If treatment was directly paid or covered by another plan, medically necessary adjustments will be covered.

The following bariatric procedures are excluded:

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

7.13 Breast Reconstruction and Breast Prostheses

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

1. Surgical services for reconstruction of the breast on which the mastectomy was performed;
2. Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
3. Post-operative breast prostheses; and
4. Mastectomy bras/camisoles and external prosthetics that meet external prosthetic placement needs.

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

7.14 Cancer Clinical Trials

Coverage shall be provided for Medically Appropriate 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 institute 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.

7.15 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 Appropriate care provided to prevent reoccurrences or to maintain the patient's current status; and
4. Vitamin therapy.

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

7.16 Cosmetic Surgery

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

7.17 Compression Garments

Compression garments for treatment of lymphedema and burns are limited to one set upon diagnosis. Coverage of up to four (4) replacements per Plan Year. When determined to be medically necessary by the Medical Management Organization and the compression stocking cannot be repaired or when required due to a change in the members physical condition.

7.18 Dental Confinements/Anesthesia

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

7.19 Dental Services – Accident Only

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

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

7.20 Diabetic Service and Supplies

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

1. Podiatric appliances for prevention of complications associated with diabetes; foot orthotic devices and inserts (therapeutic shoes: including Depth shoes or Custom Molded shoes.) Custom molded shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and *any* of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. Definitions of Depth Shoes and Custom-Molded Shoes are as follows:
   - Depth Shoes shall mean the shoe has a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.
   - Custom-Molded Shoes shall mean constructed over a positive model of the member's foot; made from leather or other suitable material of equal quality; have removable inserts that can be altered or replaced as the member's condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.
2. Any other device, medication, equipment or supply for which coverage is required under Medicare guidelines pertaining to diabetes management; and
3. Disease Self-Management Training from a Participating Provider is covered when it has a therapeutic role in the care of diabetes.

7.21 Diagnostic Testing, including Laboratory and Radiology Services

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

7.22 Durable Medical Equipment

Purchase or rental of durable medical equipment and prosthetics is covered when ordered or prescribed by a Participating Physician and provided by a contracted in-network vendor. The determination to either purchase or rent equipment will be made by the Medical Management Organization. Repair or replacement is covered when approved as medically necessary by the Medical Management Organization.

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, 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 (except where indicated for coverage);
6. Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and splints;
7. Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;

8. Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars; and
9. Hearing aid batteries (except those for cochlear implants) and chargers.

7.23 External Prosthetic Appliances

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

External prosthetic appliances shall include artificial arms and legs, wigs, hair pieces and terminal devices such as a hand or hook. Wigs and hair pieces are limited to one per Plan Year and $150 maximum. Members must provide a valid prescription verifying diagnosis of alopecia as a result of chemotherapy, radiation therapy, second or third degree burns with a submitted claim for coverage. All other diagnosis are excluded.

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

The following are specifically excluded:

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

7.24 Family Planning Services (Contraception and Voluntary Sterilization)

Covered family planning services including:

1. Medical history;
2. Physical examination;
3. Related laboratory tests;
4. Medical supervision in accordance with generally accepted medical practice;
5. Information and counseling on contraception;
6. Implanted/injected contraceptives; and
7. After appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

7.25 Foot Orthotics

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

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

7.26 Hearing Aids

Hearing aid devices limited to one per ear, per Plan Year when determined to be medically necessary by the Medical Management Organization. The following services are covered:

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

7.27 Home Health Services

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

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

A Home Health visit is considered to be up to four hours of services. Home health services do not include services of a person who is a member of your family or your dependent's family or who normally

resides in your house or your dependent's house. Physical, occupational, and speech therapy provided in the home are also subject to the 60 visit benefit limitations described under Section 7.56 Short-Term Rehabilitative Therapy.

7.28 Hospice Services

The Plan covers hospice care services which are provided under an approved hospice care program when provided to a Member who has been diagnosed by a 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.

7.29 Immunizations

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

1. Influenza, Trivalent inactivated influenza vaccine (TIV)
2. Influenza, Live attenuated influenza vaccine (LAIV)
3. Pneumococcal
4. Hepatitis A (Hep A)
5. Hepatitis B (Hep B)
6. Td/Tdap (Tetanus, diphtheria, pertussis)
7. Polio (IPV)
8. Varicella (Var)
9. Meningococcal Conjugate vaccine (MCV4)
10. MMR (Measles, mumps, rubella)
11. HPV Vaccine
12. Shingles Vaccine
13. DTap (Diphtheria, tetanus, pertussis)
14. Other immunizations approved by the plan.

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

Immunizations are not subject to the annual routine visit limitation.

7.30 Infertility Services

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

7.31 Inpatient Services at Other 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.

7.32 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.

7.33 Internal Prosthetic/Medical Appliances

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

7.34 Mammograms

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

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

7.35 Maternity Care Services

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

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

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

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

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

1. That child is legally adopted by you within one year from date of birth;

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

7.36 Medical Foods / Metabolic Supplements and Gastric Disorder Formula

Medical foods, 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 Appropriate when the Member has:

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

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

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

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

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

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

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

For Eosinophilic Gastrointestinal Disorder, amino acid-based formulas are considered medically appropriate when:

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

The following are not considered Medically Appropriate and are not covered as a Metabolic Food / Metabolic Supplement and Gastric Disorder Formula:

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

7.37 Medical Supplies

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

7.38 Mental Health and Substance Abuse Services

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

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

7.39 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.

7.40 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.

7.41 Outpatient Substance Abuse Rehabilitation Services

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

7.42 Mental Health and Substance Abuse Residential Treatment

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

7.43 Substance Abuse Detoxification Services

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

7.44 Excluded Mental Health and Substance Abuse Services

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

1. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Appropriate 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. articulation disorders.

5. Counseling for activities of an educational nature;
6. Counseling for borderline intellectual functioning;
7. Counseling for occupational problems;
8. Counseling related to consciousness raising;
9. Vocational or religious counseling;
10. I.Q. testing;
11. Marriage counseling;
12. Custodial care, including but not limited to geriatric day care;
13. Psychological testing on children requested by or for a school system;
14. Occupational/recreational therapy programs even if combined with supportive therapy forage-related cognitive decline; and
15. Biofeedback is not covered for reasons other than pain management.

7.45 Nutritional Evaluation

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

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

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

7.46 Self-Management Training

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

1. Morbid obesity
2. Diabetes

3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

7.47 Obstetrical and Gynecological Services

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

7.48 Organ Transplant Services

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

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

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

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

12. Kidney/liver.

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

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

7.49 Organ Transplant Travel Services

Travel expenses incurred by the Member in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Travel expenses are limited to $10,000. Organ transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available only for the recipient of a pre-approved organ/tissue transplant from a transplant facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following:

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

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

1. Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
2. Transportation to and from the transplant site in a personal vehicle will be reimbursed at 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.

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

7.50 Orthognathic Surgery

Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as medically necessary by the Medical Management Organization.

7.51 Ostomy Supplies

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

7.52 Oxygen and the Oxygen Delivery System

Coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the Service Area. Oxygen Services and Supplies are not covered outside of the Service Area, except on an emergency basis.

7.53 Prostate Screening

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

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

7.54 Routine Physical

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

7.55 Radiation Therapy

Radiation therapy and other therapeutic radiological procedures are covered.

7.56 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 except as required for the treatment for Autism Spectrum Disorder:

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

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

7.57 Surgical Procedures – Multiple/Bilateral

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

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

7.58 Temporomandibular Joint (TMJ) Disorder

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

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

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

7.59 Well Child Health Examinations

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

7.60 Well Woman Examinations

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

7.61 Well Man Examinations

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

ARTICLE 8

PRESCRIPTION DRUG BENEFITS

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

8.1 Prescription Drug Benefit

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

The Member must pay a portion of Covered Prescription Drugs to receive Prescription Drug Benefits. That portion is described below. The Prescription Drug Co-payment 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.

CO-PAYMENT 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 co-pay penalties.

PARTICIPATING RETAIL PHARMACY CO-PAYMENT (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

PARTICIPATING MAIL ORDER PHARMACY CO-PAYMENT (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

PARTICIPATING RETAIL CO-PAYMENT (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

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

DISPENSE AS WRITTEN or "DAW" are the rules associated with how the plan will pay for a name-brand prescription that has a generic equivalent. There are two rules related to this coverage "DAW1" and "DAW2".

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

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

To avoid additional cost above the co-payment amounts members should ask their doctor to prescribe any available generic equivalent medications.

The Preferred Medication List (PML), also known as a formulary, is a list of medications that will allow you to maximize the value of your prescription benefit. These medications, chosen by a committee of doctors and pharmacists, are lower-cost generics and brand names that are available at a lower cost than their more expensive brand-name counterparts. The PML is updated quarterly, and as needed throughout the year to add significant new medications as they become available. Medications that no longer offer the best therapeutic value for the plan are deleted from the PML once a year, and a letter is sent to any member affected by the change. To see what medications are on the PML, log on

to the PBM website or contact the Customer Service Center listed on your ID card. You may have a copy sent to you. Sharing this information with your doctor helps ensure that you are getting the medications you need, and saving money for both you and your plan.

8.2 Covered Prescription Drugs

The term Covered Prescription Drugs means:

1. A Prescription Legend Drug for which a written prescription is required. A Legend Drug is one which has on its label "caution: federal law prohibits dispensing without a prescription";
2. Insulin; pre-filled insulin cartridges for the blind; oral blood sugar control agents;
3. Needles, syringes, glucose monitors, and machines, glucose test strips, visual reading ketone strips; urine test strips, lancets and alcohol swabs are all covered when dispensed by the mail order and retail pharmacy program;
4. A compound medication of which at least one ingredient is a Prescription Legend Drug;
5. Tretinoin for individuals through age 24;
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. Growth hormones; (with prior-authorization); or
10. Injectable drugs or medicines for which a prescription is required, except injectable infertility drugs.

8.3 Limitations

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

1. For non-legend drugs, other than those specified under "Covered Prescription Drugs";
2. To the extent that payment is unlawful where the person resides when expenses are incurred;
3. For charges which the person is not legally required to pay;
4. For charges which would not have been made if the person were not covered by these benefits;
5. For experimental drugs or for drugs labeled: "Caution limited by federal law to investigational use";

6. For drugs which are not considered essential for the necessary care and treatment of a non-occupational Injury or Sickness, as determined by the 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 Choice90 Retail Pharmacy or Mail-Order Pharmacy;
11. For indications not approved by the Food and Drug Administration;
12. For immunization agents, biological sera, blood, or blood plasma;
13. For therapeutic devices or appliances, support garments and other non-medicinal substances, excluding insulin syringes;
14. For drugs for cosmetic purposes;
15. For tretinoin for individuals age 25 and over;
16. For administration of any drug;
17. For medication which is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution which operates, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
18. For prescriptions which an eligible person is entitled to receive without charge from any workers' compensation or similar law or any public program other than Medicaid;
19. For non-Medically Appropriate 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);
25. For all injectable infertility drugs; or
26. Prescription medications that have over-the-counter (OTC) equivalents.

8.4 Specialty Pharmacy

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

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

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

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

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

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

8.5 Reimbursement/Filing a Claim

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

If you or your Dependent purchases Covered Prescription Drugs from a Non-Participating Retail Pharmacy, you pay the full cost. These claims are considered not covered under any section of this Plan Description, unless the medication was obtained while traveling in a foreign country

and was for an emergency. Claim forms and foreign travel guidelines are available on the PBM's website.

8.6 Travel within the United States

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

8.7 International Travel

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

8.8 Extended Vacation

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

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

ARTICLE 9

EXCLUSIONS AND GENERAL LIMITATIONS

9.1 Exclusions and General Limitations

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

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

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

Medical literature means scientific studies published in a peer-reviewed national professional medical journal;

b. The subject of review or approval by an Institutional Review Board for the proposed use;
c. The subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the Cancer Clinical Trials provision of this plan under Covered Services and Supplies; or
d. Not demonstrated, through existing peer reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

9. Cosmetic surgery or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis depilation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function such as surgery required to repair bodily damage a person receives from an injury.
10. Non-life threatening complications of a non-covered cosmetic surgery are not covered. This includes, but is not limited to, subsequent surgery for reversal, revision or repair related to the procedure.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics including braces, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies for a continuous course of dental treatment started within six months of an accidental injury to sound natural teeth are covered. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

12. The following bariatric procedures are excluded: open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy and open adjustable gastric banding.
13. Unless otherwise included as a covered expense, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Physician or otherwise covered under the Plan under Covered Services and Supplies.
15. Reversal of voluntary sterilization procedures and voluntary termination of pregnancy.
16. 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.
18. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Plan.
19. Non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, and intellectual disabilities.
20. Therapy to improve general physical condition including, but not limited to, routine long term care.
21. Consumable medical supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the Inpatient Hospital Services, Outpatient Facility Services, Home Health Services, Diabetic Services and Supplies, or Breast Reconstruction, Ostomy Supplies and Breast Prostheses.
22. Private hospital rooms and/or private duty nursing are only available during 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. The following services are excluded: foot orthotics, corrective orthopedic shoes, and arch supports unless provided in the Diabetic Services and Supplies provision.
25. The following services and supplies are excluded: elastic/compression garments (except for treatment of lymphedema and burns), garter belts, corsets, dentures, wigs/hair pieces (exception when indicated for coverage in Section 7.17), hair transplants, and treatment of alopecia or hair loss.
26. Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post-cataract surgery); routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
27. Treatment by acupuncture.
28. All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided by this Plan.
29. Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.
30. Membership costs or fees associated with health clubs, and weight loss programs.
31. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Appropriate to determine the existence of a gender-linked genetic disorder.
32. Services rendered by a midwife for the purpose of home delivery.
33. Genetic testing and therapy including germ line and somatic unless determined Medically Appropriate by the Plan for the purpose of making treatment decisions.
34. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Plan's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
35. Blood administration for the purpose of general improvement in physical condition.
36. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks, except as otherwise referenced in this Plan Description. However, immunizations required for State of Arizona work related travel are covered by the Plan for all Members.

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

In addition to the provisions of this Exclusions and Limitations section, you will be responsible for payments on a fee-for-service basis for

Services and Supplies under the conditions described in the "Reimbursement" provision under Article 7 of this Plan Description.

9.2 Circumstance Beyond the Plan's Control

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

ARTICLE 10

COORDINATION OF BENEFITS AND OTHER SOURCES OF PAYMENT

10.1 Coordination of Benefits and Other Sources of Payment

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

Coordination of Benefits does not override plan provisions, exclusions, or Pre-Certification/Prior Authorization requirements as noted in this Plan Description. All Plan terms and conditions apply whether this Plan is primary or secondary, including the requirement to receive all services through a network provider except as specifically noted in this Plan Description.

10.2 Workers' Compensation

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

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

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

10.3 Coordination of Benefits

This section applies if you are covered under another plan besides this health plan or are a new Retiree and determines how the benefits under

the plans will be coordinated. If you are covered by more than one health benefit plan, you should file all claims with each plan.

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

When enrolling on the Benefit Options Plan as a New Retiree and if eligible for Medicare Part B at the time of retirement, a grace period will be granted until the first of the month following the retirement date. If a plan member who is eligible for Medicare Part B does not enroll in Medicare Part B, the Plan will only pay secondary benefits after the grace period has expired.

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

If you elect to enroll in a separate Medicare Part D Plan, you will not be permitted to continue in the Plan as it is considered Creditable Coverage.

10.4 Definitions

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

10.4.1. Plan

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

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

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

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

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

10.4.4. Secondary Plan
A Plan that determines and may reduce its benefits after taking into consideration 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.

10.4.5. Allowable Expense
A necessary, customary, and reasonable health care service or expense, including deductibles, coinsurance or co-payments, 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.

10.4.6. Claim Determination Period

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

10.4.7. Reasonable 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.

10.5 Order of Benefit Determination Rules

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

1. The Plan that covers you (the employee, subscriber or retiree) is primary and the Plan that covers 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.

10.6 Effect on the Benefits of this Plan

If Benefit Options is the Secondary Plan, Benefit Options may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all Allowable Expenses. All co-pays 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 physician's office	= $100
Medicare payment (including write-off)	= $ 90
Member co-pay	= $ 10
Plan payment	= $ 0
Claim filed for services in a physician's office	= $100
Medicare payment (including write-off)	= $ 70
Member co-pay	= $ 10
Plan payment	= $ 20

10.7 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 the Plan is obligated to provide under this Plan, the Plan shall have the right to recover the actual payment made. When an overpayment is identified, the refund request will be initiated to the original payee of issued check. If the payee is the Provider, the Member will receive a copy of the letter. In the event the overpayment is not refunded to the Plan, the Third Party Claim Administrator may apply future claims to the balance of the overpaid amount.

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

10.8 Right to Receive and Release Information

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

10.9 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.

10.10 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