rehabilitation.
40. Massage therapy, health spas, mineral baths, or saunas.
41. Coverage for any services incurred prior to the effective date of the Member or after the termination date of the Member's coverage.
42. Charges made by a hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury.
43. To the extent that payment is unlawful where the person resides when the expenses are incurred.
44. To the extent of the exclusions imposed by any certification requirement.
45. Charges made by an assistant surgeon or co-surgeon in excess of the network contracted rate.
46. Charges for supplies, care, treatment or surgery which is not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by the Plan.
47. Manipulations under anesthesia, except when determined to be Medically Necessary by the Third Party Claim Administrator.
48. Surgery for correction of Hyperhidrosis.
49. Any conditions Medicare identifies as Hospital-Acquired Conditions (HAC's), and or National Quality Forum (NQF) "Never Events".
50. Biofeedback except for Mental Health and Substance abuse only for pain management.
51. Any medical treatment and/or prescription related to infertility once diagnosed.
52. The following Autism Spectrum Disorder services are excluded Sensory Integration, LOVAAS Therapy and Music Therapy.
53. Purchase or rental of durable medical equipment and prosthetics are not covered when due to misuse, damage, lost or stolen.

In addition to the provisions of this Exclusions and Limitations section, you will be responsible for payments on a fee-for-service basis for Services and Supplies under the conditions described in the "Reimbursement" provision under Article 7 and 8 of this Plan Description.

9.2 Circumstance Beyond the Plan's Control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Plan, we will make a good faith effort to provide or arrange for the provision of the services or supplies, taking into account the impact of the event.

ARTICLE 10

COORDINATION OF BENEFITS AND OTHER SOURCES OF PAYMENT

10.1 Coordination of Benefits and Other Sources of Payment

Coordination of Benefits applies to medical services received under the terms of the Plan. Prescription medications are not subject to coordination of benefits. If you choose to obtain medications through coverage other than this Plan, amounts applied to deductible, copays, or coinsurance will not be reimbursed through this Plan.

Coordination of Benefits does not override Plan provisions, exclusions or Pre-Certification/Prior Authorization requirements as noted in this Plan Description. All Plan terms and conditions apply whether this Plan is primary or secondary.

10.2 Workers' Compensation

Benefits under this Plan will not duplicate any benefit which the Member is entitled to receive under workers' compensation law. In the event the Plan renders or pays for health services which are covered by a workers' compensation plan or included in a workers' compensation settlement, the Plan shall have the right to receive reimbursement either:

1. Directly from the entity which provides Member's workers' compensation coverage; or
2. Directly from the Member to the extent, if any, that the Member has received payment from such entity, where the Plan pays for services which are within the scope of the "Covered Services and Supplies" section of the Plan.

The Plan shall have a right of reimbursement to the extent that the Plan has made payments for the care and treatment so rendered. In addition, it is the Member's obligation to fully cooperate with any attempts by the Plan to recover such expenses.

10.3 Coordination of Benefits

This section applies if you are covered under another plan besides this health Plan or are a new Retiree and determines how the benefits under the plans will be coordinated. If you are covered by more than one health benefit plan, you should file all claims with each plan.

When coordinating benefits with Medicare for Retiree Members, the Benefit Options Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. All Retiree Plan Members who are eligible for Medicare Part B, should enroll in Medicare Part B so the Member does not assume the Part B claims costs. If a Plan Member who is eligible for Medicare Part B does not enroll in Medicare Part B, the Benefit Options Plan will only pay secondary benefits.

When enrolling on the Benefit Options Plan as a New Retiree and if eligible for Medicare Part B at the time of retirement, a grace period will be granted until the first of the month following the

retirement date. If a Plan Member who is eligible for Medicare Part B does not enroll in Medicare Part B, the Plan will only pay secondary benefits after the grace period has expired.

If you are eligible to enroll in Medicare as an active Employee, Dependent, or Retiree because of End-Stage Renal Disease, the Plan will pay for the first 30 months to 33 months depending on the coordination period, whether or not you are enrolled in Medicare and have a Medicare card. At the end of the 30 months to 33 months depending on coordination period, Medicare becomes the primary payer. If a Plan Member who is eligible for Medicare Part B does not enroll in Medicare Part B, the Plan will only pay secondary benefits after 30 months to 33 months depending on coordination period of primary coverage. The length of the coordination period is based on the treatment plan; Members that are scheduled for transplant or have at-home dialysis have a 30-month coordination period, while Members who have regular dialysis (at a facility) have a 33-month coordination period.

The prescription drug coverage offered by the Benefit Options Plan is considered Creditable Coverage. If you elect to enroll in a separate Medicare Part D Plan, you will not be permitted to continue in this Plan.

10.4 Definitions

For the purposes of this section, the following terms have the meanings set forth below them:

10.4.1. Plan

Any of the following that provides benefits or services for medical care or treatment:

1. Group insurance and/or group-type coverage, whether insured or self-insured, which neither can be purchased by the general public nor is individually underwritten, including closed panel coverage;
2. Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies; or
3. Medical benefits coverage of group, group type, and individual automobile contracts.

Each type of coverage you have in these three (3) categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefit rules, each of the parts shall be treated as a separate Plan.

10.4.2. Closed Panel Plan

A Plan that provides health benefits primarily in the form of services through a panel of employed or contracted providers and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

10.4.3. Primary Plan

The Plan that determines and provides or pays its benefits without taking into consideration the existence of any other Plan.

10.4.4. Secondary Plan

A Plan that determines and may reduce its benefits after taking into consideration copayments, coinsurance, deductibles, and the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover the Reasonable and Customary charges of any services it provided to you from the Primary Plan.

10.4.5. Allowable Expense

A necessary, customary, and reasonable health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you; but not including prescription medications obtained at a pharmacy, dental, vision or hearing care coverage. When a Plan provides benefits in the form of services, the amount of Allowable Expense for each service is determined by the Third Party Administrator contracts or any other Primary Plan, including Medicare, and is a covered benefit.

A plan which takes Medicare or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definitions of an Allowable Expense.

10.4.6. Claim Determination Period

The claim determination period corresponds to the Plan Year, but it does not include any part of a year during which you are not covered under this Plan or any date before this section or any similar provision takes effect.

10.4.7. Reasonable and Customary

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

10.5 Order of Benefit Determination Rules

A plan that does not have a coordination of benefits rule consistent with this section shall always be the primary plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation will be used:

1. The plan that covers you (the Employee, subscriber or Retiree) is primary and the plan that covers you (the Employee, subscriber or Retiree) as a Dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    a. Secondary to the plan covering the person as a Dependent; and
    b. Primary to the plan covering the person as other than a Dependent (e.g. Employee or Retiree).
2. If you are a Dependent Child whose parents are not divorced or legally separated under a decree of dissolution of marriage or of separate maintenance, the primary plan shall be

the plan which covers the parent whose birthday falls first in the calendar year as a Subscriber or Employee;

3. If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
    a. If a court decree states that one parent is responsible for the Child's health care expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    b. The plan of the parent with custody of the Child;
    c. The plan of the Spouse of the parent with custody of the Child;
    d. The plan of the parent not having custody of the Child; and
    e. The plan of the Spouse of the parent not having custody of the Child.
    f. If parents share joint custody and each parent is responsible for 50% of covered medical expenses, the plan will coordinate 50% payment of benefits with the other parent's Plan.
4. The plan that covers you as an active Employee (or as that Employee's Dependent) shall be the primary plan. The plan that covers you as a laid-off or Retired Employee (or as that Employee's Dependent) shall be the secondary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
5. The plan that covers you under a right of continuation which is provided by federal or state law shall be the secondary plan and the plan that covers you as an active Employee or Retiree (or as that Employee's Dependent) shall be the primary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
6. If one of the plans that cover you is issued out of the state whose laws govern this plan and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended, except for Active State of Arizona Employees otherwise Eligible under this Plan, however, when more than one plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

10.6 When this Plan is Secondary

If Benefit Options is the Secondary Plan, Benefit Options may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the lesser of the Primary Plan's or this Plan's Allowable Expense. The Member will remain responsible for all copays noted in the Schedule of Benefits. The Member copay is applied after the Primary Plan's processing and payment of the claim. Additionally, the Member

copay is applied to the total claim and will be allocated across claim lines as necessary, not to an individual service.

The Benefit Options Plan follows the non-duplication method of claim payment when the Plan is secondary to Medicare or another Plan. Under the non-duplication method, the secondary Plan does not reimburse any more than it would have paid (Medicare or Plan Allowed Expense) if it were the primary or only payer.

When Benefit Options is the Secondary Plan, Benefit Options will reduce benefits so that the total benefits paid by all plans during a Claim Determination Period are the lesser of:

1. Not more than one hundred (100%) percent of the total (all claim lines) of all Allowable Expenses (Medicare or other Primary Plan) or
2. The Third Party Claim Administrator's contracted provider rates

When a member has Medicare as primary, the Plan coverage (1 or 2 above) will be reduced by the amount of benefit paid by Medicare and the Plan will cover any Medicare copayments or deductibles. All Plan Member responsibility amounts (copays, deductibles, and coinsurance) noted in the Schedule of Benefits remain the Member's responsibility and are considered part of the Coordination of Benefits payment. The Member responsibility amounts are applied to the Allowed Expense after the primary insurance reimbursement and before the Plan pays; this may reduce the Plan's responsibility to a zero-dollar amount. Additionally, if the remaining responsibility after the Primary Plan's payment is less than a Member's copay for the service, the Member's copay will be reduced accordingly.

If the primary plan pays 100% of the lesser of its Allowable Expense amount or the Plan's Allowable Expense, there will be no remaining member or Plan responsibility payable (this includes member copays).

10.7 Medicare Opt-Out

If a Member chooses to receive Medicare eligible services from a provider who has opted out of Medicare, the Member enters into a payment contract with the provider. The claim must not be submitted to Medicare for payment, but may be submitted to the Plan.

1. If the member pays the Provider more than the lesser of the Medicare or Plan Allowable Expense, the Plan will deny any further payment on the claim.
2. If the member pays less than the lesser of the Medicare or Plan Allowable Expense, the claim would be treated by the Plan as if Medicare had paid as primary. The Plan would pay the remaining patient responsibility after any applicable Member Copays up to the lesser of the Medicare or Plan Allowable Expense.

If the services provided to the member are not covered by Medicare, but are eligible for payment by the Plan, the claim will be processed as follows:

1. If the member pays the provider more than the Plan Allowable Expense, the Plan will deny any further payment on the claim.
2. If the member pays less than the Plan Allowable Expense, the claim would be treated by the Plan as if a primary plan had paid. The Plan would pay the remaining patient responsibility after any applicable member copays up to the Plan Allowable Expense.

If the services provided to the member are not covered by Medicare or the Plan, the claim will be denied and the member is responsible for the full payment to the provider per the agreed upon contracted amount.

10.8 Recovery of Excess Benefits Paid

If the Plan provides payment for services and supplies that should have been paid by a Primary Plan or if payment is made for services greater than that for which the Plan is obligated to provide under this Plan, the Plan shall have the right to recover the actual payment made. When an overpayment is identified, the refund request will be initiated to the original payee of issued check. If the payee is the Provider, the Member will receive a copy of the letter. In the event the overpayment is not refunded to the Plan, the Third Party Claim Administrator may apply future claims to the balance of the overpaid amount.

The Plan shall have the sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If Benefit Options requests, the Member shall execute and deliver to us such instruments and documents as we determine are necessary to secure its rights.

10.9 Right to Receive and Release Information

The Plan, without consent of or notice to you, may obtain information from and release information to any Plan with respect to you in order to coordinate your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate your benefits pursuant to this section.

10.10 Injuries Covered under Med Pay Insurance

If you are injured because of a motor vehicle accident, and the medical expenses are covered in full or part by a medical payment provision under an automobile insurance policy (Med Pay Insurance), the Med Pay Insurance shall pay first, and the Plan shall pay only in the event the amount of Med Pay Insurance is insufficient to pay for those medical expenses.

The Plan reserves the right to require proof that Med Pay Insurance has paid the full amount required prior to making any payments.

Payment for such services and benefits shall be your responsibility. If the Plan paid in excess of their obligation, you may be asked to assist the Plan in obtaining reimbursement from Med Pay Insurance for expenses incurred in treating your injuries.

10.11 Subrogation and Right of Reimbursement Recovery

This provision applies whenever any payments are made pursuant to this Plan, to or for the benefit of any person covered by the Plan (for purposes of this provision only, such person shall be referred to herein as "Covered Person" and includes, but is not limited to the Covered Person's Dependents, Spouse, Children or other individuals in any way connected to the Covered Person to whom or for whose benefit any payments have been made under this Plan, the Member himself or herself, and all their heirs, legatees, administrators, executors, beneficiaries, successors, assigns, personal representatives, next friends, and any other representatives of such Covered Person). Such Covered Person has or may have any claim or right to recover any damages from any person or entity, including but not limited to, any tortfeasor, anyone vicariously liable for such tortfeasor, any tortfeasor's insurance company, any uninsured motorist insurance carrier, any underinsured motorist insurance carrier, and any others who are or may be liable for damages to the Covered Person (for purpose of this provision only, such person or entity shall hereinafter be collectively referred to as the "Third Party") as a result of any negligent or other wrongful act of anyone. In the event of any such payments under the Plan, the Plan shall, to the full extent of such payments, and in an amount equal to what the Plan paid, be subrogated to all rights of recovery of the Covered Person against such Third-Party. The Plan, either in conjunction with or independently of the Covered Person, shall be entitled to recover all such payments from the Third-Party. (This is the Plan's right of subrogation).

In addition to and separate from the above-described right of subrogation, in the event of any payments under the Plan to or for the benefit of any Covered Person, the Covered Person agrees to reimburse the Plan to the full extent of such payments, and in an amount equal to what the Plan paid, from any and all amounts recovered by the Covered Person from any Third Party by suit, settlement, judgment or otherwise, whether such recovery by the Covered Person is in part or full recovery of the damages incurred by the Covered Person. (This is the Plan's right of reimbursement.)

The above-described right of subrogation and right of reimbursement are not subject to offset or other reduction by reason of any legal fees or other expenses incurred by the Covered Person in pursuing any claim or right. The Plan is entitled to recover in full all such payments in subrogation and/or pursuant to the right of reimbursement first and before any payment whatsoever by the Third Party to or for the benefit of the Covered Person. The right of subrogation and/or right of reimbursement of the Plan supersedes any rights of the Covered Person to recover from any Third-Party, including situations where the Covered Person has not been fully compensated for all the Covered Person's damages. The priority of the Plan to be paid first exists as to all damages received or to be received by the Covered Person, and to any full or partial recovery by the Covered Person. The Covered Person agrees that the Covered Person's right to be made whole is superseded by the Plan's right of subrogation and/or right of reimbursement.

The Covered Person agrees to fully cooperate with the Plan in any effort by the Plan to recover pursuant to its rights of subrogation and/or reimbursement, and the Covered Person further agrees to do nothing to prejudice such rights. The Covered Person agrees to provide information

to the Plan necessary for the Plan to pursue such rights, and further agrees, if requested by the Plan, to acknowledge in writing the rights of the Plan to recover following any injury or illness giving rise to any payments under the Plan. If requested to do so by the Plan, the Covered Person agrees to assign in writing to the Plan the Covered Person's right to recover against any Third-Party without the Plan having been paid in full, then the Covered Person agrees to hold such payment in trust for the Plan and promptly notify the Plan in writing that the Covered Person is holding such funds and will release such funds to the Plan upon request by the Plan. The Covered Person further agrees to promptly notify the Plan in writing of the commencement of any litigation or arbitration seeking recovery from any Third-Party, and further agrees not to settle any claim against any Third-Party without first notifying the Plan in writing at least fourteen days before such settlement so the Plan may take actions it deems appropriate to protect its right of subrogation and/or right of reimbursement. In the event the Covered Person commences any litigation against any Third Party, the Covered Person agrees to name the Plan as a party to such litigation so as to allow the Plan to pursue its right of subrogation and/or right of reimbursement.

10.12 Statutory Liens

Arizona law prohibits Participating Providers from charging you more than the applicable Co-payment or other amount you are obligated to pay under this Plan for covered services. However, Arizona law also entitles certain Providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. This means that if you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, a Provider may be entitled to a lien against available proceeds from any such insurer or payor in an amount equal to the difference between: (1) the applicable Member Co-payment plus what the Participating Provider has received from Plan as payment for covered services, and (2) the Participating Provider's full billed charges.

10.13 Fraud

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit will lose all benefit coverage under any Plan offered by ADOA. You will not be eligible to re-enroll at a future date. Amounts paid on these claims may be deducted from your pay until all funds have been reimbursed to ADOA.

ARTICLE 11

CLAIM FILING PROVISIONS AND APPEAL PROCESS

Medicare Part D participants have dual drug coverage. For drugs covered under Medicare Part D, the following does not apply, please refer to www.medicaregenerationrx.com/stateofaz. For drugs not covered under Medicare Part D the following applies.

11.1 Discretionary Authority

The Plan Sponsor delegates to the Third Party Claim Administrator the discretionary authority to apply Plan terms and to make factual determinations in connection with its review of claims under the Plan. Such discretionary authority is intended to include, but not be limited to, the computation of any and all benefit payments. The Plan Sponsor also delegates to the Third Party Claim Administrator the discretionary authority to perform a full and fair review of each claim denial which has been appealed by the claimant or his duly authorized representative.

11.2 Claims Filing Procedure

The following claim definitions have special meaning when used in this Plan in accordance with Claim Procedures and Appeal Procedures.

"Claim" is any request for a Plan benefit or benefits made by a Member or by an authorized representative of the Member in accordance with the Plan's procedures for filing benefit claims.

"Urgent Care Claim" is a claim for medical care to which applying the time periods for making pre-service claims decisions could seriously jeopardize the claimant's life, health or ability to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without the care that is the subject of the claim. If the treating Physician determines the claim is "urgent," the Plan must treat the claim as urgent.

"Pre-Service Claim" is a request for approval of a benefit in which the terms of the Plan condition the receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Examples of a Pre-Service Claim include but are not limited to a Pre-Certification/Prior Authorization of general items or health services or a request for Pre-Determination to determine coverage for a specific procedure.

"Post-Service Claim" is a claim that under this Plan is not a Pre-Service Claim (i.e., a claim that involves consideration of payment or reimbursement of costs for medical care that has already been provided).

Requests for determinations of eligibility or general inquiries to the availability of particular Plan benefits or the circumstances under which benefits might be paid under the terms of the Plan will not be treated as a claim for benefits for the purposes of the Claim Procedures.

"Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

11.3 Notice of Claim – Post-Service Claims

In order to promptly process Post-Service Claims and to avoid errors in processing that could be caused by delays in filing, a written proof of loss should be furnished to the Third Party Claim Administrator as soon as reasonably possible. In no event, except in the absence of legal incapacity of the claimant, may proof be furnished later than one (1) year from the date upon which an expense was incurred. Except as indicated in the preceding sentence, Post-Service Claims will be barred if proof of loss (filing initial claim) is not furnished within one (1) year from the date incurred.

It is the responsibility of the Member to make certain each Post-Service Claim submitted by him or on his behalf includes all information necessary to process the claim, and that the Post-Service Claim is sent to the proper address for processing (the address on the Member's ID card). If a Post-Service Claim lacks sufficient information to be processed, or is sent to an incorrect address, the Post-Service Claim will be denied.

11.4 Initial Claim Determination

Provided a Member files a claim for benefits in accordance with the terms of the Plan specific to each type of claim, the Plan will make an initial claim determination:

1. Within 3 business days after receipt of an Urgent Care Claim by the Plan. This notice if adverse, must be provided to you in writing within 3 days of any oral communication;
2. Within 15 calendar days after receipt of a Pre-Service Claim by the Plan. This notice if adverse, must be provided in writing;
3. Within 30 calendar days after receipt of a Post-Service Claim by the Plan.

The time periods above are considered to commence upon the Third Party Claim Administrator receipt of a claim for benefits filed in accordance with the terms of the Plan specific to each type of claim, without regard to whether all of the information necessary to decide the claim accompanies the filing.

If a claim on review is wholly or partially denied, the written notice will contain the following information:

1. The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed in making the determination, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to the Member free of charge upon request. If the claim was denied because it does not meet the definition of a Covered Expense or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Member's medical circumstances can be provided free of charge to the Member upon request, including the names of any medical professionals consulted during the review process.
2. A description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;
3. A statement that the Member is entitled to request, free of charge, reasonable access to all documents, records, and other information relevant to the Member's claim.
4. For a denial involving urgent care claim, the notice will also include a description of the expedited review process for such claims. The notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 business days after the oral notice.
5. For medical claims, the notice will also include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount and the denial code. Further, the denial notice will include the following information (a) a statement that diagnosis and treatment codes are available upon request, (b) a description of the standard used in denying the claim, (c) a description of the external review process, and (d) the availability of, and contact information for, any applicable office of health insurance consumer or ombudsman to assist enrollees with internal claims and appeals and external review processes.
6. A statement notifying the Member about further appeal processes available, as established by the Third Party Claim Administrator.

11.5 Concurrent Care Decisions

Any decision by the Plan to terminate or reduce benefits that have already been granted with the potential of causing disruption to ongoing care, course of treatment, number of treatments or treatments provided as a Covered Expense before the end of such treatments shall constitute a denied claim. The Plan will provide a Member with notice of the denial at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review before the benefit is reduced or terminated. The written notice of denial will contain the information outlined above.

Any Urgent Care Claim requesting to extend an inpatient admission beyond the initial period approved during the Pre-Certification/Prior Authorization process, must be decided within 24 hours provided that the claim is made at least 24 hours prior to the expiration of the initially prescribed period. Notification will be provided in accordance with the Urgent Care Claim notice requirements outlined above.

Any Urgent Care Claim requesting to extend an outpatient course of treatment beyond the initially prescribed period of time, or number of treatments, must be decided within 3 business days. Notification will be provided in accordance with the Urgent Care Claim notice requirements outlined above.

11.6 Incomplete Urgent Care Claims Notification

In the case of an Urgent Care Claim, if additional information is required to make a claim determination, the Plan will provide the Member notification that will include a description of the information needed to complete the claim. This notice must be provided within 24 hours after receipt of the claim for an Inpatient admission and 3 business days for outpatient services. The Member shall be afforded at least 48 hours from receipt of the notice in which to provide the specified information. The Plan shall make its initial determination as soon as possible, but in no case later than 48 hours after the earlier of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the Member to provide the specified additional information.

11.7 Extensions of Time

The Plan may extend decision-making on both Pre-Service Claims and Post-Service Claims for one additional period of 15 days after expiration of the relevant initial period. Provided the Third Party Claim Administrator determines that an extension is necessary for reasons beyond control and the Plan notifies the Member prior to the expiration of the relevant initial period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the notice of extension is provided, a Member shall be afforded at least 45 days from receipt of the notice to respond. There is no extension permitted in the case of Urgent Care Claims.

11.8 Required Filing Procedures for Pre-Service Claims

In the event a Member or authorized representative of the Member does not follow the Plan's claim filing procedures for a Pre-Service Claim, the Plan will provide notification to the Member or authorized representative accordingly. For all Pre-Service Claims, the Plan must notify the Member or authorized representative, of failure to follow filing procedures within 5 calendar days (24 hours in the case of a failure to follow filing procedures for an Urgent Care Claim). Notification by the Plan may be oral unless written notification is requested by the Member or authorized representative. The notification of failure to follow filing procedures for Pre-Service Claims will apply only when a communication is received from a Member or health care professional representing the Member that specifies the identity of the Member, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, and the communication is received by the Third Party Claim Administrator.

11.9 Claims Appeal Procedures

In cases where a claim for benefits payment is denied in whole or in part, the Member may appeal the denial. This appeal provision will allow the Member to:

1. Request from the Plan a review of any claim for benefits. Such request must include:

   a. Employee name,
   b. Covered Employee's Member ID,
   c. Name of the patient, and
   d. Group/Client Identification number from the Member's ID card.
2. Request for review must be in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.
3. Submit written comments, documents, records, and other information relating to the claim.
4. Request, free of charge, reasonable access to documents, records, and other information relevant to the Member's claim. A document, record or other information is considered relevant if it was relied on in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination; demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The initial request for review must be directed to the Third Party Claim Administrator within 180 days after the claim payment date or the date of the notification of denial of benefits. In the case of Urgent Care Claims, a request for an expedited review may be submitted orally and all necessary information, including the Plan's benefit determination upon review, may be transmitted between the Plan and Member via telephone, facsimile, or other available similarly expeditious methods. Expedited appeals may be filed orally by calling the Third Party Claim Administrator Customer Service Center.

Upon request, the Plan will provide for the identification of experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied on in making the denial.

The review of the denial will be made by the Third Party Claim Administrator, or by an appropriate named fiduciary who is neither the party who made the initial claim determination nor the subordinate of such party. The review will not defer to the initial claim determination and will take into account all comments, documents, records and other information submitted by the Member without regard to whether such information was previously submitted or relied upon in the initial determination. In deciding an appeal of any denied claim that is based in whole or in part on a medical judgment, the Plan must consult with an appropriately qualified health care professional who is neither an individual who was consulted in connection with the denied claim that is the subject of the appeal nor the subordinate of any such individual.

The Third Party Claim Administrator will ensure that all claims and internal appeals for medical benefits are handled impartially. The Third Party Claim Administrator shall ensure the independence and impartiality of the persons involved in making the decision. Accordingly,

decisions regarding hiring, compensation, termination promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support an adverse benefit determination. The Third Party Claim Administrator shall ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Prior to deciding an appeal, the Third Party Claim Administrator must provide the claimant with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim.

In connection with an internal appeal of a medical claim, a claimant shall be able to review his or her file and present information as part of the review. Before making a benefit determination on review, the Third Party Claim Administrator shall provide the claimant with any new or additional evidence considered or generated by the Plan, as well as any new or additional rationale to be used in reaching the decision. The claimant shall be given this information in advance of the date on which the notice of final appeal decision is made to give such claimant a reasonable opportunity to respond.

For medical claims, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to the claim, the claimant is deemed to have exhausted the internal claims and appeals process and may request an expedited external review before the Plan's internal appeals process has been completed. However, this shall not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, the claimant may resubmit the claim for internal review and the claimant may ask the Plan to explain why the error is minor and why it meets this exception.

The Third Party Claim Administrator will provide the Member with a written response:

1. Within 3 business days after receipt of the Member's request for review in the case of Urgent Care Claims;
2. Within 15 calendar days after receipt of the Member's request for review in the case of Pre-Service Claims;
3. Within 30 calendar days after receipt of the Member's request for review in the case of Post-Service Claims.

If a claim on review is wholly or partially denied, the written notice will contain the following information:

1. The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed in making the determination, then the notice will state that a protocol was relied upon and that a copy of such protocol is

available to the Member free of charge upon request. If the claim was denied because it does not meet the definition of a Covered Health Service or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Member's medical circumstances can be provided free of charge to the Member upon request, including the names of any medical professionals consulted during the review process.

2. A statement that the Member is entitled to request, free of charge, reasonable access to all documents, records, and other information relevant to the Member's claim.
3. For a denial involving urgent care, the notice will also include a description of the expedited review process for such claims. The notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 business days after the oral notice.
4. For medical claims, the notice will also include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount and the denial code. Further, the denial notice will include the following information (a) a statement that diagnosis and treatment codes are available upon request, (b) a description of the standard used in denying the claim, (c) a description of the external review process, and (d) the availability of, and contact information for, any applicable office of health insurance consumer or ombudsman to assist enrollees with internal claims and appeals and external review processes.
5. A statement notifying the Member about potential alternative dispute resolution methods, if any.

11.10 Levels of Standard Appeal and Responsibility of Review

Level 1 is an initial appeal filed by the Member in regard to a denial of services. The Level 1 appeal must be filed within 180 days from the claim denial date. Level 1 appeals are reviewed and responded to by the Third Party Claim Administrator. The staff person reviewing the appeal will not be the person who made the initial decision.

Level 2 is a second appeal filed by the Member in regard to a denial of services in which the denial was upheld during the review of the Level 1 appeal. The Level 2 appeal must be filed within 60 days of the Level 1 denial. Level 2 appeals are reviewed and responded to by the Third Party Claim Administrator. The staff person reviewing the appeal will not be the person who made the initial decision nor the Level 1 appeal decision.

Level 3 is the third appeal filed by the Member in regard to a denial of services in which the denial was upheld during the review of the Level 2 appeal. The Level 3 appeal must be filed within 60 days of the Level 2 denial. Level 3 appeals are reviewed by an accredited Independent Review Organization (IRO) as required under federal law at no charge to the Member.

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the IRO must consider when

conducting the External Review. Within one (1) business day after making the decision, the IRO must notify you, Third Party Claim Administrator and the Plan.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. Your medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
4. The terms of your Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
6. Any applicable clinical review criteria developed and used by Third Party Claim Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO must provide written notice of the Final External Review Decision within 45 days after the IRO receives the request for the External Review. The IRO must deliver the notice of Final External Review Decision to you, Third Party Claim Administrator and the Plan.

After a Final External Review Decision, the IRO must maintain records of all claims and notices associated with the External Review process for six years. An IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate ftate or federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited Independent Review

The Plan must allow you to request an expedited Independent Review at the time you receive:

1. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal

would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

2. A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited Independent Review, Third Party Claim Administrator will determine whether the request meets the reviewability requirements set forth above for standard External Review. Third Party Claim Administrator must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to IRO

Upon a determination that a request is eligible for External Review following preliminary review, Third Party Claim Administrator will randomly assign an IRO. The IRO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you, Third Party Claim Administrator and the Plan.

11.11 Pharmacy Appeals

Medicare Part D participants have dual drug coverage. For drugs covered under Medicare Part D, the following does not apply, please refer to www.medicaregenerationrx.com/stateofaz. For drugs not covered under Medicare Part D the following applies.

If you are dissatisfied with any service received under this Prescription Drug Benefit, you are encouraged to contact the PBM Customer Service Center. Frequently, your concern can be resolved with a telephone call to a Member Service Representative. If the Customer Service Center cannot resolve your concern, you may proceed to the Appeals Procedures as set forth above by contacting the Third Party Claim Administrator. Examples of concerns include, but are not limited to, quality of service received, the design of the prescription drug benefit Plan, denial of a clinical authorization of a drug, payment amount, or denial of a claim issue.

11.12 Limitation

No action at law or in equity can be brought to recover on this Plan until the appeals procedure has been exhausted as described in this Plan.

No action at law or in equity can be brought to recover after the expiration of two (2) years after the time when written proof of loss is required to be furnished to the Third Party Claim Administrator.

ARTICLE 12

ADMINISTRATION

12.1 Plan Sponsor's Responsibilities

The Plan Sponsor shall have the authority and responsibility for:

1. Calling and attending the meetings at which this Plan's funding policy and method are established and reviewed;
2. Establishing the policies, interpretations, practices and procedures of this Plan; and issuing interpretations thereof;
3. Hiring all persons providing services to this Plan;
4. To decide all questions of eligibility;
5. Receiving all disclosures required of fiduciaries and other service providers under federal or state law; and
6. Performing all other responsibilities allocated to the Plan Sponsor in the instrument appointing the Plan Sponsor.

12.2 Third Party Claim Administrator's Responsibilities

The Third Party Claim Administrator shall have the authority and responsibility for:

1. Acting as this Plan's agent for the service of legal process;
2. Applying this Plan's provisions relating to coverage, including when a claimant files an appeal with the Third Party Claim Administrator;
3. Administering this Plan's claim procedures;
4. Rendering final decisions on review of claims as required by the application of this Plan Description;
5. Processing checks for Benefits in accordance with Plan provisions;
6. Filing claims with the insurance companies, if any, who issue stop loss insurance policies to the Third Party Claim Administrator; and
7. Performing all other responsibilities delegated to the Third Party Claim Administrator in the instrument appointing the Third Party Claim Administrator.

The Third Party Claim Administrator acting as the claims fiduciary will have the duty, power, and authority to apply the provisions of this Plan, to make factual determinations in connection with its review of claims under the Plan, and to determine the amount, manner, and time of payment of any Benefits under this Plan. All applications of the provisions of this Plan, and all determinations of fact made in good faith by the Third Party Claim Administrator, will be final and binding on the Members and beneficiaries and all other interested parties.

12.3 Advisors to Fiduciaries

A named fiduciary or his delegate may retain the services of actuaries, attorneys, accountants, brokers, employee benefit consultants, and other specialists to render advice concerning any responsibility such fiduciary has under this Plan.

12.4 Multiple Fiduciary Functions

Any named fiduciary may serve in more than one fiduciary capacity with respect to this Plan.

12.5 Notice of Appointments or Delegations

A named fiduciary shall not recognize or take notice of the appointment of another named fiduciary, or the delegation of responsibilities of a named fiduciary, unless and until the Plan Sponsor notifies the named fiduciary in writing of such appointment or delegation. The named fiduciaries may assume that an appointment or delegation continues in effect until the named fiduciary receives written notice to the contrary from the Plan Sponsor.

12.6 Written Directions

Whenever a named fiduciary or delegate must or may act upon the written direction of another named fiduciary or delegate, the named fiduciary or delegate is not required to inquire into the propriety of such direction and shall follow the direction unless it is clear on its face that the actions to be taken under that direction would be prohibited under the terms of this Plan. Moreover, such named fiduciary or delegate shall not be responsible for failure to act without written directions.

12.7 Co-Fiduciary Liability

A fiduciary shall not have any liability for a breach of fiduciary duty of another fiduciary, unless he participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take action to remedy such breach, or, through his negligence in performing his own specific fiduciary responsibilities, enables such other fiduciary to commit a breach of the latter's fiduciary duty.

12.8 Action by Plan Sponsor

Any authority or responsibility allocated or reserved to the Plan Sponsor under this Plan may be exercised by any duly authorized officer of the Plan Sponsor.

ARTICLE 13

LEGAL NOTICES

13.1 HIPAA Privacy Regulation Requirements

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Plan Sponsor and other parties as necessary to determine appropriate processing of claims.

Please refer to the Benefit Options Guide for details on the use of PHI.

13.2 Notice of Special Enrollment Rights for Health Plan Coverage

If you decline enrollment in the State of Arizona's health plan for you or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you or your Dependents maybe able to enroll in the State of Arizona Employee's health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new Dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 31 days after the marriage birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer Eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the State of Arizona's health plan if you become eligible for a state premium assistance program under Medicaid of CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your Dependent becomes eligible for special enrollment rights, you may add the Dependent to your current coverage or change to another health plan.

13.3 Patient Protection & Affordable Care Act (PPACA) Notices

Notice of Rescission

Under the PPACA, Benefit Services Division cannot retroactively cancel or terminate an individual's coverage, except in cases of fraud and similar situations. In the event that the Benefit

Services Division rescinds coverage under the allowed grounds, affected individuals must be provided at least 30 days advanced notice.

Form W-2 Notice
Pursuant to the PPACA for tax years starting on and after January 1, 2012, in addition to the annual wage and tax statement employers must report the value of each Employee's health coverage on form W-2, although the amount of health coverage will remain tax-free.

Notice about the Summary of Benefit and Coverage (SBC) and Uniform Glossary
On February 9, 2011, as part of the Affordable Care Act (ACA), the federal government announced new rules regarding the disclosure of the Summary of Benefits and Coverage (SBC) and Uniform Glossary. These regulations require group health plans and health insurance issuers that offer coverage for groups and individuals to provide access to the SBC and Uniform Glossary effective October 22, 2012. The SBC documents along with the uniform glossary will be posted electronically to the Benefit Options Website www.benefitoptions.az.gov. You may also contact Benefit Services to obtain a copy.

Notice of Nondiscrimination
Benefit Options complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Benefit Options provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, contact:

ADOA Benefit Services Division
100 N. 15th Avenue, Suite 260
Phoenix, AZ 85007
602-542-5008 or 1-800-304-3687, or email BenefitIssues@azdoa.gov

If you believe that we have failed to provide these services or discriminated based on a protected class noted above, you can also file a grievance with ADOA Benefit Services Division.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Language	Translated Taglines

1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃដែលមានក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꮷ ᏏᏢ ᏗCZᏢᏗ ᏗᏍᏕᏗ ᏒᏁᏍᏫW ᏥᏓ ᏩᏤᏢ ᏁᏘ ᏏᏒ ᏗᏂᏁᏍᏗ ᏍᏕᏁᏍᏗ ᏥᏍᏕᏁᏍᏗᏣ, ᏍᏤᏍᏕᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711

14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ‘ana aku iā ‘oe ma ka maopopo ‘ana o kēia ‘ike ma loko o kāu ‘ōlelo pono‘ī me ka uku ‘ole ‘ana. E kama‘ilio ‘oe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ‘ole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n’efu n’akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng

	nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。
28. Karen	နုအိုဉ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနုကဒိးန္ဒၢ်ဘဉ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိုၤလၢနုကျိုဉ်ဒဉ်နၢဝဲလၢတလိုဉ်ဟ့ဉ်အ ပ္ဒၢဘဉ်နၢ်ဉ်လီၤ.လၢတၢ်ကယ့နၢ်ပ့ၢ်ကတိၤကျိုးထံတၢ်တဂၤအဂီၢ်ကိ:ဘဉ်လီတဲစိအကျိုၤလၢကရၢဖိအတလိုဉ်ဟ့ဉ်အပ့ၢ်လၢအအိုဉ်လၢနုတၢ်အိုဉ်ဆူဉ်အိုဉ်ချအတၢ်ရဲၢ်တၢ်ကျဲၤ အက:အလိၤဒီ:ဆိုဉ်လီၤနီၢ်ဂၢ် 0 တက့ၢ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە TTY 711.
32. Laotian	ທ່ານມີສິດທີຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຜຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me

	ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bąąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvanian Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711

47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo''u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܝܫܘܥܐ ܕܝܠܟܝܢ ܢܨܝܒܘܬܐ ܕܫܘܬܦܘܬܐ ܕܡܠܬܐ ܕܝܠܟ ܒܠܫܢܟ ܒܚܢܡ ܕܬܐܝܡܢܘܬܐ ܕܝܠܟ ܕܒܟܪܛܐ ܕܐܝܕܝ ܕܐܢܫܝ ܕܚܝ

58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

13.4 General COBRA Notice

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become Eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Benefit Services Division.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee become entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being Eligible for coverage under the Plan as a "Dependent Child"

Sometime, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Benefit Options Plan, and that bankruptcy results in a loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a qualified beneficiary. The Retired Employee's Spouse, Surviving Spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

13.5 Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because your group health plan offers coverage for mastectomies, WHCRA applies to your Plan. The law mandates that a participant who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the Plan.

13.6 Newborns' and Mothers' Protection Act of 1996 Notice

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with Childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or a physician assistant), after consultation with the mother, discharges the mother or her newborn earlier. Also, under federal law, plans and insurers may not set the lever of benefits or out-of-pocket costs so that any later portion of the 48-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 up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. If you have any questions, contact Benefit Options at 602 542 5008 or 1 800 304 3687 or email Benefit Options at BenefitIssues@azdoa.gov.

ARTICLE 14

MISCELLANEOUS

14.1 State Law

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws to the extent such laws are not preempted by federal law.

14.2 Status of Employment Relations

The adoption and maintenance of this Plan shall not be deemed to constitute a contract between the Employer and its Employees or to be consideration for, or an inducement or condition of, the employment of an Employee. Nothing in this Plan shall be deemed to:

1. Affect the right of the Employer to discipline or discharge any Employee at any time.
2. Affect the right of any Employee to terminate his employment at any time.
3. Give to the Employer the right to require any Employee to remain in its employ.
4. Give to any Employee the right to be retained in the employ of the Employer.

14.3 Word Usage

Whenever words are used in this Plan Description in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine, or neutral form. The words "you" and "your" refer to Eligible Members as defined in Article 16.

Capitalized words in the Plan Description have special meanings and are defined in Article 16.

14.4 Titles are Reference Only

The titles are for reference only. In the event of a conflict between a title and the content of a section, the content of a section shall control.

14.5 Clerical Error

No clerical errors made in keeping records pertaining to this coverage, or delays in making entries in such records will invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any Benefits paid will be made.

ARTICLE 15

PLAN IDENTIFICATION

1. Name of Plan: State of Arizona Group Health Plan
AZ Benefit Options

2. Name and Address of Plan Sponsor:
Arizona Department of Administration
Benefit Services Division
100 N 15th Avenue Ste 260
Phoenix, AZ 85007

3. Third Party Claim Administrators:

Medical Vendor	**Aetna**
Claims Address	PO BOX 14079 Lexington, KY 40512-4079
Appeals/Correspondence Address	Attn: National Account CRT PO Box 14463 Lexington, KY 40512
Phone	866-217-1953
Fax	859-455-8650
TDD/TTY	800-628-3323
Website	www.aetna.com
Policy Number	476687

Pharmacy Vendor	**MedImpact**	**MedicareGenerationRX**
Claims Address	10680 Treena Street San Diego, CA 92103	Attn: Claims Department PO Box 509099 San Diego, CA 92150
Appeals/Correspondence Address	Attn: Appeals Coordinator 10680 Treena St 5th Floor San Diego, CA 92131	Attn: Appeals Department PO Box 509099 San Diego, CA 92150
Phone	888-648-6769	877-633-7943
Fax	858-621-5147	858-790-6060
Website	www.benefitoptions.az.gov	www.MedicareGenerationRx.com/stateofaz
Bin Number	003585	015574
Retail PCN Number	28914	ASPROD1

4. Sponsor Identification Number: 86-6004791

5. Type of Benefits Provided: See Schedule of Benefits

6. Type of Plan Administration: Self-Funded Third Party

7. Third Party Claim Administrator/Agent for Legal Process/Named Fiduciary:

Medical Vendors	**Aetna Life Insurance Company**
Address	151 Farmington Avenue Hartford, CT 06156

Pharmacy Vendor	MedImpact	MedicareGenerationRx
Address	10680 Treena Street San Diego, CA 92103	PO Box 509099 San Diego, CA 92150

8. Funding to Plan: Contributions for this Plan are provided partially by contributions of the Plan Sponsor and partially by contributions of Covered Employees

9. End of Plan's Year: December 31st of each year

ARTICLE 16

DEFINITIONS

This section contains definitions of words and phrases which are contained within this Plan description. Inclusion of medical service definitions does not imply that expenses related to those services are covered under the Plan.

ACCIDENT shall mean a specific, sudden, and unexpected event occurring by chance and resulting in bodily strain or harm.

AGENCY shall mean a department, university, board, office, authority, commission, or other governmental budget unit, of the state of Arizona.

AGENCY LIAISON shall mean the individual within each agency designated as the local Benefit Options representative.

ALCOHOLISM TREATMENT FACILITY shall mean a facility, providing inpatient or outpatient treatment for alcoholism, which is approved by the Joint Commission on Accreditation of Hospitals or certified by the health department of the state where it is located. Such a facility must also have in effect plans for utilization review and peer review.

AMBULANCE shall mean a vehicle for transportation of sick and/or injured persons equipped and staffed to provide medical care during transport.

AMBULATORY SURGICAL CENTER shall mean a licensed public or private facility which is primarily engaged in performing surgical procedures and which meets all of the following criteria:

1. Has an organized staff of physicians;
2. Has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
3. Has continuous physician services and registered professional nursing services whenever a patient is in the facility; and
4. Does not provide services or other accommodations for patients to stay overnight.

AMENDMENT shall mean a formal document that changes the provisions of this Plan Description, duly signed by the authorized person(s) as designated by the Plan sponsor.

APPLIED BEHAVIOR ANALYSIS THERAPIST shall mean a qualified therapist if all of the following is met:

1. Is certified by the Behavior Analyst Certification Board as either a:
    a. Board Certified Behavior Analyst

    b. Board Certified Associate Behavior Analyst
2. Is approved by medical management based on a combination of education, experience, and other qualifications.
3. An ABA therapist is QUALIFIED if he/she is approved by medical management based on a combination of education, experience, and other qualifications.
4. To ensure Plan coverage, qualifications of ABA providers must be established prior to receipt of services.

ARIZONA ADMINISTRATIVE CODE (A.A.C.) shall mean administrative rules promulgated by state agencies to govern the implementation of statutory intent and requirements.

ARIZONA REVISED STATUTE (A.R.S.) shall mean a law of the State of Arizona.

AUTISM SPECTRUM DISORDER shall mean one of the three following:

1. Autistic Disorder
2. Asperger's Syndrome
3. Pervasive Developmental Disorder – Not otherwise specified

BEHAVIORAL HEALTH FACILITY/CENTER shall mean a facility approved by a facility providing services under a community mental health or rehabilitation board established under state law, or certified by the health department of the state where it is located. Such a facility must also have in effect plans for utilization review and peer review.

BEHAVIORAL THERAPY shall mean interactive therapies derived from evidence based research, including applied behavior analysis, which includes discrete trail training, pivotal response training, intensive intervention programs and early intensive behavioral intervention.

BENEFIT shall mean the payment or reimbursement by this Plan of all or a portion of a medical expense incurred by a participant.

BILATERAL SURGICAL PROCEDURE shall mean any surgical procedure performed on any paired organ whose right and left halves are mirrored images of each other, or in which a median longitudinal section divides the organ into equivalent right and left halves. Surgery on both halves is performed during the same operative session and may involve one or two surgical incisions.

BIRTHING CENTER shall mean a licensed outpatient facility which provides accommodations for childbirth for low-risk maternity patients. The birthing center must meet all of the following criteria:

1. Has an organized staff of certified midwives, physicians, and other trained personnel;
2. Has necessary medical equipment;
3. Has a written agreement to transfer to a hospital if necessary; and

4. Is in compliance with any applicable state or local regulations.

CHILD shall mean a person who falls within one or more of the following categories:

1. A natural Child, adopted Child, stepchild, or foster Child of the Member who is younger than age 26;
2. A Child who is younger than age 26 for whom the Member has court-ordered guardianship;
3. A Child who is younger than age 26 and placed in the Member's home by court order pending adoption; or
4. A natural Child, adopted Child, stepchild, or foster Child of the Member who has a disability prior to age 26 and continues to have a disability under 42 U.S.C. 1382c, who is Dependent for support and maintenance upon the Member, and for whom the Member had custody prior to age 26.

COBRA shall mean the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended. This is a federal law requiring employers to offer continued health insurance coverage to Employees and Dependents whose group health coverage has terminated.

CODE shall mean the United States Internal Revenue Code of 1986, as amended.

COINSURANCE shall mean a percentage of the covered expenses for which each participant is financially responsible. Coinsurance applies after the deductible has been met.

COPAY or COPAYMENT shall mean a portion of the covered expenses for which the participant is financially responsible. Copayments are generally collected at the time of service or when billed by the Provider.

COSMETIC SERVICE shall mean a service rendered for the purpose of altering appearance, with no evidence that the service is Medically Necessary. Cosmetic service as noted in exclusions shall not include services or benefits that are primarily for the purpose of restoring normal bodily function as may be necessary due to an accidental injury, surgery, or congenital defect.

COVERED SERVICE shall mean a service which is Medically Necessary and eligible for payment under the Plan.

CREDITABLE COVERAGE shall mean a Medical Plan that offers a prescription plan which is expected to pay out as much as standard Medicare prescription coverage pays, and is therefore considered Creditable Coverage. Members are not permitted to enroll in a separate Part D plan and continue in the medical Plan as it is considered Creditable Coverage.

CUSTODIAL CARE shall mean the care generally provides assistance in performing activities of daily living (ADL), (e.g., assistance walking, transferring in and out of bed, bathing, dressing, using the toilet, and preparation of food, feeding and supervision of medication that usually can be

self-administered). Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. Also can be defined as the following:

- Custodial care is that care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care.
- Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered.
- Custodial care essentially is personal care that does not require the continuing attention or supervision of trained, medical or paramedical personnel.
- Custodial care is maintenance care provided by family members, health aids or other unlicensed individuals after an acute medical event when an individual has reached the maximum level of physical or mental function and is not likely to make further significant improvement.
- In determining whether an individual is receiving custodial care, the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.

DAY shall mean calendar day; not 24-hour period unless otherwise expressly noted.

DEDUCTIBLE shall mean the amount of covered expenses the participant must pay each Plan Year before benefits are payable by the Plan. There are separate In-Network and Out-of-Network Deductibles for the Plan.

DEPENDENT see ELIGIBLE DEPENDENT.

DURABLE MEDICAL EQUIPMENT shall mean equipment purchased for treatment/accommodation of a non-occupational medical condition which meets all of the following criteria:

1. Is ordered by a physician in accordance with accepted medical practice;
2. Is able to resist wear and/or decay and to withstand repeated usage;
3. Appropriate for use in the home; and
4. Is not useful in the absence of illness or injury.

EFFECTIVE DATE shall mean the first day of coverage.

ELECTED OFFICIAL shall mean a person who is currently serving in office.

ELIGIBLE DEPENDENT shall mean the Member's Spouse or Child who is lawfully present in the U.S.

ELIGIBLE EMPLOYEE shall mean an individual who is hired by the State, including the State Universities, and who is regularly scheduled to work at least 20 hours per week for at least 90 days. Eligible Employee does not include:

1. A patient or inmate employed at a state institution;
2. A non-state Employee, officer or enlisted personnel of the National Guard of Arizona;
3. A seasonal, temporary, or variable hour Employee, unless the Employee is determined to have been paid for an average of at least 30 hours per week using a 12-month measurement period;
4. An individual who fills a position designated primarily to provide rehabilitation to the individual;
5. An individual hired by a State University or college for whom the State University or college does not contribute to a state-sponsored retirement plan, unless the individual is:
   a. A non-immigrant alien Employee;
   b. Participating in a medical residency or post-doctoral training program;
   c. On federal appointment with cooperative extension;
   d. A Retiree who has returned to work under A.R.S. § 38-766.01.

Persons working for participating political subdivisions may also be considered Eligible Employees under the respective political subdivision's personnel rules.

ELIGIBLE FORMER ELECTED OFFICIAL shall mean an elected official as defined in A.R.S. § 38-801(3) who is no longer in office and who falls into one of the following categories:

1. Has at least five years of credited service in the Elected Officials' Retirement Plan;
2. Was covered under a group health or group health and accident plan at the time of leaving office;
3. Served as an elected official on or after January 1, 1983; and
4. Applies for enrollment within 31 days of leaving office or retiring.

ELIGIBLE RETIREE shall mean a person who Retired under a state-sponsored retirement plan and has been continuously enrolled in the Plan since time of retirement or a person who receives long-term disability benefits under a state-sponsored plan.

EMERGENCY shall mean a medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

EMPLOYEE see ELIGIBLE EMPLOYEE.

EMPLOYER shall mean the state of Arizona, one of the state universities, or a participating political subdivision.

ENROLLMENT FORM shall mean a paper form supplied by Benefit Options, a COBRA enrollment form, or an authorized self-service enrollment system.

EXPERIMENTAL OR INVESTIGATIONAL, OR UNPROVEN CHARGES shall mean charges for treatments, procedures, devices or drugs which the Medical Vendor, in the exercise of its discretion, determines are experimental, investigative, or done primarily for research. The Medical Vendor shall use the following guidelines to determine that a drug, device, medical treatment or procedure is experimental or investigative:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment, or procedure, was reviewed and approved for experimental use by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. Reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental, study or investigative arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

EXPLANATION OF BENEFITS shall mean a statement sent to participants by the Third Party Claim Administrator following payment of a claim. It lists the service(s) that was/were provided, the allowable reimbursement amount(s), amount applied to the participant's deductible, and the net amount paid by the Plan.

EXTENDED CARE FACILITY/SKILLED NURSING FACILITY shall mean an institution (or distinct part of an institution) that meets all of the following criteria:

1. Is primarily engaged in providing 24-hour-per-day accommodations and skilled nursing care inpatients recovering from illness or injury;
2. Is under the full-time supervision of a physician or registered nurse;

3. Admits patients only upon the recommendation of a physician, maintains adequate medical records for all patients, at all times has available the services of a physician under an established agreement;
4. Has established methods and written procedures for the dispensing and administration of drugs;
5. Is not, other than incidentally, a place for rest, a place for the aged, a place for substance abuse treatment; and
6. Is licensed in accordance with all applicable federal, state and local laws, and is approved by Medicare.

FOOT ORTHOTICS shall mean devices for support of the feet.

FORMER ELECTED OFFICIAL see ELIGIBLE FORMER ELECTED OFFICIAL

FRAUD shall mean an intentional deception or misrepresentation made by a Member or Dependent with the knowledge that the deception could result in some benefit to him/her or any other individual that would not otherwise be received. This includes any act that constitutes fraud under applicable federal or state law.

HEALTH CARE SAVINGS ACCOUNT (HSA) CONTRIBUTION LIMIT shall mean the annual maximum contribution limits for health savings accounts (HSAs) determined by the Internal Revenue Service (IRS). Failure to observe these limits may result in tax penalties.

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as presently enacted and as it may be amended in the future. It is a federal law intended to improve the availability and continuity of health insurance coverage.

HOME HEALTH CARE AGENCY shall mean a public agency or private organization or subdivision of an agency or organization that meets all of the following criteria:

1. Is primarily engaged in providing skilled nursing services and other therapeutic services such as physical therapy, speech therapy, occupational therapy, medical social services, or at-home health aide services. A public or voluntary non-profit health agency may qualify by furnishing directly either skilled nursing services or at least one other therapeutic service and by furnishing directly or indirectly (through arrangements with another public or voluntary non-profit agency) other therapeutic services;
2. Has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered nurse) to govern the services and provides for supervision of the services by a physician or a registered nurse;
3. Maintains complete clinical records on each patient;
4. Is licensed in accordance with federal, state and/or local laws; and
5. Meets all conditions of a home health care agency as required by Medicare.

HOMEBOUND shall be defined by Medicare as stated in Chapter 15 section 60.4.1 of the Medicare Benefit Policy Manual http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf.

HOSPICE FACILITY shall mean a facility other than a hospital which meets all of the following criteria:

1. Is primarily engaged in providing continuous skilled nursing care for terminally ill patients during the final stages of their illness and is not, other than incidentally, a rest home, home for custodial care, or home for the aged;
2. Regularly provides overnight care for patients in a residence or facility;
3. Provides 24-hour-per-day skilled nursing care by licensed nursing personnel under the direction of a full-time registered professional nurse; and
4. Maintains a complete medical record for each patient.

HOSPICE SERVICE shall mean an organization which is recognized by Medicare or which meets the following criteria:

1. Provides in-home nursing care and counseling by licensed professionals under the direction of a full-time registered professional nurse; and
2. Maintains a complete medical record for each patient; and
3. Is primarily engaged in providing nursing care and counseling for terminally ill patients during the final stages of their illnesses and does not, other than incidentally, perform housekeeping duties.

HOSPITAL shall mean a licensed facility which provides inpatient diagnostic, therapeutic, and rehabilitative services for the diagnosis, treatment and care of injured and sick persons under the supervision of a physician. Such an institution must also meet the following requirements:

1. Is accredited by the Joint Commission of Hospitals, or approved by the federal government to participate in federal and state programs;
2. Maintains a complete medical record for each patient;
3. Has by-laws which govern its staff of physicians; and
4. Provides nursing care 24 hours per day.

HOSPITAL CONFINEMENT shall refer to a situation in which:

1. A room and board charge is made by a hospital or other facility approved by the Third Party Claim Administrator, or
2. A participant remains in the hospital or other approved facility for 24 consecutive hours or longer.

ILLNESS shall mean physical disease or sickness, including pregnancy.

IMMEDIATE RELATIVE shall mean a Spouse, parent, grandparent, Child, grandchild, brother or sister of a participant, and any Dependent's family members.

IN-NETWORK shall mean utilization of services within the network of contracted providers associated with the Third Party Claim Administrator.

INJURY shall mean physical harm received by an individual as the result of any one (1) accident.

INPATIENT shall mean the classification of a participant who is admitted to a hospital, hospice facility or extended care facility/skilled nursing facility for treatment, and room-and-board charges are made as a result of such treatment.

INTENSIVE CARE UNIT shall mean an area in a hospital, established by said hospital as a formal intensive care program exclusively reserved for critically ill patients requiring constant audiovisual observation as prescribed by the attending physician, that provides room and board, specialized, registered, professional nursing and other nursing care, and special equipment and supplies immediately available on a stand-by basis, and that is separated from the rest of the hospital's facilities.

LICENSED PRACTICAL NURSE shall mean an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

MEDICAL EMERGENCY shall mean a sudden unexpected onset of bodily injury or serious illness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention.

MEDICAL EXPENSE shall mean the reasonable and customary charges or the contracted fee as determined by the provider's network contract for services incurred by the participant for Medically Necessary services, treatments, supplies or drugs. Medical expenses are incurred as of the date of the performance of the service or treatment, or the date of purchase of the supply or drug giving rise to the charge.

MEDICALLY NECESSARY/MEDICAL NECESSITY shall describe services, supplies and prescriptions, meeting all of the following criteria:

1. Ordered by a physician;
2. Not more extensive than required to meet the basic health needs;
3. Consistent with the diagnosis of the condition for which they are being utilized;
4. Consistent in type, frequency and duration of treatment with scientifically based guidelines by the medical-scientific community in the United States of America;
5. Required for purposes other than the comfort and convenience of the patient or provider;

6. Rendered in the least intensive setting that is appropriate for their delivery; and
7. Have demonstrated medical value.

MEDICARE shall mean the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

MEMBER shall mean an Eligible Employee, Eligible Retiree, or Eligible Former Elected Official that pays/contributes to the monthly premium required for enrollment in the Plan. Surviving Dependents and Surviving Children are considered Members in certain circumstances.

MENTAL or EMOTIONAL DISORDER shall mean a condition falling within categories 290 through 302 and 305 through 319 of the International Classification of Disease of the U.S. Department of Health, Education and Welfare (Health and Human Services), as amended.

MENTAL HEALTH shall mean the emotional well-being of an individual. Refer to the exclusions in the mental health section for specific information regarding any diagnosis that is not covered.

MULTIPLE SURGICAL PROCEDURES shall mean surgical procedures which are performed during the same operative session and which are not incidental or secondary to one primary procedure for which the operative session is undertaken. An "incidental procedure" is a procedure that is considered an integral part of another procedure and does not warrant a separate allowance. A "secondary procedure" is a procedure which is not part of the primary procedure for which the operative session is undertaken.

NATIONAL MEDICAL SUPPORT NOTICE shall mean the standardized federal form used by all state child support agencies to inform an employer that an Employee is obligated by court or administrative child support order to provide health care coverage for the Child(ren) identified on the notice. The employer is required to withhold any Employee contributions required by the health plan in which the Child(ren) is/are enrolled.

NETWORK PROVIDER/PARTICIPATING PROVIDER shall mean the group of health providers contracted for the purposes of providing services at a discounted rate. The network vendors provide access to these services through their contracted providers. The network vendors do not pay or process claims nor do they assume any liability for the funding of the claims or the Plan provisions. The State of Arizona has assumed all liability for claims payments based on the provisions and limitations stated in the Plan Document.

NETWORK shall mean the group of providers that are contracted with the networks associated with the Medical Vendor for the purpose of performing healthcare services at predetermined rates and with predetermined performance standards.

NON-OCCUPATIONAL ILLNESS or INJURY shall mean an illness or injury that does not arise out of and in the course of any employment for wage or profit; an illness for which the participant is not entitled to benefits under any workers' compensation law or similar legislation.

OPEN ENROLLMENT PERIOD shall mean the period of time established by the Plan sponsor when Members may enroll in the Plan or may modify their current coverage choices. When an Open Enrollment period is designated as "positive," all Members must complete the enrollment process.

OTHER PARTICIPATING HEALTH CARE FACILITY shall mean any facility other than a participating hospital or hospice facility that is operated by or has an agreement with the network(s) to render services to the participant. Examples include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.

OTHER PARTICIPATING HEALTH PROFESSIONAL shall mean an individual other than a physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and who is contracted to provide services to the participant. Examples include, but are not limited to physical therapists, home health aides and nurses.

OUTPATIENT shall mean the classification of a participant receiving medical care other than as an inpatient.

OUT-OF-NETWORK shall mean the utilization of services outside of the network of contracted providers.

OUT-OF-POCKET EXPENSE shall mean a portion of the covered expense for which the participant is financially responsible. A copayment is not considered an out-of-pocket expense until the deductible is met

OUT-OF-POCKET MAXIMUM shall mean the most any participant will pay in annual out-of-pocket expenses. Copayments do not accumulate toward the out-of-pocket maximum until the deductible is met. The following do not apply toward the accumulation of the out-of-pocket maximum:

1. Out-of-Network prescription costs;
2. All charges in excess of Reasonable and Customary; and
3. All charges associated with a non-covered service.

PARTICIPANT shall mean a Member or a Dependent.

PARTICIPATING PROVIDER/NETWORK PROVIDER see "Network Provider/Participating Provider.

PHARMACY shall mean any area, place of business, or department, where prescriptions are filled or where drugs, or compounds are sold, offered, displayed for sale, dispensed, or distributed to the public. A pharmacy must also meet all of the following requirements:

1. Licensed by the Board of Pharmacy;
2. Maintains records in accordance with federal and state regulations; and

3. Staffed with a licensed registered pharmacist.

PHYSICIAN shall mean a person duly licensed to practice medicine, to prescribe and administer drugs, or to perform surgery. This definition includes doctors of medicine, doctors of osteopathy, podiatrists, chiropractors, psychologists and psychiatrists provided that each, under his/her license, is permitted to perform services covered under this Plan and that this Plan does not exclude the services provided by such physician. This definition also includes any other physician as determined by the Medical Vendor to be qualified to render the services for which a claim has been filed. For the purposes of accidental dental treatment, the definition of a physician may include a dentist or oral surgeon.

PLAN referred to in this document shall mean a period of twelve (12) consecutive months. For active Employees, Retirees, long term disability (LTD) recipients, Former Elected Officials, Surviving Spouses of participating Retirees, and Employee's eligibility for normal retirement this period commences on January 1 and ending on December 31. Any and all provisions revised in the Plan Document will become effective January 1.

PLAN SPONSOR shall mean the Benefit Services Division of the Arizona Department of Administration.

PLAN DESCRIPTION shall mean this written description of the Benefits Options medical insurance program.

PLAN YEAR shall mean a period of 12 consecutive months, commencing January 1st and ending December 31st.

POTENTIAL MEMBER shall mean an individual who is not currently enrolled in the Plan but who meets the eligibility requirements.

PRE-CERTIFICATION/PRIOR AUTHORIZATION shall mean the prospective determination performed by the Third Party Claim Administrator to determine the Medical Necessity and appropriateness of a proposed treatment, including level of care and treatment setting.

PRESCRIPTION BENEFIT MANAGEMENT VENDOR shall mean the entity contracted by the Arizona Department of Administration to adjudicate pharmacy claims according to the provisions of the Plan document as set forth by the Plan Sponsor. The PBM vendor does not diagnose or treat medical conditions or prescribe medications.

PRESCRIPTION DRUG shall mean a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

PREMIUM shall mean the amount paid for coverage under the Plan.

PRIVATE DUTY NURSING shall mean services that are provided in a patient's residence from a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), in accordance with a physician's care plan. Private duty nursing services are provided by a licensed home care agency that is prescribed on an intermittent basis.

PRIVATE ROOM ACCOMODATIONS shall mean a hospital room containing one bed.

PROVIDER shall mean a duly licensed person or facility that furnishes healthcare services or supplies pursuant to law, provided that each, under his/her license, is permitted to furnish those services.

PSYCHIATRIC SERVICE shall mean psychotherapy and other accepted forms of evaluation, diagnosis, or treatment of mental or emotional disorders. This includes individual, group and family psychotherapy; electroshock and other convulsive therapy; psychological testing; psychiatric consultations; and any other forms of psychotherapeutic treatment as determined to be Medically Necessary by the Medical Vendor.

PSYCHOTHERAPIST shall mean a person licensed by the State of Arizona, degreed in counseling or otherwise certified as competent to perform psychotherapeutic counseling. This includes, but is not limited to: a psychiatrist, a psychologist, a pastoral counselor, a person degreed in counseling psychology, a psychiatric nurse, and a social worker, when rendering psychotherapy under the direct supervision of a psychiatrist or licensed psychotherapist.

QUALIFIED LIFE EVENT shall mean a change in a Member's or Dependent's eligibility, employment status, place of residence, Medicare-eligibility, or coverage options that triggers a 31-day period[14] in which the Member is allowed to make specific changes to his/her enrollment options. This includes, but is not limited to:

1. Change marital status such as marriage, divorce, legal separation, annulment, or death of Spouse;
2. Change in Dependent status such as birth, adoption, placement for adoption, death, or Dependent eligibility due to age;
3. Change in employment status or work schedule that affect benefits eligibility;
4. Change in residence that impacts available Plan options;
5. Compliance with a qualified medical child support order or national medical support notice;
6. Change in Medicare-eligibility;
7. Change in cost of coverage;
8. Restriction, loss, or improvement in coverage; or
9. Coverage under another employer plan.

[14] Pursuant to the Children's Health Insurance Program (CHIP) Reauthorization Act, individuals who lose Medicaid or CHIP coverage due to ineligibility have 60 days to request enrollment.

QUALIFIED MEDICAL CHILD SUPPORT ORDER shall mean a court order that provides health benefit coverage for the Child of the noncustodial parent under that parent's group health plan.

REASONABLE AND CUSTOMARY CHARGE shall mean the average charge for a service rendered in a specific geographical region and taking into account the experience, education and skill level of the provider rendering that service.

REGISTERED NURSE shall mean a graduate-trained nurse who has been licensed by a state authority after qualifying for registration.

REHABILITATION FACILITY shall mean a facility that specializes in physical rehabilitation of injured or sick patients. Such an institution must also meet all of the following criteria:

1. Qualifies as an extended care facility under Medicare;
2. Maintains a complete medical record for each patient;
3. Was established and is licensed and operated in accordance with the rules of legally authorized agencies responsible for medical institutions;
4. Maintains on its premises all the facilities necessary to provide for physician-supervised medical treatment of illness or injury; and
5. Must provide nursing services 24 hours per day by registered nurses or licensed practical nurses.

RELIABLE EVIDENCE shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure.

RETIREE see ELIGIBLE RETIREE.

SEASONAL EMPLOYEE shall mean an individual who is employed by the State for not more than six months of the year and whose employment is dependent on an easily identifiable increase in work associated with a specific and reoccurring season. Seasonal Employees do not include Employees of educational organizations who work during the active portions of the academic year.

SEMIPRIVATE ROOM ACCOMMODATION shall mean lodging in a hospital room that contains two, three, or four beds.

SERVICE AREA the nationwide network offered by the Third Party Claim Administrator.

SKILLED NURSING AND SKILLED REHABILITATION SERVICES (OUTPATIENT) shall mean those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists and speech pathologists or audiologists;
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the individual and to achieve the medically desired result; and
- Are not custodial in nature.

SPECIALIZED HOSPITAL shall mean a facility specializing in the treatment of a specific disease or condition. This includes, but is not limited to, hospitals specializing in the treatment of mental or emotional disorders, alcoholism, drug dependence, or tuberculosis.

SPOUSE shall mean the Member's legal husband or wife.

SUBROGATION shall mean the procedure used by the Plan for the purpose of obtaining reimbursement for any payments made for medical services, prescriptions and supplies rendered to a participant as a result of damages, illness or injury inflicted by a third party.

SUBSTANCE ABUSE shall mean:

Alcoholism – A condition that falls within category 303 of the International Classification of Diseases of the U.S. Department of Health, Education and Welfare (Health and Human Services), as amended.

Drug Dependence (Chemical Dependence) – A condition that falls within category 304 of the International Classification of Diseases of the U.S. Department of Health, Education and Welfare (Health and Human Services), as amended.

Refer to the exclusions for specific codes in these diagnoses ranges that are not covered.

SURGICAL PROCEDURE shall mean one or more of the following types of medical procedures performed by a physician:

1. The incision, excision, or electro cauterization of any part of the body;
2. The manipulative reduction or treatment of a fracture or dislocation, including the application of a cast or traction;
3. The suturing of a wound;
4. Diagnostic and therapeutic endoscopic procedures; or
5. Surgical injection treatments or aspirations.

SURVIVING CHILD shall mean the Child who survives upon the death of his/her insured parent.

SURVIVING DEPENDENT shall mean the Spouse/Child who survives upon the death of the Member.

SURVIVING SPOUSE shall mean the legal husband or wife of a current or Former Elected Official, Employee, or Retiree, who survives upon the death of his/her Spouse.

TEMPORARY EMPLOYEE shall mean an appointment made for a maximum of 1,500 hours worked in any agency in each calendar year. A temporary appointment Employee may work full time for a portion of the year, intermittently, on a seasonal basis, or on an as needed basis.

TERMINALLY ILL shall mean having a life expectancy of six months or less as certified in writing by the attending physician.

TIMELY FILING shall mean within one year after the date a service is rendered.

URGENT CARE FACILITY shall mean a facility other than a free clinic providing medical care and treatment of sick or injured persons on an outpatient basis. In addition, it must meet all of the following tests:

1. Is accredited by the Joint Commission on Accreditation of Hospitals, or be approved by the federal government to participate in federal and state programs;
2. Maintains on-premise diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment by or under the supervision of duly qualified physicians;
3. Is operated continuously with organized facilities for minor operative surgery on the premises;
4. Has continuous physician services and registered professional nursing services whenever a patient visits the facility; and
5. Does not provide services or other accommodations for patients to stay overnight.

VARIABLE HOUR EMPLOYEE shall mean an individual employed by the State, if based on the facts and circumstances at the Employee's start date, for whom the State cannot determine whether the Employee is reasonably expected to be employed an average of at least 30 hours per week, including any paid leave, over the applicable 12-month measurement period because the Employee's hours are variable or otherwise uncertain.