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

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 The Covered Person agrees that the Covered Person's right to be made whole is superseded by the Plan's right of subrogation and/or right of reimbursement.

The Covered Person agrees to fully cooperate with the Plan in any effort by the Plan to recover pursuant to its rights of subrogation and/or reimbursement, and the Covered Person further agrees to do nothing to prejudice such rights. The Covered Person agrees to provide information to the Plan necessary for the Plan to pursue such rights, and further agrees, if requested by the Plan, to acknowledge in writing the rights of the Plan to recover following any injury or illness giving rise to any payments under the Plan. If requested to do so by the Plan, the Covered Person agrees to assign in writing to the Plan the Covered Person's right to recover against any Third-Party without the Plan having been paid in full, then the Covered Person agrees to hold such payment in trust for the Plan and promptly notify the Plan in writing that the Covered Person is holding such funds and will release such funds to the Plan upon request by the Plan. The Covered Person further agrees to promptly notify the Plan in writing of the commencement of any litigation or arbitration seeking recovery from any Third-Party, and further agrees not to settle any claim against any Third-Party without first notifying the Plan in writing at least fourteen days before such settlement so the Plan may take actions it deems appropriate to protect its right of subrogation

and/or right of reimbursement. In the event the Covered Person commences any litigation against any Third Party, the Covered Person agrees to name the Plan as a party to such litigation so as to allow the Plan to pursue its right of subrogation and/or right of reimbursement.

10.11 Statutory Liens

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

10.12 Fraud

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

ARTICLE 11

CLAIM FILING PROVISIONS AND APPEAL PROCESS

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

11.1 Discretionary Authority

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

11.2 Claims Filing Procedure

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

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

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

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

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

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

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

11.3 Notice of Claim – Post-Service Claims

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

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

11.4 Initial Claim Determination

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

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

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

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

1. The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed in making the determination, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to the Member free of charge upon request. If the claim was denied because it does not meet the definition of a Covered Expense or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Member's medical circumstances can be provided free of charge to the Member upon request, including the names of any medical professionals consulted during the review process.
2. A description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;
3. A statement that the Member is entitled to request, free of charge, reasonable access to all documents, records, and other information relevant to the Member's claim.
4. For a denial involving urgent care claim, the notice will also include a description of the expedited review process for such claims. The notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 business days after the oral notice.

5. For medical claims, the notice will also include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount and the denial code. Further, the denial notice will include the following information (a) a statement that diagnosis and treatment codes are available upon request, (b) a description of the standard used in denying the claim, (c) a description of the external review process, and (d) the availability of, and contact information for, any applicable office of insurance consumer or ombudsman to assist enrollees with internal claims and appeals and external review processes.
6. A statement notifying the Member about further appeal processes available, as established by the Third Party Claim Administrator.

11.5 Concurrent Care Decisions

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

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

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

11.6 Incomplete Urgent Care Claims Notification

In the case of an Urgent Care Claim, if additional information is required to make a claim determination, the Plan will provide the Member notification that will include a description of the information needed to complete the claim. This notice must be provided within 24 hours after receipt of the claim for an inpatient admission and 3 business days for

outpatient services. The Member shall be afforded at least 48 hours from receipt of the notice in which to provide the specified information. The Plan shall make its initial determination as soon as possible, but in no case later than 48 hours after the earlier of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the Member to provide the specified additional information.

11.7 Extensions of Time

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

11.8 Required Filing Procedures for Pre-Service Claims

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

11.9 Claims Appeal Procedures

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

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

a. Employee name;
b. Covered Employee's Member ID;
c. Name of the patient; and
d. Group/Client Identification number from the Member's ID card.

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

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

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

The review of the denial will be made by the Third Party Claim Administrator, or by an appropriate named fiduciary who is neither the party who made the initial claim determination nor the subordinate of such party. The review will not defer to the initial claim determination

and will take into account all comments, documents, records and other information submitted by the Member without regard to whether such information was previously submitted or relied upon in the initial determination. In deciding an appeal of any denied claim that is based in whole or in part on a medical judgment, the Plan must consult with an appropriately qualified health care professional who is neither an individual who was consulted in connection with the denied claim that is the subject of the appeal nor the subordinate of any such individual.

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

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

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

For medical claims, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to the claim, the claimant is deemed to have exhausted the internal claims and appeals process and may request an expedited external review before the Plan's internal appeals process has been completed. However, this shall not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange

of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, the claimant may resubmit the claim for internal review and the claimant may ask the Plan to explain why the error is minor and why it meets this exception.

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

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

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

1. The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed in making the determination, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to the Member free of charge upon request. If the claim was denied because it does not meet the definition of a Covered Health Service or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Member's medical circumstances can be provided free of charge to the Member upon request, including the names of any medical professionals consulted during the review process.
2. A statement that the Member is entitled to request, free of charge, reasonable access to all documents, records, and other information relevant to the Member/Participant's claim.
3. For a denial involving urgent care, the notice will also include a description of the expedited review process for such claims. The notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 business days after the oral notice.
4. For medical claims, the notice will also include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount and the denial code. Further, the denial notice will include the following information (a)

a statement that diagnosis and treatment codes are available upon request, (b) a description of the standard used in denying the claim, (c) a description of the external review process, and (d) the availability of, and contact information for, any applicable office of health insurance consumer or ombudsman to assist enrollees with internal claims and appeals and external review processes.

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

11.10 Levels of Standard Appeal and Responsibility of Review

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

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

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

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the IRO must consider when conducting the External Review. Within one (1) business day after making the decision, the IRO must notify you, Third Party Claims Administrator and the Plan.

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

are available and the IRO considers them appropriate, will consider the following in reaching a decision:

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

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

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

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

Expedited Independent Review

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

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

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

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

11.11 Pharmacy Appeals

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

If you are dissatisfied with any service received under this Prescription Drug Benefit, you are encouraged to contact the PBM Customer Service Center. Frequently, your concern can be resolved with a telephone call to a Member Service Representative. If the Customer Service Center

cannot resolve your concern, you may proceed to the Appeals Procedures as set forth above by contacting the Third Party Claim Administrator. Examples of concerns include, but are not limited to, quality of service received, the design of the prescription drug benefit plan, denial of a clinical authorization of a drug, payment amount, or denial of a claim issue.

11.12 Limitation

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

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

ARTICLE 12

PLAN MODIFICATION, AMENDMENT AND TERMINATION

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

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

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

This document is effective January 1, 2016 and supersedes all plan descriptions and all enrollment guides previously issued by the Plan Sponsor.

ARTICLE 13

ADMINISTRATION

13.1 Plan Sponsor's Responsibilities

The Plan Sponsor shall have the authority and responsibility for:

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

13.2 Third Party Claim Administrator's Responsibilities

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

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

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

Party Claim Administrator, will be final and binding on the Members and beneficiaries and all other interested parties.

13.3 Advisors to Fiduciaries

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

13.4 Multiple Fiduciary Functions

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

13.5 Notice of Appointments or Delegations

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

13.6 Written Directions

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

13.7 Co-Fiduciary Liability

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

13.8 Action by Plan Sponsor

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

13.9 HIPAA Privacy Regulation Requirements

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

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

13.10 Patient Protection & Affordable Care Act (PPACA) Notices

Grandfather Status Notice

The Arizona Department of Administration believes the Benefit Options plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain requirements of the PPACA that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other requirements in the PPACA; for example, the elimination of lifetime limits on benefits. Questions regarding which requirements do and do not apply to a grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to Benefit Services Division at 602-542-5008 or benefitsissues@azdoa.gov.

Notice of Rescission

Under the PPACA, Benefit Services Division cannot retroactively cancel or terminate an individual's coverage, except in cases of fraud and similar situations. In the event that the Benefit Services Division rescinds coverage under the allowed grounds, affected individuals must be provided at least 30 days advanced notice.

Form W-2 Notice

Pursuant to the PPACA for tax years starting on and after January 1, 2012, in addition to the annual wage and tax statement employers must

report the value of each employee's health coverage on form W-2, although the amount of health coverage will remain tax-free.

Notice about the Summary of Benefits and Coverage (SBC) and Uniform Glossary

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

ARTICLE 14

MISCELLANEOUS

14.1 State Law

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

14.2 Status of Employment Relations

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

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

14.3 Word Usage

Whenever words are used in this Plan Description in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine, or neutral form.

14.4 Titles are Reference Only

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

14.5 Clerical Error

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

ARTICLE 15

PLAN IDENTIFICATION

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

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

3. Third Party Claim Administrators:

Medical Vendors	Aetna	Blue Cross Blue Shield of Arizona	CIGNA Health Care	UnitedHealthcare Insurance Company
Claims Address	PO BOX 14079 Lexington, KY 40512-4079	PO Box 2924 Phoenix, AZ 85062-2924 For chiropractic services: American Health Specialty Health Networks, Inc. Claims Administration PO Box 509001 San Diego, CA 92150-9001	PO BOX 188050 Chattanooga, TN 37422-8050	UnitedHealthcare PO BOX 30884 Salt Lake City, UT 84130
Appeals/ Correspondence Address	Attn: National Account CRT PO Box 14463 Lexington, KY 40512	Blue Cross Blue Shield of Arizona Medical Appeals and Grievances / Transplant Travel and Lodging Claims / Cruise Ship Claims PO Box 13466 Phoenix, AZ 85002-3466 For disputes over chiropractic care: American Specialty Health Networks, Inc. Appeals Coordinator PO Box 509001 San Diego, CA 92150-9001	CIGNA HealthCare Inc. National Appeals Unit PO Box 5225 Scranton, PA 18505-5225	UnitedHealthcare P.O. Box 740816 Atlanta, GA 30374-0816
Phone	866-217-1953	866-287-1980	800-968-7366	800-896-1067
Fax	859-455-8650	602-864-3102	888-999-1459	801-567-5498
TDD/TTY	800-628-3323	Maricopa county: 602-864-4823	Hearing impaired members are encouraged to use the	800-896-1067

		Statewide: 800-232-2345, Ext 4823	TRS (Telecommunications Relay Service) by dialing 711 from their phone or TTY.	
Website	www.aetna.com	www.azblue.com	www.cigna.com/stateofaz	www.myuhc.com
Policy Number	476687	30855	3331993	705963

Pharmacy Vendor	MedImpact
Claims Address	10680 Treena Street San Diego, CA 92103
Appeals/Correspondence Address	Attn: Appeals Coordinator 10680 Treena St 5th Floor San Diego, Ca 92131
Phone	888-648-6769
Fax	858-621-5147
Website	www.benefitoptions.az.gov
Bin Number	003585
Retail PCN Number	28914

4. Sponsor Identification Number: 86-6004791

5. Type of Benefits Provided: See Schedule of Benefits

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

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

Medical Vendors	Aetna Life Insurance Company	Blue Cross Blue Shield of Arizona	CIGNA Health Care	UnitedHealthcare Insurance Company
Address	151 Farmington Avenue Hartford, CT 06156	2444 W. Las Palmaritas Drive Phoenix, AZ 85021-4883	11001 N. Black Canyon Highway Phoenix, AZ 85029	450 Columbus Blvd. Hartford, CT 06103

Pharmacy Vendor	MedImpact
Address	10680 Treena Street San Diego, CA 92103

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

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

ARTICLE 16

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

AUTISM SPECTRUM DISORDER shall mean one of the three following:

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

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

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

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

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

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

1. Has an organized staff of certified midwives, physicians, and other trained personnel;
2. Has necessary medical equipment;
3. Has a written agreement to transfer to a hospital if necessary; and
4. Is in compliance with any applicable state or local regulations.

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

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

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

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

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

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

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

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

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

CUSTODIAL CARE shall mean the care generally provides assistance in performing activities of daily living (ADL), (e.g., assistance walking, transferring in and out of bed, bathing, dressing, using the toilet, and preparation of food, feeding and supervision of medication that usually can be self-administered). Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. Also can be defined as the following:

- Custodial care is that care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care.
- Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered.
- Custodial care essentially is personal care that does not require the continuing attention or supervision of trained, medical or paramedical personnel.
- Custodial care is maintenance care provided by family members, health aids or other unlicensed individuals after an acute medical event when an individual has reached the maximum level of

physical or mental function and is not likely to make further significant improvement.
- In determining whether an individual is receiving custodial care, the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.

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

DEDUCTIBLE shall mean the amount of covered expenses the participant must pay each Plan Year before benefits are payable by the Plan.

DEPENDENT see ELIGIBLE DEPENDENT.

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

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

EFFECTIVE DATE shall mean the first day of coverage.

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

ELIGIBLE DEPENDENT shall mean the member's spouse or child.

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

1. A patient or inmate employed at a state institution;
2. A non-state employee, officer or enlisted personnel of the National Guard of Arizona;
3. A seasonal employee, unless they are determined to have been paid for an average of at least 30 hours per week using a 12-month measurement period.

4. A variable hour employee, unless they are determined to have been paid for an average of at least 30 hours per week using a 12-month measurement period.

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

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

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

ELIGIBLE PUBLIC SAFETY SURVIVOR shall mean a spouse or child defined in A.R.S. § 38-1103 and who falls into one of the following categories:

1. A spouse who is not Medicare eligible or remarried;
2. An unmarried natural child, adopted child, or stepchild of the member under the age of 18
3. An unmarried natural child, adopted child, or stepchild of the member under the age of 23 and a fulltime student
4. An unmarried natural child, adopted child, or stepchild of the member and who had a disability prior to age 23

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

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

case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

EMPLOYEE see ELIGIBLE EMPLOYEE.

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

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

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

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

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

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

1. Is primarily engaged in providing 24-hour-per-day accommodations and skilled nursing care inpatients recovering from illness or injury;
2. Is under the full-time supervision of a physician or registered nurse;
3. Admits patients only upon the recommendation of a physician, maintains adequate medical records for all patients, at all times has available the services of a physician under an established agreement;
4. Has established methods and written procedures for the dispensing and administration of drugs;
5. Is not, other than incidentally, a place for rest, a place for the aged, a place for substance abuse treatment; and
6. Is licensed in accordance with all applicable federal, state and local laws, and is approved by Medicare.

FOOT ORTHOTICS shall mean devices for support of the feet.

FORMER ELECTED OFFICIAL see ELIGIBLE FORMER ELECTED OFFICIAL

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

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

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

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

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

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

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

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

1. Provides in-home nursing care and counseling by licensed professionals under the direction of a full-time registered professional nurse;
2. Maintains a complete medical record for each patient; and

3. Is primarily engaged in providing nursing care and counseling for terminally ill patients during the final stages of their illnesses and does not, other than incidentally, perform housekeeping duties.

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

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

HOSPITAL CONFINEMENT shall refer to a situation in which:

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

ILLNESS shall mean physical disease or sickness, including pregnancy.

IMMEDIATE RELATIVE shall mean a spouse, parent, grandparent, child, grandchild, brother or sister of a participant, and any dependent's family members.
IN-NETWORK shall mean utilization of services within the network of contracted providers associated with the Third Party Claim Administrator.

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

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

INTENSIVE CARE UNIT shall mean an area in a hospital, established by said hospital as a formal intensive care program exclusively reserved for critically ill patients requiring constant audiovisual observation as

prescribed by the attending physician, that provides room and board, specialized, registered, professional nursing and other nursing care, and special equipment and supplies immediately available on a stand-by basis, and that is separated from the rest of the hospital's facilities.

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

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

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

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

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

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

MEMBER shall mean an eligible employee, eligible retiree, or eligible former elected official that pays/contributes to the monthly premium required for enrollment in the Plan. Surviving dependents and surviving children are considered members in certain circumstances.

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

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

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

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

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

NETWORK shall mean the group of providers that are contracted with the networks associated with the Medical Vendor for the purpose of

performing healthcare services at predetermined rates and with predetermined performance standards.

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

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

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

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

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

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

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

OUT-OF-POCKET MAXIMUM shall mean the most any participant will pay in annual out-of-pocket expenses.

PARTICIPANT shall mean a member or a dependent.

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

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

1. Licensed by the Board of Pharmacy;
2. Maintains records in accordance with federal and state regulations; and
3. Staffed with a licensed registered pharmacist.

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

PLAN referred to in this document shall mean a period of twelve (12) consecutive months. For active employees, retirees, long term disability (LTD) recipients, former elected officials, surviving spouses of participating retirees, and employees eligibility for normal retirement this period commences on January 1 and ending on December 31. Any and all provisions revised in the Plan Document will become effective January 1 unless specified otherwise.

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

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

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

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

PRE-CERTIFICATION/PRIOR AUTHORIZATION shall mean the prospective determination performed by the Medical Vendor to determine the medical

necessity and appropriateness of a proposed treatment, including level of care and treatment setting.

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

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

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

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

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

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

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

QUALIFIED LIFE EVENT shall mean a change in a member's or dependent's eligibility, employment status, place of residence, Medicare-

eligibility, or coverage options that triggers a 31-day period[12] in which the member is allowed to make specific changes to his/her enrollment options. This includes, but is not limited to:

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER shall mean a court order that provides health benefit coverage for the child of the noncustodial parent under that parent's group health plan.
REASONABLE AND CUSTOMARY CHARGE shall mean the average charge for a service rendered in a specific geographical region and taking into account the experience, education and skill level of the provider rendering that service.

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

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

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

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

5. Must provide nursing services 24 hours per day by registered nurses or licensed practical nurses.

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

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

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

SERVICE AREA shall mean the nationwide network offered by the Medical Network Vendor.

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

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

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

SPOUSE shall mean the member's marital partner under Arizona law.

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

SUBSTANCE ABUSE shall mean:

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

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

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

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

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

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

SURVIVING DEPENDENT shall mean the spouse/child who survives upon the death of the member.

SURVIVING SPOUSE shall mean the husband or wife, as provided by Arizona law, of a current or former elected official, employee, or retiree, who survives upon the death of his/her spouse.

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

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

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

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

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