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HARRINGTON EPO PLAN

EFFECTIVE OCTOBER 1, 2007

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The wording contained within this Plan Description may be revised at any time for clarification purposes without prior notice.

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ARTICLE I

ESTABLISHMENT OF PLAN

PURPOSE

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

EXCLUSIVE BENEFIT

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

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 Plan Description has been executed with the invalid portion thereof eliminated.

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.

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 Plan 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 EPO Networks and Travel Network and do not have a contract with the Plan Sponsor or Plan Administrator.

ARTICLE II

ELIGIBILITY AND PARTICIPATION

EFFECT OF SECTION 125 REGULATIONS ON THIS PLAN

The Plan is administered in accordance with Section 125 Regulations of the Internal Revenue Code and the Arizona Administrative Code.

ENROLLMENT PROVISIONS

Standard Enrollment Period

Eligibility Effective Date for Eligible Employees (does not apply to University employees)

The 1st day of the first pay period following receipt of a properly executed enrollment and required supporting documentation; provided the request is received within thirty-one (31) days of the date of hire. Enrollment shall be completed using the Self-service enrollment option or submitting a completed Benefits Enrollment Form to your Agency or ADOA.

Eligibility Effective Date for Eligible University Employees

The 1st day of the first month following receipt of a properly executed enrollment and required supporting documentation; provided the request is received within thirty-one (31) days of the date of hire. Enrollment shall be completed using an appropriate method of notification.

Eligibility Effective Date for Eligible Retirees, Long Term Disability (LTD) Recipients, Former Elected Officials, and Surviving Spouses of participating Retirees, Employees eligible for normal retirement, LTD Recipients and Former Elected Officials.

The first payroll cycle following the end of active coverage for active employees.

For non-active employees the 1st of the month following the Plan's receipt of a completed enrollment form provided the request is received within thirty-one (31) calendar days of the qualifying event.

Sequence of Coverage

Under no circumstances will coverage for a Dependent become effective prior to the Primary Member's coverage.

Qualified Life Events

After the new hire period, you are allowed to enroll for or change coverage only during the Annual Open Enrollment Period prior to each annual Plan Year. However, exceptions are allowed if you enroll for or change coverage within thirty-one (31) days of a Qualified Life Event.

The following is a list of Qualified Life Events:

1. Change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation under a decree of dissolution of marriage or of separate maintenance;
2. Change in number of dependents due to birth, adoption, placement for adoption, legal guardianship;
3. Change in the number of dependents due to death of a dependent;
4. Change in employment status of Employee due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under Family and Medical Leave Act (FMLA) or change in worksite;
5. Changes in employment status of Employee, spouse or dependent resulting in eligibility or ineligibility for coverage (e.g., full-time to part-time status);
6. Changes in residence of Employee, spouse or dependent that affects network options available for the Employee;
7. Change in dependent status which cause a dependent to become eligible or ineligible for coverage;

Any changes in coverage must pertain directly to the change in status. In regard to the birth of a child, the effective date of the Qualified Life Event is the actual date of birth. Newborns not enrolled by the Primary Member within thirty-one (31) days of the child's birth are not considered eligible until the following Annual Open Enrollment Period.

Court Order

A change in coverage due to and consistent with a qualified medical child support order (QMCSO) of the Employee or other person to cover an Eligible Dependent or Spouse to whom the Employee is legally married as defined by Arizona Revised Statute. A court order does not, in any way, override or provide exceptions to the services covered or excluded under this Plan.

Medicare Eligibility/Entitlement

When a Retiree, LTD, Former Elected Official, Surviving Spouse or an eligible dependent becomes Medicare Eligible either by age or disability, payment of the health insurance claims will be coordinated with Medicare as primary and the Plan secondary. It is the Member's responsibility to notify the Plan when he/she becomes Medicare eligible.

The Member may cancel or reduce coverage due to entitlement to Medicare, or may enroll or increase coverage due to loss of Medicare eligibility. The Effective Date will be the first of the month following ADOA's receipt of the paperwork.

Please see the Coordination of Benefits section for further information concerning payment of your health care claims.

CHANGE IN COST OF COVERAGE

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

When the Plan Sponsor determines that a change in cost is significant, you may either increase your contribution or elect less-costly coverage.

OTHER CHANGES IN COVERAGE

The following are additional situations in which you may change your current coverage:

1. Restriction or Loss of Coverage – If your coverage is significantly restricted or ceases entirely, you may revoke your elections and elect coverage under another option that provides similar coverage. Coverage is considered "significantly restricted" if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election.
2. Addition to or Improvement in Coverage – If the Plan Sponsor adds a coverage option or significantly improves a coverage option during the Plan Year, and you elected a different option providing similar coverage, you may revoke your existing election and elect the newly added or newly improved option.

3. Changes in Coverage under Another Employer Plan – If your spouse is employed and his or her employer’s plan allows for a change in your family members’ coverage (either during that employer’s open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family coverage during his or her employer’s open enrollment period, you may request to end your coverage under the Plan effective the date of coverage for the new plan.
4. Loss of Other Group Health Plan Coverage – If you or your spouse or dependent child(ren) lose coverage under another group health plan sponsored by a governmental or education institution, including a state children’s health insurance program (SCHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll for coverage under this Plan.

CONSISTENCY REQUIREMENTS

The changes you make to your coverage must be “on account of and correspond with” the event. To satisfy the “consistency rule,” both the event and the corresponding change in coverage must meet all the following requirements:

1. Effect on Eligibility – The event must affect eligibility for coverage under the Plan or under a plan sponsored by your Eligible Spouse’s employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.
2. Corresponding election change – The election change must correspond with the event. For example, if your dependent child(ren) loses eligibility for coverage under the terms of the Plan, you may cancel health coverage only for that dependent child(ren). You may not cancel coverage for yourself or other covered dependents, and you may not change the health plan in which you are enrolled.

TIME PERIOD FOR MAKING CHANGES

If you experience one of the events described above and want to make a change to your coverage due to such event, you must notify your Agency or ADOA within thirty-one (31) days of the event. If you do not

notify your Agency or ADOA within the thirty-one (31) period, you will not be able to make any changes to your coverage until the next Annual Open Enrollment Period.

Please note that in order to change your benefit elections due to a change in status, you will be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.).

EFFECTIVE DATES FOR QUALIFIED LIFE EVENTS CHANGES

Excluding a Change in number of dependents due to birth, placement for adoption, legal guardianship;

Coverage is effective as noted below following receipt of a properly executed enrollment and required supporting documentation; provided the request is received within thirty-one (31) days of the Qualified Life Event.

Eligibility Effective Date for Eligible Employees (does not apply to University employees)

The 1st day of the first pay period following receipt of a properly executed enrollment and required supporting documentation.

Eligibility Effective Date for Eligible University Employees

Effective dates for University employees can not be made prior to the Qualified Life Event. The effective dates of coverage may be based on the University payroll schedule. Consult with your Human Resources Office to determine the effective date of change and for the documentation you are required to submit.

Eligibility Effective Date for Eligible Retirees, Long Term Disability (LTD) Recipients, Former Elected Officials, and Surviving Spouses of participating Retirees, Employees eligible for normal retirement, LTD Recipients and Former Elected Officials

The 1st of the month following the Plan's receipt of a completed enrollment form.

ELIGIBILITY PROVISIONS QUALIFIED LIFE EVENTS

Eligibility Effective Date for Newborns

Any Eligible Dependent child of the Eligible Employee or Employee's Legal Spouse born while the Employee is covered under the Plan will

become covered under the Plan on the date of his/her birth if the Employee has family coverage. Coverage for the child will end on the 31st day if the Employee does not provide their Agency or ADOA with written notification within thirty-one (31) days of the date of birth. If the Employee provides their Agency or ADOA with the written notification within thirty-one (31) days of the date of birth , coverage for that child will become effective the date of the child's birth.

Eligibility Effective Date for Adopted Children

On the date of the adoption or pending adoption pursuant to A.R.S. Section 8-105 or Section 8-108, provided enrollment is within thirty-one (31) days of the date the child is legally placed with you for adoption or within thirty-one (31) days of the date you are granted legal guardianship.

Eligibility Effective Date for Foster Care Placement

An Eligible Dependent of the Employee placed by a court order in a foster care arrangement while the Employee is covered for Medical Insurance will become covered for Medical Insurance as follows provided enrollment is within thirty-one (31) days of the date of placement:

For non-University Employees:

The 1st day of the first pay period following receipt of a properly executed enrollment and required supporting documentation.

For University Employees:

Effective dates for University employees can not be made prior to the Qualified Life Event. The effective dates of coverage may be based on the University payroll schedule. Consult with your Human Resources Office to determine the effective date of change and for the documentation you are required to submit.

For Eligible Retirees, Long Term Disability (LTD) Recipients, Former Elected Officials, and Surviving Spouses of participating Retirees, Employees eligible for normal retirement, LTD Recipients and Former Elected Officials:

The 1st of the month following the Plan's receipt of a completed enrollment form.

Eligibility Effective Date for Spouses

An Eligible Spouse of the Employee entering into marriage while the Employee is covered under this Plan will become covered for Medical

Insurance as follows provided enrollment is within thirty-one (31) days of the date of marriage:

For non-University Employees:

The 1st day of the first pay period following receipt of a properly executed enrollment and required supporting documentation.

For University Employees:

Effective dates for University employees can not be made prior to the Qualified Life Event. The effective dates of coverage may be based on the University payroll schedule. Consult with your Human Resources Office to determine the effective date of change and for the documentation you are required to submit.

For Eligible Retirees, Long Term Disability (LTD) Recipients, Former Elected Officials, and Surviving Spouses of participating Retirees, Employees eligible for normal retirement, LTD Recipients and Former Elected Officials:

The 1st of the month following the Plan's receipt of a completed enrollment form.

Active Primary Member Eligibility

Any Employee as defined by Arizona Administrative Code (A.A.C) R2-5-416, R2-5-418, R2-5-419, and R2-4-420.

Dependent Eligibility

Any Eligible Dependent of an Eligible Employee or Eligible Retiree may be covered by this Plan if the Employee or Retiree enrolls for family coverage, subject to the provisions stated in this Article and as defined by A.A.C. R2-5-101.10 or in compliance with Federal and State law regarding a Medical Child Support Order or National Medical Support Notice.

Eligibility of Eligible Employees or Eligible Retirees Married to Each Other

Eligible Employees or Eligible Retirees who are married to each other may enroll as individuals or as a family unit; however, no person shall be covered both as a Primary Member and as a Dependent. Eligible Dependents may enroll as Dependents of one (1) Primary Member or the other, but not as both.

Verification of Eligibility

The Plan Administrator has the right to request information needed to determine an individual's eligibility for Benefits under this Plan.

Notification

The Plan Sponsor shall give all Eligible Members reasonable notification of their eligibility to become Members under this Plan and of the availability and terms of this Plan.

TERMINATION OF COVERAGE

For an Employee

An Employee's coverage under this Plan will terminate at the earliest of the following times:

1. For any Employee who fails to remit required contributions for their coverage when due, at the end of the period for which the last contribution was made.
2. For an Employee, at 11:59pm on the last day of the pay period in which employment in an eligible class ceases.
3. For any Employee whose coverage has been extended under the provisions set forth in this Plan Description 11:59pm on the last day that the Employee is eligible for coverage through such an extension of coverage.
4. For any Employee whose coverage has been continued under COBRA, at 11:59pm on the last day that the Employee is eligible for such coverage.
5. At 11:59pm the last day of the pay period following the date an Employee becomes an active member of the armed forces of any country other than the United States of America.
6. At 11:59pm on the date that this Plan is terminated.

For a Dependent

A Dependent's coverage under this Plan will terminate at the earliest of the following times:

1. At the earliest of any time when coverage ceases for the covered Employee.
2. For any Dependent whose coverage has been continued under COBRA, at 11:59pm on the last day that the Dependent is eligible for such coverage.
3. At At 11:59pm the day before the Dependent child reaches the limiting age (19) for non-student Dependents.

4. At 11:59pm on the last day of the month in which a Dependent child, who has already reached the limiting age for non-student Dependents, ceases to be a Full-Time Student. If a Dependent child ceases classes for a period longer than one school term, termination is retroactive to the last day of the month in which the classes ceased.
5. At 11:59pm the day before the Dependent child, who is a Full-Time Student, reaches the limiting age (25) for Student Dependents.
6. At 11:59pm on the date when a Dependent child is legally married.
7. At 11:59pm on the date that a Dependent becomes an active member of the armed forces of any country other than the United States of America.
8. At 11:59pm on the date when the Employee is relieved of a court-ordered obligation to furnish health care coverage for a child.
9. At 11:59pm on the date when a covered Dependent Spouse is legally separated under a decree of dissolution of marriage or of separate maintenance or divorced from the covered Employee; or their marriage is legally annulled or dissolved.
10. On the date of the Dependent's death.

For a Retiree, LTD Member or Surviving Spouse

A Member's coverage under this Plan will terminate at the earliest of the following times:

1. For any Member who fails to remit required premiums for his/her coverage when due, at the end of the period for which the last contribution was made or as agreed upon by the Plan.
2. For a Retiree, at 11:59pm on the last day in which coverage in an eligible class ceases.
3. For any Retiree whose coverage has been extended under the provisions set forth in this Plan Description 11:59pm on the last day that the Retiree is eligible for coverage through such an extension of coverage. For an LTD participant, at 11:59pm on the last day of the month in which the disability ends.
4. For an LTD participant, at 11:59pm on the last day of the month in which the disability ends.
5. At 11:59pm on the date that this Plan is terminated.

Upon termination in this Plan, you will receive a HIPAA certificate of credible coverage that confirms you had medical coverage and states the period of time coverage was in effect. If you become eligible for other medical coverage that excludes or delays coverage for certain

pre-existing conditions, you may be able to use this certificate to receive credit against the new plan's pre-existing condition limit for the time you were covered under this Plan.

CONTINUATION OF COVERAGE UNDER COBRA

Under a federal law known as COBRA, you and/or your covered Dependents may be eligible to continue group health coverage under this Plan (called "COBRA coverage") at group rates. This COBRA coverage is available in certain instances, called "qualifying events," where group health coverage under this Plan would otherwise end. You may elect to continue group health coverage at your own expense on an after-tax basis when the group health coverage that you have through this Plan ends. The COBRA coverage described below may change as permitted or required by changes in any applicable law.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. For more information, contact the ADOA Benefits Office at 602-542-5008 OR 1-800-304-3687, or write to 100 N 15th Ave. Suite 103, Phoenix, AZ 85007.

COBRA coverage is provided subject to your eligibility for coverage as described below. The State of Arizona (the "State") reserves the right to terminate your coverage retroactively if it's determined that you're ineligible under the terms of the Plan.

You'll have to pay the entire cost of coverage – your share and the State's share – plus an administrative fee. There's a grace period of 30 days for the payment of the regularly scheduled premium. A 45-day grace period applies for your first premium payment.

COBRA at a glance

The following table provides an overview of available COBRA coverage. See the sections following the table for more details.

Who Is Affected	Qualifying or Other Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	You leave employment with the State for reasons other than gross misconduct	You, your Dependent spouse, and Dependent children (who lose coverage)	Up to 18 months
	You experience a reduction in hours with the State below the level required for benefit eligibility	You, your Dependent spouse, and Dependent children (who lose coverage)	Up to 18 months
	You are Social Security disabled when you become eligible for COBRA or within the first 60 days after an 18-month COBRA continuation coverage period begins	You, your Dependent spouse, and Dependent children (who lose coverage)	Up to 29 months*
Your Dependent Spouse or Child	You die	Your Dependent spouse, and Dependent children (who lose coverage)	Up to 36 months
	You and your spouse become divorced or legally separated under a decree of dissolution of marriage or of separate maintenance	Your Dependent spouse: Dependent children if the decree causes them to lose coverage	Up to 36 months

Who Is Affected	Qualifying or Other Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
	Your Dependent spouse and/or Dependent child is disabled when he/she becomes eligible for COBRA or within the first 60 days after an 18-month COBRA continuation coverage period begins	You, your Dependent spouse, and Dependent children (who lose coverage)	Up to 29 months*
Your Dependent Child	Your Dependent child is no longer an eligible Dependent (for example, due to age limit)	Your Dependent child (who loses coverage)	Up to 36 months

*You're required to provide proof of eligibility for Social Security disability benefits to be eligible for the additional 11 months of COBRA coverage. Proof is required before the end of the 18 month period.

Who is eligible for COBRA

If you're enrolled in group health coverage under the Plan on the day before a qualifying event, you have the right to choose COBRA coverage if you lose that coverage because of a reduction in your hours of employment with the State, including retirement, or the termination of your employment with the State (unless you're terminated because of your gross misconduct).

If you're an Eligible Retiree enrolled in group health coverage under the Plan, you and/or your Surviving Spouse or Dependent children enrolled in group health coverage under the Plan may also have COBRA coverage rights due to a bankruptcy proceeding with respect to the State under Title 11 of the U.S. Code.

If you're enrolled in the group health coverage under the Plan at the time you begin a leave of absence qualifying under the Family and Medical Leave Act (FMLA) and don't return to work following your FMLA leave, the event that will trigger COBRA coverage is the date that you indicate you won't be returning to work following the leave or the last day of the FMLA leave period, whichever is earlier.

If you're the Dependent spouse of an Employee and you're enrolled in group health coverage under the Plan on the day before the qualifying event, you may be considered a qualified beneficiary. That means you have the right to choose COBRA coverage for yourself if you lose group health coverage under the Plan for any of the following qualifying events:

- Your spouse dies;
- Your spouse's employment with the State is terminated (for reasons other than your spouse's gross misconduct) or your spouse's hours of employment with the State are reduced;
- You divorce or legally separate under a decree of dissolution of marriage or of separate maintenance from your Employee spouse;
- There's a bankruptcy proceeding with respect to the State under Title 11 of the U.S. Code.

If you're a Dependent child of an Employee and you're enrolled in health coverage under the Plan on the day before the qualifying event, you may be considered a qualified beneficiary. This means you have the right to COBRA coverage if your group health coverage under the Plan is lost for any of the following qualifying events:

- The Employee dies;
- The Employee's employment with the State is terminated (for reasons other than the Employee's gross misconduct) or the Employee's hours of employment with the State are reduced;
- The Employee divorces or legally separates under a decree of dissolution of marriage or of separate maintenance;
- You cease to be a "Dependent child" under the Plan; or
- There's a bankruptcy proceeding with respect to the State under Title 11 of the U.S. Code.

If the covered Employee elects COBRA coverage and then has a child (either by birth, adoption or placement for adoption) during that period of COBRA coverage, the new child is a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing the Plan Administrator with a written notice of the new child's birth, adoption or placement for adoption at Fiserv Health - Harrington, PO BOX 1143, Dayton, OH 45401-1143 within thirty-one (31) days of the date of birth, adoption or placement for adoption. This written notice should include information about the Employee or qualified beneficiary receiving COBRA coverage and the new child who will be receiving COBRA coverage. The Plan Administrator may ask you to provide documentation supporting the birth, adoption or placement for adoption of the new child.

If the covered Employee fails to notify the Plan Administrator within the 31 day time period in writing or provide the requested documentation (in accordance with the terms of the Plan), the covered Employee won't be offered the option to elect COBRA coverage for the new child. Newly acquired Eligible Dependents (other than children born to, adopted by, or placed for adoption with the employee) won't be considered qualified beneficiaries but may be added to the employee's COBRA coverage as dependents by notifying the Plan Administrator according to the Plan's rules that apply to active Employees.

Your duties

Under the law, an active Employee, a family member, or their representative must inform the ADOA Benefits Office of a divorce, legal separation under a decree of dissolution of marriage or of separate maintenance, or child's loss of Dependent status under the Plan. This notice must be provided within 60 days from the latest of (1) the date of the divorce, legal separation under a decree of dissolution of marriage or of separate maintenance, or loss of Dependent status or (2) the date group health coverage under the Plan is lost (or would be lost) because of the event.

Notice must be provided to the ADOA Benefits Office in writing at the following address:

100 N 15th Ave. Suite 103, Phoenix, AZ 85007.

The notice must include information about the Employee or qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual's right to COBRA coverage. In addition, the employee or qualified beneficiary may be required to provide the ADOA Benefits Office with documentation supporting the occurrence of the qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the ADOA:

- Divorce – a copy of the divorce decree;
- Legal separation – a copy of the separation agreement; and
- Child no longer qualifying as a Dependent – a copy of a driver's license or birth certificate showing the child's age (in the case of a child's becoming too old for coverage), a copy of the child's marriage certificate (in the case of the child's marriage), or a letter from a university or institution indicating a change in student status.

If an active Employee, family member, or personal representative fails to provide the written notice and the applicable supporting documentation to the ADOA Benefits Office during this 60-day period, any family member who loses group health coverage under the Plan will lose the right to elect COBRA coverage.

When the ADOA Benefits Office is notified that one of these events has happened, it will in turn notify you that you have the right to choose COBRA coverage.

State's duties

Qualified beneficiaries will be notified of the right to elect COBRA coverage (without any action required by the Employee or a family member) if they lose coverage because of any of the following events:

- The Employee dies;
- The Employee's employment with the State is terminated (for reasons other than the employee's gross misconduct) or the Employee's hours of employment with the State are reduced;
- The State files for bankruptcy protection.

Electing COBRA

To elect or inquire about COBRA coverage, contact your Agency or the ADOA Benefits Office at 602-542-5008 OR 1-800-304-3687, or write to 100 N 15th Ave. Suite 103, Phoenix, AZ 85007.

Under the law, you have 60 days to elect COBRA coverage measured from the date you would lose your active group health coverage because of one of the qualifying events described earlier, or, if later, 60 days from the date of the COBRA notice. An Employee or family member who doesn't choose COBRA coverage within the time period described above loses the right to elect COBRA coverage. The Employee and family members will be required to reimburse the Plan for any claims mistakenly paid after the date coverage would normally have ended.

If you choose COBRA coverage, your coverage will be the same group health coverage under the Plan you had immediately before the event and the same group health coverage that is being provided to similarly situated beneficiaries. "Similarly situated" refers to a current Employee or Dependent who hasn't had a qualifying event. You'll have the same opportunity to change group health coverage as active Employees have, e.g. at annual enrollment or if you gain a new Dependent. This also means that if the coverage for similarly situated Employees or

Dependents is modified, your coverage will be modified in the same way. Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

Separate elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a Dependent spouse or Dependent child may elect COBRA coverage even if the covered Employee chooses not to. However, an Employee or Dependent spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor Dependent child.

Length of COBRA coverage

If elected, COBRA coverage begins on the date your coverage as an active employee ends. For Dependents who no longer satisfy the requirements for Dependent coverage, COBRA coverage begins on the date their Dependent coverage ends. However, coverage won't take effect unless COBRA coverage is elected as described above and the required premium is received. The maximum duration of COBRA coverage depends on the reason you or your covered Dependents are eligible for COBRA coverage.

If group health coverage ends because of your termination of employment or reduction in hours, COBRA coverage may continue for you and your covered Dependent spouse and Dependent children for up to 18 months.

COBRA coverage for your covered Dependent spouse and Dependent children may continue for up to 36 months if their coverage would otherwise end because:

- You die;
- You divorce or legally separate under a decree of dissolution of marriage or of separate maintenance; or
- Your Dependent child loses eligibility for coverage.

However, if termination of employment or reduction of hours follows Medicare entitlement, the COBRA coverage period for your Dependent spouse and Dependent children is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer.

Additional qualifying events

Your Dependent spouse and Dependent children may have additional qualifying events while they are covered by COBRA. These events may

extend their 18-month continuation period to 36 months, but in no event will they have more than 36 months of COBRA measured from the date of the loss of coverage due to the first qualifying event that originally allowed them to elect coverage. This extension may be available to the Dependent spouse and any Dependent children receiving COBRA coverage if the Employee or former Employee dies, or gets divorced or legally separated under a decree of dissolution of marriage or of separate maintenance, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the additional event would have caused the Dependent spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The law requires a qualified beneficiary to notify the Plan Administrator if any of these additional qualifying events occur. This notice must be provided within 60 days from the latest of (1) the date of the second qualifying event or (2) the date coverage would have been lost because of the event.

Notice of the additional qualifying event must be provided in writing to Fiserv Health - Harrington, Inc. at PO BOX 1143, Dayton OH 45401-1143. You may call Fiserv Health - Harrington at 1-800-523-9398 ext. 8869.

The notice must include information about the qualified beneficiary requesting additional COBRA coverage and the qualifying event that gave rise to the individual's right to additional COBRA coverage. In addition, the qualified beneficiary may be required to provide the Plan Administrator with documentation supporting the occurrence of the qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the Plan Administrator:

- Death – a copy of the death certificate;
- Divorce – a copy of the divorce decree;
- Legal separation – a copy of the separation agreement;
- Child no longer qualifying as a dependent – a copy of a driver's license or birth certificate showing the child's age (in the case of a child's becoming too old for coverage), a copy of the child's marriage certificate (in the case of the child's marriage), or a letter from a university or institution indicating a change in student status.

If a qualified beneficiary (or their representative) fails to provide the appropriate notice and supporting documentation, if required, to the

Plan Administrator during the 60-day notice period, the qualified beneficiary won't be entitled to extended COBRA coverage.

Special rules for disability

The 18 months of COBRA coverage may be extended to 29 months if an Employee or covered Dependent spouse or Dependent child is determined by the Social Security Administration to be disabled at the time of the first qualifying event or at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the covered Employee's termination of employment or reduction in hours with the State. It applies even to family members who aren't disabled.

To benefit from the extension, the qualified beneficiary must provide The Plan Administrator with the disability determination within 60 days after the later of (1) the Social Security Administration's determination of disability, (2) the date on which a qualifying event occurs, or (3) the date coverage is lost (or would be lost) because of the qualifying event. The notice of Social Security disability must be furnished to the Plan Administrator before the end of the original 18-month COBRA coverage period.

If, during COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the Plan Administrator must be informed within 30 days of either the re-determination or the date on which the qualified beneficiary is informed of the responsibility to provide the notice and the procedures for providing such notice. This notice must be provided in writing to the Plan Administrator. The notice must include information about the employee or covered family member requesting a disability COBRA coverage extension or notifying the Plan Administrator that he/she is no longer disabled.

The 11-month COBRA extension will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

If a qualified beneficiary is receiving COBRA coverage under a disability extension and has another qualifying event during the 29-month continuation period, then the COBRA coverage period extends until 36 months after the date coverage was originally lost due to the first qualifying event. The qualified beneficiary must provide the appropriate

notice to Fiserv Health - Harrington at PO BOX 1143, Dayton OH 45401-1143. You may also call Fiserv Health – Harrington at 1-800-523-9398 ext. 8869.

Early termination of COBRA coverage

The law provides that your COBRA coverage may be cut short before the expiration of the 18-, 29- or 36-month period for any of the following reasons:

- The State no longer provides group health coverage to any of its Employees;
- The premium for COBRA coverage isn't paid on time (within the applicable grace period);
- The qualified beneficiary becomes covered – after the date COBRA coverage is elected – under another group health plan that doesn't contain any applicable exclusion or limitation for any pre-existing condition of the individual;
- The qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected; or
- Coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated early because of your participation in that other plan.

COBRA and FMLA

Taking an approved leave under the Family and Medical Leave Act (FMLA) isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if:

- You or your Dependent is enrolled in group health coverage under the Plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave); and
- You don't return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the following:

- When you definitively inform the ADOA Benefits Office or your Agency that you're not returning to work; or
- The end of the leave, if you don't return to work.

Cost of COBRA Coverage

Under the law, you may be required to pay up to 102% of the cost of COBRA coverage. If your coverage is extended from 18 months to 29 months for disability, you may be required to pay up to 150% of the cost of COBRA coverage beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, the Plan Administrator will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the Plan has been charging less than the maximum permissible amount, if the qualified beneficiary changes coverage level, or in the case of a disability extension.

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of 30 days. COBRA premiums must be received or postmarked prior to the end of the 30 day grace period.

Contacting the COBRA Administrator

If you have any questions about COBRA coverage or the application of the law, contact the Plan Administrator at the addresses listed below:

Fiserv Health - Harrington
PO BOX 1143
Dayton, OH 45401-1143

Or you may call 1-800-523-9398 ext. 8869 for assistance.

Information about COBRA provisions for state and local governmental employees is available from the:

Centers for Medicare & Medicaid Services
Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16
Baltimore, MD 21244-1850

Or you may call 410-786-1565 for assistance. This is not a toll-free number. The CMS website is www.cms.hhs.gov.

Also, you must notify the Plan Administrator in writing immediately at the address listed below if:

- Your marital status has changed;
- You, your Dependent spouse or child has changed address; or

- A Dependent loses eligibility for dependent coverage under the terms of the Plan.

All notices and other communications regarding COBRA coverage and the Plan-sponsored group health plan should be directed to the Plan Administrator:

Fiserv Health - Harrington
PO BOX 1143
Dayton, OH 45401-1143

Or you may call 1-800-523-9398 ext. 8869 for assistance.

Coverage certificate

When your COBRA coverage ends, you automatically receive a certificate of coverage that:

- Confirms that you had whatever medical coverage you continued through COBRA; and
- States how long you were covered.

If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you may use this certificate, in combination with the certification provided at the termination of coverage due to the initial qualifying event, to receive credit – against the new plan's pre-existing condition limit – for the time you were covered by the Plan-sponsored group health coverage.

In addition to the certificate you receive automatically, you also may request an additional certificate within 24 months after coverage ends. You should contact the Plan Administrator for additional certificates at:

Fiserv Health - Harrington
PO BOX 1143
Dayton, OH 45401-1143

Or you may call 1-800-523-9398 ext. 8869 for assistance.

REINSTATEMENT OF COVERAGE

COBRA Members

An Employee who has elected COBRA continuation of coverage will be considered to have had no lapse of coverage, provided that the coverage is in effect on the day before the Employee returns to eligible employment.

Reinstatement of Coverage after Termination of Employment

If an Employee terminates his employment with the Plan Sponsor and is subsequently rehired by the Plan Sponsor within the same Plan Year, deductible, coinsurance, and maximum benefit accumulators will continue from the level met at the time of termination. Reinstatement of coverage will occur the first day of the month following your Agency's or ADOA's receipt of a completed enrollment form provided the request is received within thirty-one (31) days of the qualifying event.

Reinstatement of Coverage Following a Military Leave of Absence

Regardless of established leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee or Dependent entering military service. Additional information concerning the USERRA may be obtained from your Agency or ADOA.

ELIGIBILITY DUE TO FAMILY MEDICAL LEAVE ACT (FMLA)

An Employee who is on approved FMLA leave is eligible to participate in the Plan by paying the employee contribution for medical coverage.

The medical coverage of an individual on FMLA who fails to pay insurance premiums or contributions when due shall terminate at 11:59 pm on the last day of the period covered by the last premium or contribution paid.

ELIGIBILITY DUE TO INDUSTRIAL LEAVE WITHOUT PAY

An Employee who is on leave without pay due to an industrial illness or injury may continue to participate in the Plan for a maximum of six (6) months from the date of illness or injury by paying the employee contribution for medical coverage.

At the end of the 6-month period, an Employee who remains on leave without pay due to industrial illness or injury may continue to participate in the Plan by paying both the State and Employee contributions until the Employee returns to work or is determined to be eligible for Medicare coverage or Long-term Disability, whichever occurs first.

The insurance coverage of an individual on leave without pay who fails to pay insurance premiums or contributions when due shall terminate at

11:59 pm on the last day of the period covered by the last premium or contribution paid.

ELIGIBILITY DUE TO NON-OCCUPATIONAL LEAVE

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 to continue participation in the Plan shall terminate on the earliest of:

1. Receipt of long-term disability benefits for which there is eligibility to continue the Plan participation under A.A.C. R2-5-418(A)(3);
2. A determination of eligibility for Medicare coverage; or
3. Thirty (30) months after the incapacity began.

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 (6) months by paying both the State and the Employee contributions.

The insurance coverage of an individual on leave without pay who fails to pay insurance premiums or contributions when due shall terminate at 11:59pm on the last day of the period covered by the last premium or contribution paid.

ELIGIBILITY DUE TO MILITARY LEAVE

An Employee who is on leave without pay due to entering military service, may continue to participate in the Plan for a maximum of twenty-four (24) months by paying both the State and the Employee contributions. An Employee on military leave for less than thirty-one (31) days will not be required to pay more than the active Employee contribution for that period of time.

The insurance coverage of an individual on leave without pay who fails to pay insurance premiums or contributions when due shall terminate at 11:59pm on the last day of the period covered by the last premium or contribution paid.

ELIGIBILITY THROUGH THE VOLUNTARY SEPARATION PROGRAM (Not Applicable to University Employees.)

An Eligible Employee who volunteers for separation and who signs a written agreement that the Employee agrees to the voluntary separation terms of the program and that outlines the separation date, amount of payment, length of shared insurance premium payments, exceptions to severance and insurance, method of payment, and information pertinent to any return to work in State service or employment with a contractor who provides services to the State.

An Agency shall offer a voluntary separation program to all Eligible Employees and shall provide, subject to funding availability, severance pay in the amount of one week of pay at current base salary for each year of service, prorated for service in increments of less than one year, and eligibility to continue enrollment in the Plan for up to six (6) months after separation if the Employee pays the Employee contribution.

ARTICLE III

PRE-CERTIFICATION AND NOTIFICATION FOR MEDICAL SERVICES AND PRESCRIPTION MEDICATION

Pre-certification 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 XVI. Pre-Certification is initiated by calling the toll-free Pre-Certification phone number shown on the back of your ID card and providing information on the planned medical services. Pre-Certification may be requested by you, your dependent or your Physician. However, the Member is ultimately responsible to ensure Pre-Certification 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 Plan Administrator do not provide or ensure quality of care.

Pre-certification should be initiated for specific services are noted in the Plan Description by calling toll-free 1-888-999-1459 and providing information on the planned medical services. The patient or the physician/facility may request pre-certification; however, the member is ultimately responsible to ensure pre-certification is obtained.

If Pre-certification 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 is required before claim processing can continue. This must be initiated by calling 1-888-999-1459 and providing information on the incurred medical services. If pre-certification is not initiated within 60 days of the first pend letter, the claim will be denied.

PENALTIES FOR PRE-CERTIFICATION REQUIREMENTS

Treatment by Participating Providers

If you do not Pre-Certify as required above, the Claims Administrator will review the claims submitted for Medical Necessity after the services

have been rendered. If the claim is denied based on the plan provisions or Medical Necessity, the member is responsible for payment.

Treatment by Non-Participating Providers

Except in emergency situations, treatment provided by a non-Participating Provider is not covered by the Plan. However, there may be rare circumstances where the Plan will provide coverage for services rendered by a non-Participating Physician (e.g. there is only one specialist who is able to treat your specific disease and that specialist does not contract with the network). The only way you can obtain coverage in these instances is by obtaining Pre-Certification.

MEDICAL SERVICES

Inpatient Admissions

Pre-Certification 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 is performed through a utilization review program by a Review Organization with which the State of Arizona has contracted. Pre-Certification should be requested by you, your dependent or an attending physician by calling the toll-free Pre-Certification phone number shown on the back of your ID card prior to each inpatient Hospital admission. Pre-Certification should be requested, prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

You should start the Pre-Certification process by calling the Review Organization 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 Review Organization 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 Plan Administrator.

The Review Organization is an organization with a staff of Registered Nurses and other trained staff members who perform the Pre-Certification process in conjunction with consultant Physicians.

Other Services & Supplies

Pre-Certification should be requested for those services that require Pre-Certification. Pre-Certification 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 c-section;
3. A separate Pre-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 (except circumcision);
5. Accidental dental services;
6. Dental confinements/anesthesia required due to a hazardous medical condition;
7. Mental/nervous and substance abuse services (both inpatient and outpatient);
8. Outpatient and ambulatory magnetic resonance imaging (MRI/MRA), PET Scans, ECT, BEAM (Brain Electrical Activity Mapping), Gamma Knife;
9. Non-emergency ambulance transportation;
10. Organ transplant services;
11. Cancer clinical trials;
12. Pain management treatment (including biofeedback);
13. Infusion/IV Therapy in an Outpatient setting to include: Infliximab (Remicade), Alefacept (Amevive), and Etanercept (Enbrel);
14. Injectable medication in the Physician's office to include: Alefacept (Amevive), Etanercept (Enbrel), Sodium Hyaluronate (Hyalgan, Synvisc), Infliximab (Remicade), Omalizumab (Xolair), Lupron, Syranel, Forteo, Lupron Depot;
15. Home health, including hospice, and parenteral;
16. Outpatient and ambulatory cardiac testing, angiography, PFT, 23-hour sleep studies, video EEG;
17. Rental of Durable Medical Equipment which is expected to have a purchase price of \$1000 or more;
18. Purchase of Durable Medical Equipment and prosthetics costing more than \$1000;
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. Rehabilitation therapy in excess of 60 visits per Member per Plan Year; and
 24. 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.

Notification of 23-hour observation admissions

While Pre-Certification is not required for 23-hours observation admissions, we encourage you to contact the Review Organization if you will be receiving these services. This will assist in the Pre-Certification process should the admission exceed 23 hours.

Notification of maternity services

While Pre-Certification 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 Review Organization if you will be receiving any maternity services. This will assist in the Pre-Certification process should Inpatient services be required that exceed 48 hours for a normal delivery and 96 hours for a c-section. Notification also enables the Review Organization staff to assist you with education and/or resources to maintain your health during your pregnancy.

Prescription Medications

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. Walgreens Health Initiatives (WHI), in their capacity as pharmacy benefit manager, administers the clinical prior authorization process.

Clinical Prior Authorization (CPA) may be initiated by the pharmacy, the physician, you, and/or your covered family members by calling 1-877-665-6609, Monday through Friday, 8:00 AM - 8:00 PM, Central. The pharmacy *may* call after being prompted by a medication denial stating "*Prior Authorization required, call 1-877-665-6609.*" 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 CPA

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 WHI's receipt of the completed form, not including weekends and holidays.

If the prior authorization request is APPROVED, the WHI Clinical Service 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 prior authorization request is DENIED, the WHI 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 and Grievance Procedures" section of this document.

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

1. Anabolic steroids – injectable (Deca-Durabolin[®], Virilon IM[®]);
2. Anabolic Steroids - Oral (Anadrol-50[®], Android Testred[®], Oxandrin[®], Winstrol[®]);
3. Anabolic Steroids – Topical (Androderm[®], Androgel[®], Testoderm[®]);
4. Botulinum Toxins (Myobloc[®], Botox[®]);
5. Lamisil[®];
6. Sporanox[®]; and
7. Penlac[®].

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 prior authorization. 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 prior authorization resulting from medication management programs include, but are not limited to:

1. Topical Anti-acne products after the age of 24 (e.g. Retin-A[®], Avita[®], Differin[®]);
2. Medications for Attention Deficit Hyperactivity Disorder/ Narcolepsy after the age of 19 (e.g. Dexedrine[®], Ritalin[®], Cylert[®]);
3. Oral Antiemetics beyond defined quantity limitations (e.g. Kyrtil[®], Zofran[®]);
4. Medications to treat insomnia beyond defined quantity limitations (e.g. Ambien[®], Restoril[®], Sonata[®]); and
5. Medications used to treat migraine headaches beyond defined quantity limitations (e.g. Imitrex[®])

A certain class of medications will be managed through the Walgreens Health Initiatives Specialty Pharmacy Program. For more information, see the "Specialty Pharmacy" section of this document. Medications included in the 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 WHI Specialty Pharmacy program requires prior authorization and include, but are not limited to:

1. Xolair[®];
2. Remicade[®], Amevive[®], Enbrel[®], Kineret[®], Humira[®], Raptiva[®];
3. Hyalgan[®], Supartz[®], Synvisc[®];
4. Forteo[®];
5. Lupron[®], Synarel[®];
6. Lupron Depot[®], Viadur[®], Zoladex[®], Eligard[®], Trelstar[®];
7. Synagis[®]; and
8. Growth Hormones.

To confirm whether you need prior authorization and/or to request a prior authorization, call **WHI's Clinical Member Services at 877-665-6609**, Monday through Friday, 8:00 AM – 8:00 PM, Central. Please have the information listed below when initiating your request for prior authorization:

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

ARTICLE IV

CASE MANAGEMENT / DISEASE MANAGEMENT

Case Management

Case Management is a service provided through an organization contracted with the State of Arizona, 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, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for 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 the back of your ID card during normal business hours, Monday through Friday. In addition, the Plan Administrator or a utilization review program may refer an individual for Case Management.

Each case is assessed 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.

Participation in the program is voluntary – no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

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 Plan Administrator, 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.

While participation in Case Management is strictly voluntary, 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.

Disease Management

Disease Management is a service provided through an organization contracted with the State of Arizona, which assists Members with treatment needs for chronic conditions. Disease Management is a voluntary program – no penalty or benefit reduction is imposed if you do not wish to participate in Disease Management.

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.

ARTICLE V

TRANSITION OF CARE

If you are a new Member, upon written request to the Review Organization, you may continue an active course of treatment with your current health care provider who is not a 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.

Transition of Care request forms are available by contacting Harrington Customer Service at 1-888-999-1459.

ARTICLE VI

OPEN ACCESS TO PROVIDERS

Open Access refers to how you “access” physicians. This plan does not require members to designate a Primary Care Physician (PCP) and members may schedule an appointment directly with a specialist of his/her choosing; however, the specialist **MUST** be contracted within your medical plan provider network.

Members may still choose to maintain a primary relationship with one physician and are encouraged to do so, but are not required to. For assistance finding a health care provider, contact the member services office at the number listed on the back of your ID card.

In order for eligible services to be covered by this plan, it is the member’s responsibility to confirm the facilities, specialists and physicians they use are contracted with his/her medical plan network of providers at the time services are provided.

ARTICLE VII

**SCHEDULE OF MEDICAL BENEFITS
COVERED SERVICES AND SUPPLIES**

It is important to note that all inpatient services, specific outpatient services, and certain prescription medications require Pre-Certification. Please refer to Article III of this document for details.

	Copayment
Semi-Private Room & Board. The Plan allows charges up to 90% of the Private room rate if the facility has no Semi-Private rooms.	No charge
Private rooms when medically necessary	No charge
Intensive Care Unit	No charge
Physician Visits (General Practice, Family Practice and Internal Medicine, Chiropractor, Behavioral Health, Speech Therapy, Occupational Therapy, Cardiac Therapy, Respiratory Therapy and Physical therapy, OB/GYN, and Pediatrics)	No charge \$10.00
All other specialists	\$20.00
Chiropractic & Osteopathic Includes all spinal manipulation or treatment regardless of provider type. Limited to 20 visits per Member per Plan Year subject to medical necessity.	\$10.00 copay
Surgery/Anesthesia/Asst Surgeon (inpatient)	No charge
Radiology and Laboratory (inpatient)	No charge
Mental/Nervous Substance Abuse (inpatient)	No charge

	Copayment
Periodic Routine Physical Exam. Well-Child through age 1. (Copay is waived if the only service rendered is a well-child immunization). Age 2 and over: 1 visit per Member per Plan Year limited to \$1500 per Member per Plan Year (includes laboratory and radiology).	\$10.00 copay
Adult Immunizations Refer to page 56 for a complete list of Adult Immunizations.	\$10.00 copay
Well Woman Exam (OV, PAP). 1 visit per Member per Plan Year. Includes laboratory.	\$10.00 copay
Well Man Care (OV, PSA Blood test). 1 visit per Member per Plan Year. Includes laboratory.	\$10.00 copay
Allergy Testing	\$20.00 copay
Antigen Administration Desensitization/treatment	\$20.00 copay
Family Planning Services Voluntary Tubal ligation (outpatient facility) Vasectomy (physician's office) Implantable contraceptive products One per every five years	No charge \$20.00 copay \$20.00 copay
Contraceptive Appliances obtained at a Physician's office.	\$10.00 copay

	Copayment
Infertility visits Subject to medical necessity.	\$20.00 copay
Infertility treatment Subject to medical necessity (excluding in vitro, embryo/zygote transfers, GIFT, donor sperm expenses)	50% coinsurance. up to \$1,000 per individual or \$2,000 per family Out-of-Pocket Maximum per plan year. Note that copayments do not apply to the Out-of-Pocket maximum.
Diagnostic Testing, including Laboratory and Radiology	No charge
Prenatal Care and Program For initial diagnosis; 100% thereafter	\$10.00 copay
Mammography screening Age 35-39 one baseline Age 40-and older annually Non-routine services covered more frequently based on recommendation of the Member's Physician.	No charge
Surgery Facility and Associated Physician fees	
In physician's office	\$10.00 copay
In Freestanding ambulatory facility	No charge
In hospital outpatient surgical center	No charge
Outpatient Mental/Nervous	\$10.00 copay
Outpatient Substance Abuse	\$10.00 copay

	Copayment
Hospital Emergency Room. Must be a Medical Emergency as defined by the Plan.	\$125.00 copay (waived if admitted directly from emergency room)
Out of Area Emergencies. Must be a Medical Emergency as defined by the Plan. Emergency Room	\$125.00 copay (waived if admitted directly from emergency room)
Urgent Care Center	\$20.00 copay
Urgent Care Center	\$20.00 copay
Ambulance (for medical emergency or required interfacility transport)	No charge
Non-emergency ambulance transportation with Pre-Certification.	No charge
Rehabilitation Services, Short-Term, limited to 60 visits per Member per Plan Year for all therapy types listed. Additional visits subject to medical necessity with Pre-Certification. Includes: Physical therapy, Occupational therapy, Speech therapy, Respiratory therapy, and Cardiac therapy.	\$10.00 copay per visit
Skilled Nursing Facility/Rehabilitation Hospital or sub-acute facilities. 90 day limit per Member per Plan Year.	No charge

	Copayment
Home Health/Home Infusion Care. No limit.	No charge
Organ and Tissue Transplantation & Donor Coverage. No coverage if Member is an organ donor for a recipient other than a Member enrolled under this Plan. Travel & lodging expenses are limited to \$10,000 per transplant. Travel and lodging are not covered if the Member is a donor.	No charge
Hospice Care Inpatient facility or home hospice for life expectancy of 6 months or less.	No charge
Durable Medical Equipment (DME) Medically Necessary.	No charge
Corrective Appliances, Prosthetics, Medically Necessary foot orthotics. Foot orthotics limited to diabetic treatment.	No charge
Ostomy supplies	No charge
Hearing Aids Limited to \$2,000 per Member per Plan Year	No charge
Hearing Exam One per Member per Plan Year	\$10.00 copay

	Copayment
Medical Foods/Metabolic Supplements and Gastric Disorder Formula . Limited to 75% to \$20,000 max per Member per Plan Year.	25% coinsurance up to \$1,000 per individual or \$2,000 per family Out-of-Pocket Maximum per plan year. Note that copayments do not apply to the Out-of-Pocket maximum.
PRESCRIPTION MEDICATION AND DIABETIC SUPPLIES AS IDENTIFIED UNDER ARTICLE VIII.	
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.
Smoking cessation aids both prescribed and over-the counter will be covered at a maximum of \$500 per lifetime per member. All co-pays based on the formulary will apply. 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.	\$500 maximum per lifetime
Retail Pharmacy (30-day supply) Generic Formulary Brand Non-Formulary Brand Infertility – oral medication	\$10.00 copay \$20.00 copay \$40.00 copay \$40.00 copay
Mail Order (90-day supply) Generic Formulary Brand Non-Formulary Brand Infertility – oral medication	\$20.00 copay \$40.00 copay \$80.00 copay \$80.00 copay

Retail (90-day supply)	
Generic	\$25.00 copay
Formulary Brand	\$50.00 copay
Non-Formulary Brand	\$100.00 copay
Infertility – oral medication	\$100.00 copay

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 copays and coinsurance stated in the Schedule of Benefits.

Out-of-Pocket Maximum

Out-of-Pocket Expenses are Covered Expenses incurred for charges made by a Provider for which no payment is made on a portion of the claim because of the 50% coinsurance factor for either infertility treatment or metabolic supplements.

The following do not apply to the accumulation of the maximum out-of-pocket:

1. Prescription copays;
2. All flat dollar medical copays such as, office visit, urgent care, emergency room, and rehabilitation therapy;
3. Charges in excess of Reasonable and Customary; and
4. All charges associated with a non-covered service.

When a Member has incurred Out-of-Pocket Expenses of \$1,000 in a Plan Year, benefits for Covered Expenses normally payable at 50% and incurred during the rest of that Plan Year will be payable at the rate of 100% not to exceed any stated Plan maximum.

When two or more Members enrolled under a policy have incurred a combined amount of Out-of-Pocket Expenses of \$2,000 in a Plan Year, benefits for you and all of your Dependents for Covered Expenses normally payable at 50% and incurred during the rest of that Plan Year will be payable at the rate of 100% not to exceed any stated Plan maximum.

All copays noted that are not a percentage coinsurance will continue to apply regardless of the Maximum Out-of-Pocket amount.

Notification, Proof of a Claim, and Payment

Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and Pre-Certification by the Review Organization.

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 Review Organization as soon as reasonably possible.

Coverage for Emergency Services and Urgent Care received through non-Participating Providers shall be limited to covered services to which you would have been entitled under the Plan, and shall be reimbursed at the prevailing Reasonable and Customary rate for self-pay patients in the area where the services were provided.

Claims 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 website at www.myazhealth.com or by calling Customer Service noted on your ID card.

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 www.myazhealth.com website.

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.

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 Member/Participants only if:

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

All non-emergency services within the network Service Area must be incurred at a Participating Provider. All non-emergency services outside of the network Service Area must be incurred at a Travel Network Participating Provider.

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.

Physician Services

Physician Services are diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, periodic health assessments, well-child care and

routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures.

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.

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.

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 Review Organization to obtain necessary authorizations for care or hospitalization.

If you receive Emergency Services outside the Service Area, you must notify the Plan 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.

“Emergency Services” are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required for relief of acute pain, for the

initial treatment of acute infection or to treat a sudden unexpected onset of a bodily injury or a 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.

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 must 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.

Continuing or Follow-up Treatment

Continuing or follow-up treatment by providers out of the Service Area is not covered unless it is Pre-Certified by the Review Organization.

Ambulance Service

Ambulance services to/from an appropriate provider or facility are covered for emergencies. Pre-Certification for non-emergency ambulance services may be obtained from the Review Organization 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.

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. Bras/camisoles are limited to two (2) articles per Member per Plan Year.

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

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 usual 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.

Chiropractic Care Services

Chiropractic care services include diagnostic and treatment services utilized in an office setting by Participating 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.

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.

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, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia). All charges for services by a dental provider or surgeon are not covered.

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.

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. Charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
 - a. Medically Necessary visits when diabetes is diagnosed;
 - b. Visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
 - c. Visits when reeducation or refresher training is prescribed by the Physician; and
 - d. Medical nutrition therapy (education) related to diabetes management.

Diagnostic testing, including Laboratory and Radiology Services

Diagnostic testing includes radiological procedures, laboratory tests, and other diagnostic procedures.

Durable Medical Equipment

Purchase or rental of durable medical equipment is covered when ordered or prescribed by a Participating Physician and provided by a vendor approved by the Plan. The determination to either purchase or rent equipment will be made by the Plan. Coverage for repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to anatomical growth or a change in medical condition.

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, crutches, hospital beds (to maximum of \$5,000), wheel chairs, respirators, and dialysis machines.

Unless covered in connection with the services described in the "Inpatient Services at Other Participating 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;
6. Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, foot orthotics, 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; and
8. Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars.
9. Hearing aid batteries and chargers

Erectile Dysfunction

Erectile Dysfunction services are medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered when the Member has an established medical condition that clearly causes erectile dysfunction, such as postoperative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.

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 or congenital defect. External prosthetic appliances shall include artificial arms and legs, hearing aids and terminal devices such as a hand or hook. Replacement of external prosthetic appliances (except for hearing aids) is covered only if necessitated by normal anatomical growth or as a result of wear and tear.

The following are specifically excluded:

1. Any biomechanical devices. Biomechanical devices are any external prosthetics operated through or in conjunction with nerve conduction or other electrical impulses;
2. Replacement of external prosthetic appliances due to loss or theft; and
3. Wigs or hairpieces.

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).

Foot Orthotics

The following foot Orthotics are covered by the plan for treatment of diabetes (see 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.

Home Health Services

Home health services are covered when you:

1. Require skilled care;
2. Are unable to obtain the required care as an ambulatory outpatient; and
3. Do not require confinement in a hospital or Other Participating Health Care Facility.

Home health services are provided only if the Plan has determined that the home is a medically appropriate and cost-effective setting. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), home health services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs. Home health services are those skilled health care services that are provided during visits of two (2) hours or less by Other Participating Health Professionals. Necessary consumable medical supplies, home infusion therapy, and durable medical equipment administered or used by Other Participating Health Professionals in providing home health services are covered. 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 subject to the benefit limitations described under Short-term Rehabilitative Therapy.

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 Participating Provider 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 Participating Hospital; a Participating skilled nursing facility or a similar institution; a Participating home health care agency; a Participating 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 a Participating 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.

Immunizations

Immunizations are not subject to the annual routine maximum benefit. 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 poly-saccharide (PPV23)
4. Hepatitis B (Hep B)
5. Hepatitis A (Hep A)
6. Td (Tetanus, diphtheria)
7. Polio (IPV)
8. Varicella (Var)
9. Meningococcal Conjugate vaccine (MCV4)
10. MMR (Measles, mumps, rubella)
11. HPV Vaccine, Gardasil
12. Shingles Vaccine, Zoster

Infertility Services

Infertility services are services related to diagnosis of infertility and treatment of infertility of the Employee or Employee's Spouse once a condition of infertility has been diagnosed. Covered services include approved surgical and medical treatment programs that have been established to have a reasonable likelihood of resulting in pregnancy.

The following are specifically excluded infertility services:

1. Infertility drugs;
2. In-vitro fertilization;
3. Gamete intrafallopian transfer (GIFT);
4. Zygote intrafallopian transfer (ZIFT) and variations of these procedures;
5. Any costs associated with the collection, washing, preparation, or storage of sperm for the non-covered assisted reproduction procedures listed above, as well as costs associated with the storage of sperm or sperm donor fees for artificial insemination;
6. Reversal of voluntary sterilization;
7. Infertility services when the infertility is caused by or related to voluntary sterilization;
8. Ovarian transplant;
9. Cryopreservation of donor sperm and eggs;
10. Charges related to a surrogate; and
11. Any Experimental or Investigational infertility procedures or therapies.

Inpatient Services at Other Participating 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.

Insulin Pumps and Supplies

Insulin pumps and insulin pump supplies are covered when ordered by a Physician and obtained through a contracted durable medical equipment supplier. You may call the Customer Service number on your ID card if you need assistance locating a contracted supplier.

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.

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.

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 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.

Medical Foods / Metabolic Supplements and Gastric Disorder Formula

Medical foods, 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.

The Plan will cover up to 75% of the cost of medical foods prescribed to treat metabolic disorders covered under this Plan. There is a maximum Plan Year limit for medical foods of \$20,000 which applies to the cost of all prescribed modified low protein foods and metabolic formula.

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: formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy:

1. 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;
2. 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
3. Essential to a person’s optimal growth, health and metabolic homeostasis.

The following are not considered Medically Necessary 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.

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.

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.

Inpatient Mental Health Services

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

Outpatient Mental Health Services

Outpatient Mental Health Services are services by Participating 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.

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.

Residential Substance Abuse Treatment

Voluntary and court-ordered residential substance abuse treatment will be covered for a maximum of 30 days and limited to two treatments per plan year for chemical and alcohol dependency.

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 Review Organization will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting. In-patient detoxification coverage is limited to two treatments per year and a lifetime maximum of five.

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. Residential treatment; (unless associated with chemical or alcohol dependency as described in the Residential Substance Abuse Treatment provisions)
12. Marriage counseling;
13. Custodial care, including but not limited to geriatric day care;
14. Psychological testing on children requested by or for a school system; and
15. Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.
16. Biofeedback is not covered for reasons other than pain management.

Nutritional Evaluation

Nutritional evaluation and counseling from a Participating Provider is covered when diet is a part of the medical management of a documented organic disease, including morbid obesity.

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.

Obstetrical and Gynecological Services

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

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; or
11. Small bowel/liver
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.

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 Plan 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 37.5 cents per mile 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.

The following are specifically excluded travel expenses:

1. Travel costs incurred due to travel within 60 miles of your home;
2. Laundry bills;
3. Telephone bills;
4. Alcohol or tobacco products; and
5. Charges for transportation that exceed coach class rates.

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.

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.

Periodic Routine Health Examinations

Well woman exams are covered in addition to periodic health exams. Covered expenses include an annual office visit and one Papanicolaou test (PAP smear). Laboratory charges are covered as a separate expense. Limited to 1 visit per Member per Plan Year.

Well man exams are covered in addition to periodic health exams. Covered expenses include an annual office visit with prostate-specific antigen (PSA) test. Laboratory charges are covered as a separate expense. Limited to 1 visit per Member per Plan Year.

Periodic Routine Health Examinations age 2 and over, including vision and hearing screening, laboratory, and radiology services provided by a Physician limited to 1 visit per Member per Plan Year and \$1500 maximum benefit paid per Member per Plan Year.

Well child, well woman, and well man exams do not apply to the stated periodic routine health examination limits.

Radiation Therapy

Radiation therapy and other therapeutic radiological procedures are covered.

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.

The following limitations apply to short-term rehabilitative therapy:

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.

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.

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.

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 not covered.

ARTICLE VIII

PRESCRIPTION DRUG BENEFITS

If a Member incurs expenses for charges made by a Pharmacy for Covered Prescription Drugs for a non-occupational Injury or a Sickness, the Plan will pay that 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 Walgreens Health Initiatives (WHI), an organization which has been contracted by the Plan Sponsor to perform these services.

The Member must pay a portion of Covered Prescription Drugs to receive Prescription Drug Benefits. That portion is described below. The Prescription Drug Copayment is not considered an Eligible Expense under the medical portion of this Plan and do not accrue to the medical Plan Maximum Out-of-Pocket.

The Walgreens Health Initiatives 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 mywhi.com or contact the WHI Customer Care Center to 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.

COPAYMENT is that portion of Covered Prescription Drugs which you are required to pay under this benefit. In addition to the co-payments outlined below, members will be required to pay 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 (NTI) drugs from the copay penalties.

PARTICIPATING RETAIL PHARMACY COPAYMENT (up to a 30-day supply)

An amount as follows for each Prescription Order:

For Generic Drugs \$10

For Formulary Brand-Name Drugs \$20

For Non-Formulary Brand-Name Drugs \$40

For Infertility – Oral medications \$40

PARTICIPATING MAIL ORDER PHARMACY COPAYMENT (up to a 90-day supply)

An amount as follows for each Prescription Order:

For Generic Drugs \$20

For Formulary Brand-Name Drugs \$40

For Non-Formulary Brand-Name Drugs \$80

For Infertility – Oral medications \$80

PARTICIPATING RETIAL COPAYMENT (up to a 90-day supply)

An amount as follows for each Prescription Order:

For Generic Drugs \$25

For Formulary Brand-Name Drugs \$50

For Non-Formulary Brand-Name Drugs \$100

For Infertility – Oral medications \$100

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.

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;
6. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a Physician;

7. Oral contraceptives or contraceptive devices, regardless of intended use, except that implantable contraceptive devices, such as Norplant, are not considered Covered Prescription Drugs;
8. Prenatal vitamins, upon written prescription;
9. Oral infertility drugs; or
10. Injectable drugs or medicines for which a prescription is required, except injectable infertility drugs.

Limitations

No payment will be made for expenses incurred:

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 Plan 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 30-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 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 nutritional or dietary supplements, or anorexients;
21. Implantable contraceptive devices;
22. For prescription vitamins other than prenatal vitamins, upon written prescription;
23. For all medications administered for the purpose of weight loss/obesity;
24. For treatment of erectile or sexual dysfunction (both male and female); or
25. For injectable infertility drugs.

Specialty Pharmacy

Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Health Initiatives (WHI) 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 program may only be obtained through retail Walgreens store or through WHI's home delivery service. Specialty medications are limited to a 30-day supply.

A Specialty Care Representative may contact a member to facilitate your enrollment in **WHI's Specialty Care 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 1-888-782-8443.

Reimbursement/Filing a Claim

If you or your Dependent purchases 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 WHI claim form to obtain reimbursement. The claim form is available on the www.myazhealth.com 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 unforeseen condition. Claim forms and foreign travel guidelines are available on the www.myazhealth.com website.

	Travel Within the United States	International Travel
Walgreens Health Initiatives	Benefits are covered in-network. You may call 1.866.722.2141 to locate a pharmacy in the area in which you are traveling.	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 1.800.345.1985 to make arrangements. If you obtain medications outside of the U.S., you will not be reimbursed.

ARTICLE IX

EXCLUSIONS AND GENERAL LIMITATIONS

Any Services and Supplies which are not described as covered or are specifically excluded in any other Article of this Plan Description are excluded.

In addition, the following are specifically excluded Services and Supplies:

1. Charges for services filed with the Plan 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, or surgery, which is medically necessary.
10. Orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, medically necessary non-surgical treatment of TMJ disorder is covered.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, 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. Medical and surgical services intended primarily for the treatment or control of obesity which are not Medically Necessary. 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, stomach stapling, jejunal bypass, dietary formulae, hypnosis, cosmetics, and health and beauty aids.

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. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
17. Treatment of erectile dysfunction and sexual dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile 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, autism or mental retardation.
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 and Breast Prostheses.
22. Private hospital rooms and/or private duty nursing are only available during inpatient stays and determined to be medically appropriate 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. Artificial aids including, but not limited to, foot orthotics, corrective orthopedic shoes, arch supports, elastic/compression stockings, garter belts, corsets, dentures, and wigs, except as provided in the Diabetic Services and Supplies provision of the Covered Service and Supplies Article of this plan.
 25. 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.
 26. Treatment by acupuncture.
 27. All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided by this Plan.
 28. Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.
 29. Membership costs or fees associated with health clubs, and weight loss programs.
 30. 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.
 31. Services rendered by a midwife for the purpose of home delivery.
 32. Genetic testing and therapy including germ line and somatic unless determined Medically Necessary by the Plan for the purpose of making treatment decisions.
 33. 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.
 34. Blood administration for the purpose of general improvement in physical condition.
 35. 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 AZ work related travel are covered by the Plan for all Members.
 36. Cosmetics, dietary supplements, nutritional formula (except for treatment of malabsorption syndromes), and health and beauty aids.

37. 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.
38. Phase 3 Cardiac rehabilitation.
39. Massage therapy, health spas, mineral baths, or saunas.
40. Coverage for any services incurred prior to the effective date of the Member or after the termination date of the Member.
41. 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.
42. To the extent that payment is unlawful where the person resides when the expenses are incurred.
43. To the extent of the exclusions imposed by any certification requirement.
44. Charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by co-surgeons in excess of the normal surgical allowance plus 20 percent (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts).
45. 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.
46. Charges made by any covered provider who is a member of your family or your Dependent's family.
47. Manipulations under anesthesia. This does not include reductions of fractures and/or dislocations done under anesthesia.
48. Surgery for correction of Hyperhidrosis.

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 VII of this Plan Description.

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 X

COORDINATION OF BENEFITS AND OTHER SOURCES OF PAYMENT

Coordination of Benefits applies to medical services received under the terms of the Plan. Prescription medications obtained through WHI (retail or mail order) 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 Pre-certification requirements or exclusions as noted in this Plan Description. All Plan terms and conditions apply whether this Plan is primary or secondary, including the requirement to receive all services through a network provider except as specifically noted in this Plan Description.

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.

Coordination of Benefits

This section applies if you are covered under another plan besides this health plan 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, this 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 plan will only pay secondary benefits.

Definitions

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

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.

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.

Primary Plan

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

Secondary Plan

A Plan that determines and may reduce its benefits after taking into consideration the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover the Reasonable Cash Value of any services it provided to you from the Primary Plan.

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 Reasonable Cash Value of each service is the Allowable Expense and is a paid 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.

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.

Reasonable Cash Value

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.

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 the person 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. First, 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. Then, the Plan of the parent with custody of the child;
 - c. Then, the Plan of the spouse of the parent with custody of the child;
 - d. Then, the Plan of the parent not having custody of the child;
 - e. Finally, the Plan of the spouse of the parent not having custody of the child; and
 - 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 and 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 covers 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.

Effect on the Benefits of this Plan

If we are the Secondary Plan, we 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 total of all Allowable Expenses. All copays noted in the Schedule of Benefits remain the Member's responsibility and are not considered an Allowable Expense when this Plan is secondary.

For example:

Claim filed for services in a physicians office	= \$100
Medicare payment (including write-off)	= \$ 90
Member copay	= \$ 10
Plan payment	= \$ 0

Claim filed for services in a physicians office	= \$100
Medicare payment (including write-off)	= \$ 70
Member copay	= \$ 10
Plan payment	= \$ 20

Recovery of Excess Benefits

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 in excess of those for which we are 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 Plan 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 we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure its rights.

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.

Injuries Covered under Med Pay Insurance

If you are injured as a result 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.

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.

Statutory Liens

Arizona law prohibits Participating Providers from charging you more than the applicable Copayment 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 Copayment plus what the Participating Provider has received from Plan as payment for covered services, and (2) the Participating Provider's full billed charges.

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 XI

CLAIM FILING PROVISIONS AND APPEAL PROCESS

Discretionary Authority

The Plan Sponsor delegates to the Plan Administrator the discretionary authority to interpret and 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 limited to, the computation of any and all benefit payments. The Plan Sponsor also delegates to the Plan 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.

CLAIMS FILING PROCEDURE

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

A "**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.

An "**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.

A "**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 of general items or health services or a request for Pre-Determination to determine coverage for a specific procedure.

A "**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.

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 Plan 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 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.

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 Plan Administrator's 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 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. A statement notifying the Member about further appeal processes available, as established by the Plan Administrator.

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 initially period approved during the Pre-certification 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.

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.

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 Plan 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.

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 Plan Administrator.

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 request for review must be directed to the Plan 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 Customer Service at 888-999-1459.

The review of the denial will be made by the Plan 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 Plan 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 Claims;
2. Within **15** calendar days after receipt of the Member's request for review in the case of Pre-Service Claims;
3. Within **45** 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/Participant's claim.

3. A statement notifying the Member about potential alternative dispute resolution methods, if any.

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. Level 1 appeals are reviewed and responded to by the Plan 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. Level 2 appeals are reviewed and responded to by the Plan 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. Level 3 appeals are reviewed by an Independent Review Organization (IRO) at no charge to the Member. The Plan Administrator will respond to the Member with the decision based on the IRO review process.

PHARMACY APPEALS

If you are dissatisfied with any service received under this Prescription Drug Benefit, you are encouraged to contact Walgreens Health Initiatives (WHI) Member Services Department, 24 hours per day, 7 days a week at 1-866-722-2141. Frequently, your concern can be resolved with a telephone call to a Member Service Representative. If the WHI Member Service's Department cannot resolve your concern, you may proceed to the Appeals Procedures as set forth above by contacting the Plan 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.

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 Plan Administrator.

ARTICLE XII

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.

ARTICLE XIII

ADMINISTRATION

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;
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.

PLAN ADMINISTRATOR'S RESPONSIBILITIES

The Plan Administrator shall have the authority and responsibility for:

1. Acting as this Plan's agent for the service of legal process; and
2. Interpreting this Plan's provisions relating to coverage, including when a claimant files an appeal with the Plan Administrator, in which case the Plan Administrator shall interpret this Plan;
3. Administering this Plan's claim procedures;
4. Rendering final decisions on review of claims as described in 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 Plan Sponsor; and
7. Performing all other responsibilities delegated to the Plan Administrator in the instrument appointing the Plan Administrator.

The Plan Administrator acting as the claims fiduciary will have the duty, power, and discretionary authority to construe and interpret this Plan, and to determine the amount, manner, and time of payment of any Benefits under this Plan. All interpretations under this Plan, and all determinations of fact made in good faith by the Plan Administrator, will

be final and binding on the Members and beneficiaries and all other interested parties.

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.

MULTIPLE FIDUCIARY FUNCTIONS

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

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.

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.

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.

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.

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.

ARTICLE XIV

MISCELLANEOUS

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.

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.

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.

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.

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 XV

PLAN IDENTIFICATION

1. Name of Plan: State of Arizona Group Health Plan
AZ Benefit Options - Harrington
2. Name and Address of Plan Sponsor:
Arizona Department of Administration
100 N 15th Avenue Ste 103
Phoenix, AZ 85007
3. Plan Administrator:

<u>Appeals and other correspondence</u>	<u>Claims address</u>
Fiserv Health - Harrington	AZ Benefit Options –
PO BOX 33396	Fiserv Health - Harrington
Phoenix AZ 85067-3396	PO BOX 785
Phone: 888-999-1459	Pueblo CO 81002-0785
Fax: 866-366-2379	
TDD/TTY: 866-503-3463	
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. Plan Administrator/Agent for
Legal Process/Named Fiduciary:
Fiserv Health – Harrington
675 Brookside Blvd
Westerville OH 43081
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 Fiscal Year: September 30 of each year.

ARTICLE XVI

DEFINITIONS

This section contains definitions of words and phrases which are contained within the Plan Description. The presence of a word or phrase in this section does not constitute a description of a covered service under the terms of the Plan.

ACCIDENT shall mean a specific sudden 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.

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 Department of Health of the state where it is located. Such a facility must also have in effect a plan for utilization review and a plan for 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 fully 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.

ANNUAL OPEN ENROLLMENT PERIOD or **SPECIAL OPEN ENROLLMENT PERIOD** shall mean the period of time established by the Plan Sponsor

as the time when Primary Members may enroll for coverage or modify their current coverage choices.

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

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

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

BENEFIT shall mean the payment or reimbursement by this Plan of a portion of a Medical Expense incurred by a Member.

BILATERAL SURGICAL PROCEDURE(s) shall mean any Surgical Procedure performed on any paired organ whose right and left halves are mirror images of each other or in which a median longitudinal section divides the organ into equivalent right and left halves or on any pair of limbs. Surgery on either halves or both limbs is performed during the same operative session and may involve one (1) or two (2) surgical incisions.

BIRTHING CENTER shall mean a licensed outpatient facility which provides childbirth facilities for low-risk maternity patients. The Birthing Center must fully 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 backup of Physicians;
4. Has a written agreement to transfer to a Hospital if necessary;
and
5. Is in compliance with any applicable state or local regulations.

COBRA shall mean the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.

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

COINSURANCE shall mean a percentage of the cost of covered expenses for which each Member is responsible.

COPAY or COPAYMENT shall mean a portion of the cost of covered expenses for which the Member is responsible.

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 EXPENSE(S) shall mean charges for services which are Medically Necessary and eligible for payment under the Plan. A covered expense can be no more than the maximum amount stated in the Plan.

CREDITABLE COVERAGE shall mean health care coverage which may be used to reduce a Member's pre-existing condition exclusion period as of the Enrollment Date. Creditable Coverage shall only include individual or group health insurance coverage and other health care coverage specifically set forth in HIPAA, including Medicaid and Medicare. Likewise, Creditable Coverage shall not include coverage consisting of excepted benefits as defined by HIPAA.

CUSTODIAL CARE means any type of service, including room and board and/or institutional service, which is designed essentially to assist a Member, whether disabled or not, in activities of daily living. Such services include, but are not limited to, assistance in walking, getting in or out of bed, bathing, dressing, feeding, preparation of special diets and supervision over medication which can normally be self administered. Custodial Care is care which is non-rehabilitative and primarily for maintenance of function and as may be determined by the Plan Administrator.

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

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

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

EFFECTIVE DATE shall mean the first day of coverage.

ELECTED OFFICIALS shall mean those identified by the Arizona Administrative Code, R2-5-419.

ELIGIBLE DEPENDENT and DEPENDENT shall mean:

1. The Spouse of an Employee who is legally married to the Employee as defined by Arizona Revised Statute, who is not divorced from the Employee, or whose marriage to the Employee has not been otherwise legally terminated;
2. Each unmarried child of the Employee/Spouse through 11:59pm on the day before their nineteenth (19th) birthday who is:
 - a. A natural son or daughter of the Employee;
 - b. A stepchild
 - c. A child placed by court order in the Employee's home;
 - d. A legally adopted child or a child to whom a court of competent jurisdiction has entered an interlocutory order of adoption; or
 - e. The Employee is required to provide health care coverage for the child under a qualified medical child support order;
3. Each unmarried child of an Employee who has attained their nineteenth (19th) birthday, through 11:59pm on the day before he ceases to be a Full-Time Student at an accredited institution of higher learning but in no event beyond 11:59pm on the day before their twenty-fifth (25th) birthday; and
4. Each unmarried child of an Employee who has attained their nineteenth (19th) birthday who is mentally or physically handicapped based on the Social Security Administration guidelines and who is incapable of engaging in self-sustaining

employment due to such incapacity. Application for such continuation of Dependent status must be made with the Plan Administrator within thirty-one (31) days of the child's 19th birthday. The Plan Administrator has the right to require proof of the continuation of such incapacity upon attainment of age nineteen (19) or anytime thereafter as deemed necessary by the Plan Administrator.

This Plan processes Medical Child Support Orders (MCSO's) and National Medical Support Notices (NMSN's) in compliance with applicable Federal and State law (information on the Plan's procedures regarding MCSO's and NMSN's may be obtained without charge from the Plan Administrator).

ELIGIBLE EMPLOYEE and EMPLOYEE shall mean those identified under Arizona Administrative Code R2-5-416 or as determined by the Arizona Department of Administration (ADOA).

ELIGIBLE PROVIDER shall mean a medical professional, facility or institution when duly licensed in the state where providing services, and when rendering services or furnishing supplies within the scope of that license, provided that such expenses are covered and authorized under this Plan.

ELIGIBLE RETIREE shall mean those identified as defined by Arizona Administrative Code R2-5-418.A and an eligible long term disability recipient as required by Arizona Administrative Code R2-5-418 and A.R.S. and 38-651.

EMERGENCY shall mean the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required for relief of acute pain, for the initial treatment of acute infection or to treat a sudden unexpected onset of a bodily injury or a 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.

EMPLOYER shall mean the State of Arizona, including all agencies, boards and commissions, and universities.

ENROLLMENT FORM shall mean a paper form supplied by ADOA, a COBRA enrollment form, or an authorized Self-service enrollment system.

EXPERIMENTAL OR INVESTIGATIONAL CHARGES shall mean charges for treatments, procedures, devices or drugs which the Plan Administrator determines, in the exercise of its discretion, are experimental, investigative, or done primarily for research.

The Plan Administrator shall use the following guidelines to determine that a drug, device, medical treatment or procedure is experimental or investigative:

1. If 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. If 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. If 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. If 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.

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; or the informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

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 accommodations and skilled nursing care on a twenty-four (24) hour per day basis to 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 treatment of substance abuse; 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 shall mean those identified and eligible for benefits as defined by A.R.S. 38-651.01.

FRAUD shall mean an intentional deception or misrepresentation made by any Eligible Employee, Retiree, LTD Recipient, Surviving Spouse or Dependent with the knowledge that the deception could result in some benefit to them or any other individual to which they or others would not otherwise receive. This includes any act that constitutes fraud under applicable Federal or State law.

FULL-TIME STUDENT shall mean a student at an accredited institution of higher learning. A student is considered full time if the student meets any one of the following three criteria:

1. The student is an undergraduate taking at least 12 credit hours;
2. The student is a graduate student taking at least 9 credit hours;
- or
3. The post-secondary school, which does not record class time in credit hours, classifies the student as full-time.

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as presently enacted and as it may be amended from
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The wording contained within this Plan Description may be revised at any time for clarification purposes without prior notice.

time to time, together with its related rules and regulations. References to any section of HIPAA shall include any successor provision.

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 (1) 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 (1) Physician and at least one (1) Registered Nurse) to govern the services and provides for supervision of the services by a Physician or a Registered Nurse;
3. Maintains a complete clinical record 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.

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 twenty-four (24) hour skilled nursing care by licensed nursing personnel under the direction of a full-time Registered 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 all of the following criteria:

1. Provides in-home nursing care and counseling by licensed professionals under the direction of a full-time Registered 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 all of the following requirements:

1. Must be accredited by the Joint Commission of Hospitals, or be approved by the federal government to participate in federal and state programs;
2. Maintains a complete medical record for each patient;
3. Must have by-laws which govern its staff of Physicians; and
4. Must provide nursing care twenty-four (24) hours per day.

HOSPITAL CONFINEMENT shall refer to a situation in which:

1. A room and board charge is made to a Member by a Hospital or other facility approved by the claims administrator, or
2. A Member remains in the Hospital or other approved facility for twenty-four (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 Member.

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

INPATIENT shall mean the classification of a Member when that person is admitted to a Hospital, Hospice Facility or Extended Care Facility/Skilled Nursing Facility for treatment, and charges are made for room and board to the Member as the result of such treatment.

INTENSIVE CARE UNIT shall mean an area in a Hospital, established by such Hospital for 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 standby 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 the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required for relief of acute pain, for the initial treatment of acute infection or to treat a sudden unexpected onset of a bodily injury or a 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 contract with the Network for services incurred by the Member for Medically Necessary services, treatments, supplies or drugs. Medical Expenses shall be deemed to be 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 mean charges for covered services, supplies and prescriptions, which meet all of the following criteria:

1. Are ordered by a Physician;
2. No more than required to meet the basic health needs;
3. Consistent with the diagnosis of the condition for which they are required;
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 the purposes other than the comfort and convenience of the patient, or Provider;
6. Rendered in the least intensive setting that is appropriate for the delivery of health care; and

7. Of 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.

MEMBERS, there are two types of members in the plan, PRIMARY MEMBERS and MEMBERS. The definitions are as follows:

PRIMARY MEMBER shall mean all of the following:

1. eligible Employee;
2. eligible Retiree;
3. eligible Former Elected Official,
4. eligible Long Term Disability recipient;
5. eligible Surviving Spouse of a former Retiree, former Elected Official, former LTD Recipient; and
6. eligible COBRA enrollee who is enrolled in this Plan and satisfies the eligibility and participation requirements specified in this Plan Description.

MEMBER, shall mean all MEMBERS as defined above, and all of the following:

1. eligible dependent(s) and eligible spouse of an Eligible Employee;
2. eligible dependent(s) and eligible spouse of a Retiree;
3. eligible dependent(s), eligible spouse, of a Former Elected Official in accordance with R2-5-419;
4. eligible surviving dependents of a former Retiree, or of a former LTD Recipient, or of a former active employee eligible for normal retirement;
5. eligible dependent(s) and eligible spouse of a COBRA enrollee who is enrolled in the Plan and satisfies the eligibility and participation requirements specified in this Plan Description.

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

In connection with Mental or Emotional Disorders, the following terms are hereby defined:

CHRONIC CONDITIONS shall mean mental illness, disorders and disabilities which are not subject to a favorable modification or

stabilization according to generally accepted standards of medical practice as determined by the Plan Administrator. These services are not covered.

MENTAL HEALTH shall mean services directed to the Effective Treatment of the emotional well-being of the individual including individual counseling, and counseling for Primary Members and Members, group psychotherapeutic treatment, and psychological testing.

Refer to the exclusions in the Mental Health section for specific information regarding any diagnosis and treatments that are not covered.

MULTIPLE or BILATERAL SURGICAL PROCEDURES shall mean Surgical Procedures which are performed during the same operative session and which are not incidental or secondary to one (1) 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.

NETWORK PROVIDER/PARTICIPATING PROVIDER shall mean any Hospital, facility, Physician or other provider who participates in the Provider networks contracted by the Plan Sponsor to provide health care services at a negotiated rate.

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; and, with respect to an Illness, it means an Illness in which the Member is not entitled to benefits under any workers' compensation law or similar legislation.

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 Member. Examples of Other Participating Health Care Facilities 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 has an agreement with the Network(s) to provide services to the Member. Other Participating Health Professionals include, but are not limited to physical therapists, home health aides and nurses.

OUTPATIENT shall refer to a Member receiving medical care other than as an Inpatient or shall refer to Medical Expenses other than those associated with a Hospital Confinement, Hospice Facility, Extended Care Facility or Skilled Nursing Facility.

OUT-OF-POCKET EXPENSES shall mean Covered Expenses incurred for charges made by any Provider for which no payment is made on a portion of the claim because of the 50% coinsurance factor for either infertility or metabolic supplements. Copayments are not considered Out-of-Pocket expenses under the Plan.

OUT-OF-POCKET MAXIMUM shall mean the most any Member will pay for Out-of-Pocket Expenses related to Infertility, Medical Foods, or Metabolic supplements during the year before the Plan begins paying 100% of Covered Expenses for the rest of the year up to any stated benefit maximums. See Article VII, Determination of Eligible Expenses for more information about the accumulation of the Out-of-Pocket Maximum. Copayments are not considered Out-of-Pocket expenses under the Plan.

PARTICIPATING PROVIDER/NETWORK PROVIDER shall mean any Hospital, facility, Physician or other provider who participates in the Provider networks contracted by the Plan Sponsor to provide health care services at a negotiated rate.

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

1. It must be licensed by the Board of Pharmacy;
2. It must maintain records in accordance with federal and state regulations; and
3. It must be 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

their 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 includes any other Physician as determined by the Plan Administrator to be qualified to render the services for which a claim has been filed. For the purpose of accidental dental treatment, the definition of a physician may include a dentist or oral surgeon.

PLAN shall mean the State of Arizona Group Health Plan as set forth in this Plan Description.

PLAN ADMINISTRATOR shall mean Fiserv Health - Harrington,

PLAN SPONSOR shall mean the Arizona Department of Administration (ADOA).

PLAN DESCRIPTION shall mean this written description of the Benefits for medical expenses provided by the Plan Sponsor to its covered Eligible Members.

PLAN YEAR shall mean a period of twelve (12) consecutive months. For active employees, this period commences October 1 and ends September 30. For Retirees, Long Term Disability (LTD) Recipients, Former Elected Officials, and Surviving Spouses of participating Retirees, Employees eligible for normal retirement and Former Elected Officials, this period commences on January 1 and ends on December 31. Any and all provisions revised in the plan document will become effective October 1 for actives and January 1 for retirees unless specified otherwise.

PRE-CERTIFICATION shall mean the process of the Review Organization to review a request for specific services noted as pre-certification required prior to the service being rendered and to determine Medical Necessity and appropriateness of the care. Examples include but are not limited to inpatient hospital care and home care.

PRE-DETERMINATION shall mean the process of the Plan Administrator to review a request for benefit determination for specific services prior to the service being rendered. Examples include, but are not limited to, medical supplies and durable medical items costing less than \$1000.

PRIVATE ROOM ACCOMMODATIONS shall mean a Hospital room containing one (1) bed.

PROVIDER shall mean a duly licensed person or facility that furnishes health care services or supplies pursuant to law, provided that each, under their license, is permitted to perform the medically necessary services covered under this Plan and that this Plan does not exclude the services provided. This definition includes any medical professional or facility as determined by the Plan Administrator to be qualified to render the services for which a claim has been filed.

PSYCHIATRIC SERVICES 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 Plan Administrator.

PSYCHOTHERAPIST shall mean a licensed person 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 the criteria set forth in 26 US Code 125, Internal Revenue Code of 1986 and the Arizona Administrative Code which may allow a Member to make a change in their coverage elections and/or list of Eligible Dependents in a non-open enrollment period.

REASONABLE AND CUSTOMARY CHARGES shall mean charges made by licensed facilities and Providers for services, which do not exceed the general level of charges for those services in the geographical region where the services are furnished. The reasonable and customary charge for each particular service is an amount determined by the use of statistical data. In determining whether a charge is reasonable, differences in charges, which are due to differences in the experience, education and skill level required for the performance of a particular service because of medical circumstances, will be considered.

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. Must qualify as an Extended Care Facility under Medicare;
2. Must maintain a complete medical record for each patient;
3. Must be constituted, licensed, and operated in accordance with the laws of legally authorized agencies responsible for medical institutions;
4. Must maintain on its premises all the facilities necessary to provide for the medical treatment of Illness or Injury, for compensation by or under the supervision of Physicians; and
5. Must provide nursing services on a twenty-four (24) hour per day basis by Registered Nurses or Licensed Practical Nurses.

REVIEW ORGANIZATION shall mean Medical Management Organization

SEMIPRIVATE ROOM ACCOMMODATIONS shall mean the actual daily rate charged by the Hospital for such accommodations. Semiprivate accommodations include two (2), three (3), or four (4) bed wards or rooms.

SERVICE AREA shall mean the geographic area specific to the following listed networks:

1. For RAN+AMN – all counties within the State of Arizona and the cities of Blythe CA, Needles CA, Henderson NV, Las Vegas NV, Laughlin NV, Mesquite NV, Farmington NM, Gallup NM, Kanab UT, and St. George UT.
2. For Schaller Anderson – all counties within the State of Arizona.

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 legally recognized marital partner of a Primary Member as defined by Arizona Revised Statute.

SUBROGATION shall mean the right of the Plan to seek reimbursement for any payments made for medical services, prescriptions and supplies to any Member as a result of damages, illness or injury inflicted by any third-party.

SUBSTANCE ABUSE shall mean:

Alcoholism - A condition diagnosed as falling 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 diagnosed as falling 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 diagnosis ranges that are not covered.

SURGICAL PROCEDURE shall mean one (1) 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 SPOUSE of Eligible retirees, Eligible former elected officials, Eligible long term disability recipients, and employees eligible for normal retirement, shall mean those eligible for benefits as defined by A.R.S. 38-651.02 (C), and Arizona Administrative Code R2-5-101.

TERMINALLY ILL shall mean having a life expectancy of six (6) months or less as certified in writing by the attending Physician.

TIMELY FILING shall mean within one (1) year after the date services are rendered.

TRAVEL NETWORK shall mean a network contracted with to provide access to Participating Providers outside the Service Area of the primary networks, but within the United States of America. The travel network is provided by Beech Street.

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 operative surgery on the premises;
4. Is staffed with continuous physician services and registered professional nursing services whenever a patient attends the facility; and
5. Does not provide services or other accommodations for patients to stay overnight.