Exhibit 22

ARIZONA **BENEFIT SERVICES** DIVISION

ARIZONA DEPARTMENT OF ADMINISTRATION

BENEFIT OPTIONS

EPO PLAN

EFFECTIVE JANUARY 1, 2017

www.benefitoptions.az.gov

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ARTICLE 1

PLAN MODIFICATION, AMENDMENT AND TERMINATION

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

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

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

This Plan document is effective January 1, 2017 and supersedes all Plan Descriptions and all enrollment guides previously issued by the Plan Sponsor.

ARTICLE 2

ESTABLISHMENT OF PLAN

2.1 Purpose

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

2.2 Exclusive Benefit

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

2.3 Compliance

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

2.4 Legal Enforceability

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

2.5 Note to Members

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

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

ARTICLE 3

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility

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

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

Please see Article 17 for definitions of the terms used in this section.

3.2 Member Eligibility

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

Members' legal Spouse and eligible children under the age of 26 may participate in the Plan. An Eligible Dependent may not participate in the Plan unless an Eligible Employee, Eligible Retiree, or Eligible Former Elected Official is also enrolled. Please see Article 17 for definitions of the terms used in this section.

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

3.3 Continuing Eligibility through COBRA

See Section 3.13 of this article.

3.4 Non-COBRA Continuing Eligibility

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

Eligible Employee on Leave without Pay

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

- Receiving long-term disability benefits that include the benefit of continued participation;
- Becoming eligible for Medicare coverage; or

- Completing 30 months of leave without pay.

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

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

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

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

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

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

Surviving Spouse/Child of Insured Employee Eligible for Retirement under the Arizona State Retirement System (ASRS)
Upon the death of an insured Employee meeting the criteria for retirement under the ASRS, the Surviving Spouse and Children, provided each was enrolled at the time of the Member's death, are eligible to continue participation in the Plan by payment of the Retiree premium.

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

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

In the case where insured Children survive but no Spouse survives, each Child, for purposes of Plan administration, will be reclassified as a Member. As such, each Child may enroll

Dependents as allowed under Section 3.2. In this circumstance, coverage for each Surviving Child may be continued indefinitely.

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

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

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

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

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

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

3.5 Eligibility Audit

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

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

3.6 Grievances Related to Eligibility

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

- Name and contact information of the individual filing the grievance;

- Nature of the grievance;
- Nature of the resolution requested; and
- Supporting Documentation

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

3.7 Enrollment Procedures and Commencement of Coverage

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

3.8 Initial Enrollment

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

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

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

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

[1] Under no circumstance will coverage for a Dependent become effective prior to the Member's coverage becoming effective.

[2] For state employees entering retirement and their Dependents, coverage begins the first day of the first pay period following the end of coverage as a state employee. This results in no lapse in coverage.

Category	Must enroll within 31 days	Enrollment contact	Coverage begins on the[1]
Eligible Former Elected Official	Date of leaving office or retiring	Benefit Services	first day of first month after completion of enrollment process[3]

3.9 Open Enrollment

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

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

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

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

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

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

3.10 Qualified Life Event Enrollment

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

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

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

[3] Eligibility is subject to A.R.S. § 38-802.

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

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

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

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

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

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

[5] University and political subdivision employees should contact the appropriate human resources office for information regarding effective date of coverage changes.
[6] Born to Member or Member's legal Spouse.
[7] Coverage ends on 31st day after date of birth if Member does not enroll newborn in the Plan.

Type of event	Must enroll/change coverage within 31 days of:	Coverage/change in coverage begins on the[5]:
Child placed under legal guardianship	date Member granted legal guardianship	date Member granted legal guardianship[8]
Child placed in foster care	date of placement in foster care	See above

3.11 Change in Cost of Coverage

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

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

3.12 Termination of Coverage

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

Category	Coverage ends at 11:59 p.m. on the earliest of:
Eligible state/university Employee	• last day of the pay period for/in which the Member: ➢ makes last contribution; ➢ fails to meet the requirements for eligibility; or ➢ becomes an active Member of the armed forces of a foreign country; or • last day Member is eligible for extension of coverage.
Eligible participating political subdivision Employee	*Please contact the appropriate human resources office*
Eligible Retiree[9]/Former Elected Official	• last day of the month for/in which the Member: ➢ makes last premium payment; or ➢ fails to meet the requirements for eligibility.
Eligible long-term disability recipient	• last day of the month in which the disability benefit ends.
Eligible Dependent	• the last day of the month which the Dependent Child reaches the limiting age of 26; • day the Dependent: ➢ dies; ➢ loses eligibility for reason other than limiting age; or ➢ becomes an active Member of the armed forces of a

[8] A Child adopted, placed under legal guardianship, or placed in foster care covered from date of adoption *only if* Member subsequently enrolls Child in the Plan.
[9] Excluding long-term disability recipient.

Category	Coverage ends at 11:59 p.m. on the earliest of:
	foreign country; or • day the Member: ➢ is relieved of a court-ordered obligation to furnish coverage for a Dependent Child; or ➢ is no longer covered.
Eligible Employee on leave without pay	• last day of period in which Member becomes eligible for: ➢ long-term disability benefits for which there is eligibility to continue coverage under the Plan; or ➢ coverage under Medicare; or • 30 months after the leave-without-pay period began; • Last day of the period for which the Member makes last payment.
Surviving Child/Spouse of Eligible Retiree	• last day of the period for which the Member makes last payment; or • day the Surviving Child fails to be eligible as a Child.
Surviving Spouse of elected official or Eligible Former Elected Official	• last day of the period for which the Member makes last payment.

3.13 Continuing Eligibility through COBRA

Eligibility of Enrolled Members/Dependents

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

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

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

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

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

3.14 Subsequent Qualifying Events

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

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

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

3.15 Eligibility of Newly Acquired Eligible Dependents

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

3.16 Special Rules Regarding Disability

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

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

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

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

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

3.17 Payment for COBRA Coverage

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

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

3.18 Notification by the Member/Dependent

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

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

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

Written notification should be directed to:

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

3.19 Notification by the Plan

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

3.20 Electing COBRA Coverage

Information related to COBRA coverage and enrollment may be obtained through an agency liaison or by calling ADOA Benefit Services Division at 602-542-5008 or 1-800-304-3687 or by writing to the address provided in Article 16.

3.21 Early Termination of COBRA Coverage

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

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

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

3.22 Contact Information for the COBRA Administrator

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

3.23 Certificate of Creditable Coverage

When COBRA coverage ends, the medical vendor will send a certificate of creditable coverage. This certificate confirms that each participant was covered under the Plan and for what length of time.

ARTICLE 4

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

4.1 Pre-Certification/Prior Authorization and Notification

Pre-Certification/Prior Authorization is the process of determining the Medical Necessity of services before the services are incurred. This ensures that any medical care a Member receives meets the Medical Necessity requirements of the Plan. The definition and requirements of Medical Necessity are identified in Article 17. Pre-Certification/Prior Authorization is required if the Plan is considered primary as defined in Article 11. Pre-Certification/Prior Authorization is initiated by calling the toll-free Pre-Certification/Prior Authorization phone number shown on your ID card and providing information on the planned medical services. Pre-Certification/Prior Authorization may be requested by you, your Dependent or your Physician. However, the Member is ultimately responsible to ensure Pre-Certification/Prior Authorization is obtained.

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

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

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

4.2 Treatment by Participating Providers

If you do not pre-certify as required above, the Claims Administrator will review the claims submitted for Medical Necessity after the services have been rendered. If the claim is denied based on the Plan provisions or Medical Necessity, the Plan is not responsible for payment.

4.3 Treatment by Non-Participating Providers

Except in emergency situations, treatment provided by a Non-Participating Provider is not covered by the Plan. However, there may be rare circumstances where the Plan will provide coverage for services rendered by a Non-Participating Physician (e.g. there is only one specialist who is able to treat your specific disease and that specialist does not contract with the

network). The only way you can obtain coverage in these instances is by obtaining Pre-Certification/Prior Authorization.

4.4 Medical Services Inpatient Admissions

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

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

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

4.5 Other Services and Supplies

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

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

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

4.6 Notification of 23-Hour Observation Admissions

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

4.7 Notification of Maternity Services

While Pre-Certification/Prior Authorization is not required for maternity services in the physician's office, outpatient, and inpatient within federally mandated stay limits, we

encourage you to contact the Third Party Claim Administrator if you will be receiving any maternity services. This will assist in the Pre-Certification/Prior Authorization process should inpatient services be required that exceed 48 hours for a normal delivery and 96 hours for a cesarean section. Notification also enables the Third Party Claim Administrator staff to assist you with education and/or resources to maintain your health during your pregnancy.

4.8 Prescription Medications

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 5

CASE MANAGEMENT / DISEASE MANAGEMENT AND INDEPENDENT MEDICAL ASSESSMENT

5.1 Case Management

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

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

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

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

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

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

The Case Manager arranges for alternate treatment services and supplies, as needed. (For example, nursing services or a hospital bed and other durable medical equipment for the home.)

The Case Manager also acts as a liaison between the patient, his or her family, and physician as needed. (For example, by helping you to understand a complex medical diagnosis or treatment plan.)

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

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

5.2 Disease Management

Disease Management is a service provided by the Third Party Claim Administrator, which assists Members with treatment needs for chronic conditions. Disease Management is a voluntary program – no penalty or benefit reduction is imposed if you do not wish to participate in Disease Management.

If you are being treated for certain conditions which have been initiated under this program, you will be contacted by the Disease Management staff with further information on the program. The goal of Disease Management is identification of areas in which the staff may assist you with education and/or resources to maintain your health.

5.3 Independent Medical Assessment

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

ARTICLE 6

TRANSITION OF CARE

6.1 Transition of Care

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

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

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

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

ARTICLE 7

OPEN ACCESS TO PROVIDERS

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

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

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

ARTICLE 8

SCHEDULE OF MEDICAL BENEFITS
COVERED SERVICES AND SUPPLIES

8.1 Schedule of Medical Benefits Covered Services and Supplies Chart

It is important to note that all inpatient services, specific outpatient services, and certain prescription medications require Pre-Certification/Prior Authorization. Please refer to Article 4 of this document for details.

	Copayment
Physician Visits	
Adult Immunizations. Refer to Section 8.29 for a complete list of Adult Immunizations.	$15.00
Routine Physical 1 visit per Member per Plan Year	$15.00
Chiropractic & Osteopathic Includes all spinal manipulation or treatment. Limited to 20 visits per Member per Plan Year subject to being Medically Necessary.	$15.00
Hearing Exam One per Member per Plan Year	$15.00
Obstetrics & Gynecology OB/GYN	$10.00
Physician Visits (one copay per day per provider) (General Practice, Family Practice and Internal Medicine, Chiropractor, Speech Therapy[12], Occupational Therapy[12], Cardiac Therapy[12], Respiratory Therapy[12], and Physical Therapy[12], and Pediatrician)	$15.00
Specialists Visit	$30.00
Prenatal Care and Program For initial diagnosis; covered at 100% thereafter	$10.00
Rehabilitation Services, Short-Term, limited to 60 visits per Member per Plan Year for all therapy types listed combined.	$15.00
Urgent Care Center	$40.00

[12] Subject to the benefit limitations described under Short-term Rehabilitative Therapy Section 8.56.

	Copayment
Well-Child through 47 months. (Copay is waived if the only service rendered is a well-child immunization).	$15.00
Well-Man Care 1 visit per Member per Plan Year.	$15.00
Well-Woman Exam 1 visit per Member per Plan Year.	$15.00 PCP[13] $10.00 OB-GYN[13]
Hospital Services	
Ambulance (for medical emergency or required interfacility transport)	No charge
Hospice Care Inpatient facility or home hospice for life expectancy of 6 months or less.	No charge
Hospital Admission (including Intensive Care Unit and Private Rooms when Medically Necessary)	$150.00[14]
Hospital Emergency Room (In-network and out-of-network). Must be a Medical Emergency as defined by the Plan.	$125.00[15]
Non-emergency ambulance transportation with Pre-Certification/Prior Authorization.	No charge
Radiology and Laboratory	No charge
Rehabilitation Facility Hospital or sub-acute facilities	No charge
Skilled Nursing Facility Hospital or sub-acute facilities. 90-day limit per Member per Plan Year.	No charge
Surgery/Anesthesia/Asst Surgeon (inpatient)	No charge
Bariatric Surgery	20% coinsurance
Mental Health Services	
Mental/Nervous, and Substance Abuse Office Visit	$15.00
Mental/Nervous, and Substance Abuse (inpatient & residential)	$150.00

[13] Copayment is subject to the type of provider at visit.

[14] Hospital in-patient admission copayment would apply to any in-patient hospital admission with or without an authorization excluding: Subacute Care, Post-Acute Care, Hospice, Bariatric Surgery and Maternity Admission. Subacute Care would include but not be limited to: long-term care, hospital-based skilled nursing facilities (SNFs), and free standing SNFs.

[15] Waived if admitted to hospital directly from emergency room but subject to hospital admission copayment.

	Copayment
Other Services	
Allergy Testing	$30.00
Antigen Administration Desensitization/treatment	$30.00
Autism Spectrum Disorder Services	$15.00
Contraceptive appliances, Contraceptive injections, diaphragms, and cervical caps obtained at a Physician's office. PCP OBGYN	 $15.00 $10.00
Corrective Appliances, Prosthetics, Medically Necessary foot orthotics.	No charge
Diagnostic Testing, including Laboratory and Radiology	No charge
Durable Medical Equipment (DME) Medically Necessary.	No charge
Family Planning Services Voluntary Tubal ligation (outpatient facility) Vasectomy (physician's office) Implantable contraceptive products as approved by the FDA.	 $50.00 $30.00 $30.00
Hearing Aids Limited to one per ear/per Plan Year.	No charge
Home Health/Home Infusion Care. Limited to 42 visits per Member per Plan Year as described in Section 8.27 Home Health Services.	No charge
Mammography screening	No charge
Nutritional Evaluation	$15.00
Organ and Tissue Transplantation and Donor Coverage. No coverage if Member is an organ donor for a recipient other than a Member enrolled under this Plan. Travel & lodging expenses are limited to $10,000 per transplant. Travel and lodging are not covered if the Member is a donor.	No charge
Ostomy supplies	No charge
Prostate Screening	No charge
Surgery Facility and Associated Physician Fees	
In primary physician's office In a specialist office In freestanding ambulatory facility In hospital outpatient surgical center	$15.00 $30.00 $50.00 $50.00

8.2 Determination of Eligible Expenses

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

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

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

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

8.3 Notification, Proof of a Claim, and Payment

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

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

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

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

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

8.4 Covered Expenses

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

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

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

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

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

8.5 Autism Spectrum Disorder Services

Behavioral therapy is only covered for the treatment of Autism Spectrum Disorder as defined in Article 17.

Short-term rehabilitative therapy included in an outpatient facility or physician's office that is part of a rehabilitation program for treatment of Autism Spectrum Disorder, including physical, speech, and occupational therapy is subject to the 60 visit benefit limitations described under Section 8.56 Short-Term Rehabilitative Therapy.

The following services are excluded: Sensory Integration, LOVAAS Therapy and Music Therapy.

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

8.6 Physician Services

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

8.7 Inpatient Hospital Services

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

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

8.8 Outpatient Facility Services

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

8.9 Emergency Services and Urgent Care

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

If you receive Emergency Services outside the Service Area, you must notify the Third Party Claim Administrator as soon as reasonably possible. We may arrange to have you transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

"Emergency Services" are defined as a medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect

the absence of immediate medical attention to result in placing the health of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

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

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

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

8.10 Continuing or Follow-up Treatment

Continuing or follow-up treatment by providers out of the Service Area is not covered unless it is Pre-Certified by the Third Party Claim Administrator.

8.11 Ambulance Service

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

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

8.12 Bariatric Surgery

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

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

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

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

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

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

The following bariatric procedures are excluded:

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

8.13 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.

8.14 Cancer Clinical Trials

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

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

For the purposes of this specific covered service and benefit, coverage outside the State of Arizona will be provided under the following conditions:

(a) The clinical trial treatment is curative in nature; (b) The treatment is not available through a clinical trial in the State of Arizona; (c) There is no other non-investigational treatment alternative;

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

1. "Cooperative Group" – means a formal network of facilities that collaborates on research projects and that has an established national 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 reasonable and customary care.

   Patient cost does not include the cost: (a) of any drug or device provided in a phase I cancer clinical trial; (b) of any investigational drug or device; (c) of non-health services that might be required for a person to receive treatment or intervention; (d) of managing the research of the clinical trial; (e) that would not be covered under the Plan; and (f) of treatment or services provided outside the State of Arizona.

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

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

8.16 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.

8.17 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 Third Party Claim Administrator and the compression stocking cannot be repaired or when required due to a change in the Member's physical condition.

8.18 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.

8.19 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.

8.20 Diabetic Service and Supplies

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

1. Podiatric appliances for prevention of complications associated with diabetes; foot orthotic devices and inserts (therapeutic shoes: including Depth shoes or Custom

Molded shoes.) Custom molded shoes will only be covered when the Member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and *any* of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. Definitions of Depth Shoes and Custom-Molded Shoes are as follows:

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

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

8.21 Diagnostic Testing, including Laboratory and Radiology Services

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

8.22 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 Third Party Claim Administrator. Repair or replacement is covered when approved as medically necessary by the Third Party Claim Administrator.

Durable medical equipment is defined as:

1. Generally for the medical or surgical treatment of an Illness or Injury, as certified in writing by the attending medical provider;
2. Serves a therapeutic purpose with respect to a particular Illness or Injury under treatment in accordance with accepted medical practice;
3. Items which are designed for and able to withstand repeated use by more than one person;
4. Is of a truly durable nature;

5. Appropriate for use in the home; and
6. Is not useful in the absence of Illness or Injury.

Such equipment includes, but is not limited to, 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.

8.23 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).

8.24 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).

8.25 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 8.20 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.

8.26 Hearing Aids

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

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

8.27 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 Third Party Claim Administrator.
4. The home health agency delivering care must be certified within the state the care is received.
5. The care that is being provided is not custodial care.

A Home Health visit is considered to be up to four hours of services. Home health services do not include services of a person who is a Member of your family or your Dependent's family or who normally resides in your house or your Dependent's house. Physical, occupational, and speech therapy provided in the home are also subject to the 60 visit benefit limitations described under Section 8.56 Short-Term Rehabilitative Therapy.

8.28 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.