THE UNIVERSITY OF ARIZONA
HEALTH PLANS

CANYON PLANS

University Healthcare Marketplace

2015

Evidence of Coverage

THE UNIVERSITY OF ARIZONA
HEALTH PLANS
University Healthcare Marketplace

Health Insurance Marketplace

THE UNIVERSITY OF ARIZONA
HEALTH PLANS
University Healthcare Marketplace

The University of Arizona Health Plans- University Healthcare Marketplace
2701 E. Elvira Rd., Tucson, AZ 85756 •520-874-3500

INDIVIDUAL COMPREHENSIVE HMO INSURANCE POLICY

In this Policy, the Owner is referred to as "You" or "Your". The University of Arizona Health Plans-University Healthcare Marketplace is referred to as "We", "Our", "Us", or "The Company.

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US. READ YOUR POLICY CAREFULLY.

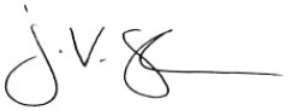
We will pay the benefits set forth in this Policy. Benefit payment is governed by all the terms, conditions and limitations of this Policy. This Policy is effective on the Policy Effective Date shown in Your Schedule of Benefits at 12:01 a.m. local time at Your place of residence. This Policy is issued in consideration of the application for this Policy and payment of the initial Premium.

RIGHT TO EXAMINE THE POLICY: If, for any reason, You are not completely satisfied with this Policy, You may cancel this Policy by returning it to Us or to any agent appointed by Us within ten (10) days after You receive it. Returning this Policy to Us will void it from the Policy Effective Date, and We will promptly refund Your entire Premium payment, including any Policy fee or other charges.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY: If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from The Company.

GUARANTEED RENEWABLE: This Policy is Guaranteed Renewable. This means that We may not, on Our own cancel coverage provided under this Policy except in certain circumstances. Subject to the Grace Period and Termination provisions in this Policy; this Policy will remain in force as long as the required Premiums are paid when due. We may change Your Premium on the Policy Anniversary Date but only if We change the Premium on all similar policies in force in Your State.

Signed for The University of Arizona Health Plans-University Healthcare Marketplace



James Stover, Chief Executive Officer

Individual Comprehensive Health Insurance

IMPORTANT NOTICE
PLEASE READ THE COPY OF THE APPLICATION ATTACHED TO THIS POLICY. IF ANY INFORMATION ON THE APPLICATION IS NOT TRUE AND COMPLETE, WRITE TO US AT OUR CUSTOMER CARE DEPARTMENT WITHIN TEN (10) DAYS. THE APPLICATION IS A PART OF THIS POLICY. THIS POLICY IS ISSUED ON THE BASIS THAT THE ANSWERS TO ALL QUESTIONS AND THE INFORMATION SHOWN ON THE APPLICATION ARE CORRECT AND COMPLETE.

TABLE OF CONTENTS

IMPORTANT INFORMATION

The University of Arizona Health Plans-University Healthcare Marketplace is pleased to provide You with this Policy which was purchased **off the Exchange.** This Policy provides Comprehensive Medical Health Maintenance Organization (HMO) insurance. Except for Emergency Services, benefits are payable only when services are provided by Participating Providers within Our HMO Network.

This Policy requires that each Covered Person select a Primary Care Physician who will be responsible for providing primary medical care and helping to guide any care received from other medical care providers. This Policy also requires that a referral be obtained from the Primary Care Physician before receiving medical care from certain specialty providers.

This Policy provides You with detailed information regarding Your coverage. It explains what is covered and what is not covered. It also identifies Your duties and how much You must pay when obtaining services.

Read Your Policy carefully.

Health Care Reform

The Patient Protection and Affordable Care Act (The PPACA), as amended by the Health Care and Education Affordability Reconciliation Act of 2010, expands health coverage for various groups and provides many Americans with the ability to get health insurance at an affordable cost. As the Federal government gives Us new guidance on Health Care Reform, The University of Arizona Health Plans-University Healthcare Marketplace may need to change its benefits. Please see [www.healthcare.gov] for updates.

CUSTOMER CARE

To reach The University of Arizona Health Plans-University Healthcare Marketplace **Customer Care Department** please contact Us at:

Telephone Number: [855-231-9236]
Address: The University of Arizona Health Plans-University Healthcare Marketplace, [2701 E. Elvira Rd., Tucson, AZ 85756]
Website: [www.uamarketplace.com]

To reach The University of Arizona Health Plans-University Healthcare Marketplace **Utilization Review Management Program,** please contact Us at:

Telephone Number: [855-231-9236]
Address: The University of Arizona Health Plans-University Healthcare Marketplace, [2701 E. Elvira Rd., Tucson, AZ 85756]

For **Grievances and Appeals**, please contact: The University of Arizona Health Plans, Attn: Grievance and Appeals Manager, [2701 E. Elvira Rd., Tucson, AZ 85756, grievance@uahealth.com, 866-465-8340 (fax)]

For **Expedited Appeals**, please contact: Customer Care Department, [855-231-9236, Email – grievance@uahealth.com, Fax – 866-465-8340]

IMPORTANT NOTICE:

Notice of Women's Health Cancer Rights Act

In accordance with The Women's Health and Cancer Rights Act of 1998 (WHCRA), the Policy covers mastectomy in the Treatment of cancer and reconstructive Surgery after a mastectomy. If You are receiving benefits in connection with a mastectomy, coverage will be provided according to the Policy's benefit and Utilization Review Management Program criteria and in a manner determined in consultation with the attending Physician and the Patient, for

1. All stages of reconstruction on the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications in all stages of mastectomy, including lymphedemas.

Coverage of mastectomies and breast reconstruction benefits are subject to applicable Deductibles and Copayment limitations consistent with those established for other benefits.

Medical services received more than five (5) years after a Surgery covered under this section will not be considered a complication of such Surgery.

Following the initial reconstruction of the breast(s), any additional modification or revision to the breast(s), including results of the normal aging process, will not be covered. All benefits are payable according to the Policy's Schedule of Benefits. Prior Authorization requirements apply.

SECTION 1 – DEFINITIONS

The following are key words used in this Policy. When they are used, they are capitalized. Also, some terms are capitalized and described within the Schedule of Benefits or the provisions in which they appear in this Policy.

Accident means an unexpected traumatic incident or unusual strain which: (1) is identified by time and place or occurrence; (2) is identifiable by part of the body affected; (3) is caused by a specific event on a single day; (4) results in a bodily Injury; and (5) occurs while coverage under this Policy is in force for the Covered Person. Accident does not mean an unintentional Accident caused by or during medical Treatment or Surgery for an Illness or Injury.

Advanced Practice Nurse means a Registered Professional Nurse (RN) who has completed educational requirements related to the Nurse's specific practice role, in addition to basic nursing education, as specified by the board pursuant to State law.

Allowable Fee or Maximum Allowable Fee means the maximum amount that a Participating Provider has contractually agreed to accept as full payment to provide services for Covered Benefits under this Policy.

Annual Out-of-Pocket Maximum means the maximum amount that the Covered Person must pay every Calendar Year for Covered Medical Expenses incurred for Covered Benefits. The Annual Out-of-Pocket Maximum is shown in the Schedule of Benefits. It applies to all Covered Benefits except the Preventive Health Care Services Benefit.

The Annual Out-of-Pocket Maximum includes the following:

1. Calendar Year Deductible;
2. Copayments; and
3. Coinsurance.

When the Annual Out-of-Pocket Maximum is satisfied in the Calendar Year, We will then pay one hundred percent (100%) of Covered Medical Expenses incurred for Covered Benefits for the remainder of that Calendar Year. The Annual Out-of-Pocket Maximum must be satisfied each Calendar Year.

Family Limit for the Annual Out-of-Pocket Maximum
When two (2) of Your Family members who are insured under this Policy have each met his or her Annual Out-of-Pocket Maximum during the Calendar Year, no further Annual Out-of-Pocket Maximum will be required for any other member of Your insured Family members for the remainder of that Calendar Year.

Coinsurance means the percentage of the Allowable Fee payable by the Covered Person for Covered Medical Expenses incurred for Covered Benefits. After the Covered Person satisfies the Annual Out-of-Pocket Maximum during the Calendar Year, We will then pay one hundred percent (100%) of Covered Medical Expenses incurred for Covered Benefits for the remainder of that Calendar Year. The Coinsurance amount is shown in the Schedule of Benefits.

Copay or Copayment means a fixed dollar amount the Covered Person is required to pay for specifically listed Covered Benefits as shown in the Schedule of Benefits. The required Copayment must be paid before benefits are payable under this Policy. Copayments are generally paid to the Provider at time of service. Copayments do apply to the satisfaction of the Deductible.

Convalescent Home means an institution, or distinct part of such institution, other than a Hospital, which is licensed pursuant to Arizona State or local law. A Convalescent Home is: (1) a Skilled Nursing Facility; (b) an Extended Care Facility; (3) an Extended Care Unit; or (4) a Transitional Care Unit.

A Convalescent Home is primarily engaged in providing:

1. Continuous nursing care services;
2. Health-related services; and
3. Social services.

Such Convalescent Home services must be provided by or under the direction and supervision of a licensed registered Nurse, on a twenty-four-hour (24-hour) basis, for Ill or Injured persons during the convalescent state of their Illness or Injuries. A Convalescent Home is not, other than incidentally: (1) a rest home; (2) a home for Custodial Care; or (3) a home for the aged. It does not include an institution or any part of an institution otherwise meeting this definition, which is primarily engaged in the care and Treatment of Mental Illness or Chemical Dependency.

Covered Benefits means all services covered under this Policy as provided under Section 5, Covered Benefits. Covered Benefits are payable as shown in the Schedule of Benefits.

Covered Dependent means Your lawful spouse or domestic partner, and any of Your Dependent Children (as defined in this Policy) who are insured under this Policy. A Covered Dependent must be listed as Your Dependent in Your Application for this Policy and approved by Us. The required Premium for the Covered Dependent's coverage under this Policy must be paid.

Covered Medical Expense means expenses incurred for Medically Necessary services, supplies, and medications that are based on the Allowable Fee and:

1. Covered under this Policy;
2. Provided to the Covered Person by and/or prescribed by a Participating Provider for the diagnosis or Treatment of an active Illness or Injury or for maternity care.

The Covered Person must be charged for such services, supplies and medications.

Covered Person means the Policyowner and/or his or her Covered Dependents.

Custodial Care means provision of room and board, nursing care (excluding skilled nursing care), and personal care designated to assist an individual who, in the opinion of the University of Arizona Health Plans – University Healthcare Marketplace's Medical Director, has reached the maximum level of recovery. Custodial Care also includes rest cures, respite care, and home care that is or can be performed by Family Members or non-medical personnel.

Deductible means the fixed dollar amount of Covered Medical Expenses that the Covered Person must incur for certain Covered Benefits before We begin paying benefits for them. The Deductible must be satisfied each Calendar Year by each Covered Person, except as provided under Family Aggregate Deductible Limit provision. The Deductible is shown in the Schedule of Benefits. Only the Maximum Allowable Fee for Covered Medical Expenses is applied to the Deductible. The following do not apply towards satisfaction of the Deductible: (1) services, Treatments or supplies that are not covered under this Policy; and (2) amounts billed by any Non-Participating Providers.

Family Deductible

The Family Deductible is shown in the Schedule of Benefits. The Family Deductible is an Aggregate Deductible and is the amount that must be satisfied during the Calendar Year. When two (2) or more family members, who are insured under this Policy, have paid an amount(s) toward the Deductible that equal the Family Deductible during the Calendar Year, the Family Deductible will be met for that Calendar Year. Once the Family Deductible is met for the Calendar Year no further contributions toward the Family Deductible is required. The Family Deductible must be met each Calendar Year.

Dependent means Your:

1. Lawful spouse or domestic partner; and
2. Dependent Child as defined in this Policy.

Dependent Child or Dependent Children means Your children who are:

1. Under age twenty-six (26), regardless of their place of residence, marital status or student status; including: (a) newborn children; (b) stepchildren; (c) legally adopted children; (d) children placed for adoption with the Policyowner in accordance with applicable Arizona State or Federal law; and (e) children for whom You are a legal guardian substantiated by a court or administrative order; and
2. Unmarried Dependent Handicap Children age twenty-six (26) and over. Refer to the Continued Coverage for Handicapped Children provision in Section 2.

Emergency Medical Condition means 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 Covered Person in: (1) serious jeopardy; (2) serious impairment to bodily functions; (3) serious disfigurement of the Covered Person; (4) serious impairment of any bodily organ or part of the Covered Person; or (5) in the case of a behavioral condition, placing the health of the Covered Person or other persons in serious jeopardy.

Examples of Emergency medical condition or situations include, but are not limited to: (1) uncontrolled bleeding; (2) seizures or loss of consciousness; (3) shortness of breath; (4) chest pains or severe squeezing sensations in the chest; (5) suspected overdose of medication or poisoning; (6) sudden paralysis or slurred speech; (7) burns; (8) cuts; and (9) broken bones.

Exchange means the Health Insurance Exchange, sometimes referred to as the Federally Facilitated Exchange or Federally Facilitated Marketplace (FFM), as operated in the State of Arizona under the authority of the PPACA. Also, it is referred to as the Health Insurance Marketplace (HIM) or Marketplace. This policy was not purchased on the Exchange.

Family Coverage means coverage for: (1) You; and (2) Your spouse or Domestic Partner; and/or (3) one (1) or more Dependent Children.

HMO Network means as an HMO, The University of Arizona Health Plans-University Healthcare Marketplace has contracted with the Providers and facilities that will be needed to provide the Covered Benefits and benefits You are entitled to receive as the Policyholder of this Policy. These Providers and facilities make up Our HMO Network. Except for Emergency Services and certain Urgent Care Services, the Covered Person must receive all of his or her Covered Benefits from Providers and facilities who are in Our HMO Network. The Providers and facilities in Our HMO Network are referred to as Participating Providers, Participating Physician, and Participating Facility.

Home Health Agency means a public agency or private organization or subdivision of the agency or organization that is engaged in providing Home Health Services to individuals in the places where they live. Home Health Services must include the services of a licensed Registered Nurse (RN) and at least one (1) other therapeutic service and may include additional support services.

Home Infusion Therapy Agency means a health care facility that provides Home Infusion Therapy Services.

Home Infusion Therapy Services means the preparation, administration, or furnishing of parenteral medications or parenteral or enteral nutritional services to an individual in that individual's residence. The services include an educational component for the Patient, the Patient's caregiver, or the Patient's Family Member.

Hospice means a coordinated program of home and Inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill Patient and the Patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of Illness and dying and that includes formal bereavement programs as an essential component. The term includes:

1. An Inpatient Hospice facility, which is a facility managed directly by a Medicare-certified Hospice that meets all Medicare certification regulations for freestanding Inpatient Hospice facilities; and
2. A residential Hospice facility, which is a facility managed directly by a licensed Hospice program that can house three (3) or more Hospice patients.

Hospital means an institution which:
Is operated for the care and Treatment of sick or injured persons as in-patients; and
On its premises or in facilities available to the Hospital on a pre-arranged basis, meets fully each of the following requirements:

1. It is operated in accordance with the laws pertaining to Hospitals in the jurisdiction in which it is located;
2. It is under the supervision of a medical staff and has one (1) or more Physicians available at all times; and
3. It provides twenty-four (24) hour-a-day service by Registered Nurses (RNs).

A Covered Person will not be considered Hospital confined if he or she is in a special unit of a Hospital used as a nursing, rest, or Convalescent Home.

Hospital includes a licensed ambulatory surgical facility.

The term Hospital does not include the following even if such facilities are associated with a Hospital:

1. A nursing home;
2. A rest home;
3. A Hospice facility;
4. A rehabilitation facility;
5. A Skilled Nursing Facility;
6. A place for the mentally ill;
7. A Convalescent Home;
8. A long-term, chronic care institution or facility providing the type of care listed above.

Illness means any sickness, infection, disease or any other abnormal physical condition which is not caused by an Injury.

Injury means physical damage to the Covered Person's body, caused directly and independently of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

Inpatient or Inpatient Care means care and Treatment provided to a Covered Person who has been admitted to a facility in a registered bed and who is receiving services, supplies and medications under the direction of a Participating Provider with staff and privileges at the facility. Such facilities include:

1. Hospitals, including State-designated Critical Access Hospitals;
2. Transitional care units;
3. Skilled nursing facilities;
4. Convalescent homes; or
5. Freestanding Inpatient facilities.

Such facilities must be licensed or certified by the State in which it operates.

Investigational/Experimental Service means surgical procedures or medical procedures, tests, supplies, devices, or drugs which at the time provided, or sought to be provided, are in Our judgment not recognized as conforming to accepted medical practice or the procedure, test, drug, or device:

1. Has not received the required final approval to market from appropriate government bodies;
2. Is one about which the peer-reviewed Medical Literature does not permit conclusions concerning its effect on health outcomes;
3. Is not demonstrated to be as beneficial as established alternatives;
4. Has not been demonstrated to improve the net health outcomes; or
5. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Phases I, II, and III clinical studies are considered investigational and are not covered.

Maximum Allowable Fee means the maximum amount that a Participating Provider agrees contractually to accept as full payment to provide services for Covered Benefits under this Policy.

Medically Appropriate means services which have been determined by Us to be of value in the care of a specific Covered Person. To be Medically Appropriate a service must:

1. Be Medically Necessary;
2. Be provided in the most appropriate site and at the most appropriate level of service of the Covered Person's medical condition;
3. Be used to diagnose or treat a member's condition caused by disease, Injury or congenital malformation;
4. Be consistent with current standards of good medical practice for the Covered Person's medical condition;

5. On an ongoing basis, have a reasonable probability of:
    a. Correcting a significant congenital malformation or disfigurement caused by Illness or Injury;
    b. Preventing significant malformation or disease; or
    c. Substantially improving a life sustaining bodily function impaired by Illness or Injury;
6. NOT be provided solely to improve the Covered Person's condition beyond normal variation in individual development and aging including:
    a. Comfort measures in the absence of disease or Injury;
    b. Improving physical appearance that is within normal individual variation; and
    c. Not be for the sole convenience of the Covered Person or his or her family.

Medically Necessary or Medical Necessity means Treatment, services, medicines, or supplies that are necessary and appropriate for the diagnosis or Treatment of a Covered Person's Illness, Injury, or medical condition according to accepted standards of medical practice.

Medically Necessary or Medical Necessity does not include Treatment, services, medicines, or supplies that are:
1. Considered experimental, investigatory, or primarily limited to research in its application to the Injury or Illness;
2. Primarily for scholastic, vocational or developmental training;
3. Primarily for educational training, except for educational training services provided for Preventive Health Care Services or medical conditions as provided under this Policy. Prior authorization is required for all educational services;
4. Primarily for the comfort, convenience or administrative ease of the Physician or other health care Provider, or the Covered Person or his or her family or caretaker; and
5. Custodial Care.

We reserve the right to review medical care and/or Treatment plans. We may rely on Our independent medical reviewer to determine if Treatment is Medically Necessary. The fact that a Physician may order Treatment does not, in itself, make it Medically Necessary, or make the expense a Covered Medical Expense.

Medical Policy means the Utilization Review Management Program guidelines used for this Policy. The guidelines are used to determine if health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:
1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

Refer to Section 6, Utilization Review Management Program.

Non-Participating Provider means a Provider who does not have a participation contract in effect with Our HMO Network to provide services to Covered Persons under this Policy. Except for Emergency Services, no benefits are provided for services rendered by a Non-Participating Provider. If there are no In-Network Providers available, a Non-Participating Provider may be used with Prior Authorization.

Osteopath means a practitioner of Osteopathy; such practitioners are known as Doctor of Osteopathy, (DO).

Other Participating Health Professional means a Provider other than a Physician who is: (1) licensed or otherwise authorized under the applicable State law to deliver medical services; and (2) contracted with Us to provide services to the Covered Person. Examples include, but are not limited to: (1) Physical Therapists; (3) Home Health Aides; (4) Nurse Practitioner; (4) Physician Assistants; and (5) Nurses.

Outpatient means Treatment or services that are provided when the Covered Person is not confined as a bed Patient in a Covered Facility. This includes Outpatient Treatment at a Covered Facility as well as visits to a Physician or other Participating Providers.

Participating Chiropractic Physician means a Provider who is a licensed Chiropractor and who has contracted with Our HMO Network to provide chiropractic services to Covered Persons under this Policy. The Participating Chiropractic Physician has

agreed to accept the Maximum Allowable Fee for the services he or she renders for this Policy. The Participating Chiropractic Physician contract must be active when services are received by the Covered Person.

Participating Provider means a Provider who has contracted with Our HMO Network to provide services to Covered Persons under this Policy. The Participating Provider has agreed to accept the Maximum Allowable Fee for the services he or she renders for this Policy. The Participating Providers contract must be active when services are received by the Covered Person.

Patient Protection and Affordable Care Act means the Federal Patient Protection and Affordable Care Act (PPACA) that was signed into law on March 23, 2010.

Physician means a person licensed to practice medicine in the State where the service is provided. A Physician is a Participating Provider if he or she has an active contract with Our HMO Network to provide services to Covered Persons under this Policy. A Physician is a Non-Participating Provider if he or she does not have an active contract with Our HMO Network to provide services to Covered Persons under this Policy. The Covered Person must make sure that the Physician is a Participating Provider when seeking medical services.

Physician Specialist means a Physician who: (1) has obtained advanced training in various areas of a medical specialty. Physician Specialist includes, but is not limited to: (1) Anesthesiologists; (2) Dermatologists; (3) Ophthalmologists; (4) Orthopedic Surgeons; (5) Psychiatrists; (6) Radiation Oncologist; and (7) Surgeons. Physician Specialist does not include: (1) a Family Practice Physician; (2) an Internal Medicine Physician; or (3) an Obstetrician; or (4) Gynecologist.

Policy Anniversary Date means January 1 for each succeeding year this Policy remains in force. The Policy Anniversary Date is the date on which this Policy is renewed each year. The Policy Anniversary Date is shown in the Schedule of Benefits.

Policy Effective Date means the date on which this Policy becomes effective. The Policy Effective Date is shown in the Schedule of Benefits.

Policyowner means the person to whom this Policy is issued and is named as the Policyowner in the Schedule of Benefits. The Policyowner is the owner of this Policy, which means the Policyowner may exercise the rights set forth in this Policy. On the Policy Effective Date, the Policyowner is as designated in the application for this Policy. The Policyowner is also referred to as "You" or "Your".

Preventive Care means the set of benefits and services mandated by the PPACA that We must cover at no cost to You, when these services are provided by an In-Network Provider. More information on Preventive Care and what services are included can be found in Section 5, Covered Benefits.

Primary Care Physician means a Provider who is:

1. Acting within the scope of his or her license;
2. A Participating Provider.

A Primary Care Physician is selected by the Covered Person to be his or her Primary Care Physician.

A Primary Care Physician includes the following providers: (1) Family Practice (FP); (2) Internal Medicine (IM); (3) Pediatrician (PED); Obstetrics and Gynecology (OBGYN); (4) Gynecologist (GYN); (5) Geriatrician (GER); (6) Osteopath (DO); and (7) other providers performing services for Covered Persons in connection with the services provided by preceding specified providers, listed in (1) through (6), including: (a) Registered Nurse (RN); (b) Advanced Practical Registered Nurse (APRN); (c) Nurse Practitioner (NP); (d) Certified Nurse Midwife (CNM); and (e) Physician Assistant (PA).

The following Participating Providers who are qualified and willing to provide Primary Care services as the Covered Person's Primary Care Physician may be elected by the Covered Person to be the Covered Person's Primary Care Physician:

1. an Obstetrician;
2. a Gynecologist; or
3. a Pediatrician

Please see Section 4, How the HMO Works, for a good explanation of what You and Your Primary Care Physician will do to provide Covered Benefits to You.

Prior Authorization is a requirement that Your Provider or Physician obtain approval from Us to perform certain covered services or prescribe certain covered medications. Without Prior Authorization, We may not provide coverage, or pay for, your services or medications. See Section 6, Utilization Review Management Program, for more information. Prior authorization must be obtained for:

1. Benefits that specify that Prior Authorization is required; and
2. Procedures listed in the Prior Authorization Medical Treatments List.

Provider means a licensed practitioner of the healing arts acting within the scope of the Provider's practice, limited to the following Providers: (1) Medical Doctor (MD); (2) Chiropractor (DC); (3) Osteopath (DO); (4) Podiatrist (DPM); (5) Psychologist (PhD); (6) Licensed Clinical Social Worker (LCSW); (7) Psychiatric Nurse Specialist (RN, NS); (8) Doctor of Medical Dentistry (DMD); (9) Dentist (limited) (DDS); (10) Registered Nurse (RN); (11) Advanced Practical Registered Nurse (APRN); (12) Nurse Practitioner (NP); (13) Physician Assistant (PA); (14), Licensed Practical Nurse (LPN); (15) Certified Registered Nurse Anesthetist (CRNA); (16) Certified Nurse Midwife (CNM); (17) Registered Physical Therapist (RPT); (18) Occupational Therapist (OT); (19) Speech Therapist (ST); (20) Optometrist (limited [OD]); (20) Audiologist, Licensed Professional Counselor (LPC); and (21) Registered Dietician.

The Provider is a Participating Provider only if the Provider is actively contracted as a Participating Provider with Our HMO Network when services are provided for a Covered Person.

Referral means a pre-approval that You must obtain from Your Primary Care Physician before seeing an In-Network Physician Specialist or any Non-Participating Provider in the case that there are no In-Network Providers within a particular specialty or facility type reasonably available.

Skilled Nursing Facility (Refer to the definition of Convalescent Home).

Surgery means manual procedures that: (a) involve cutting of body tissue; (b) debridement or permanent joining of body tissue for repair of wounds; (c) Treatment of fractured bones or dislocated joints; (d) endoscopic procedures; and (e) other manual procedures when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Treatment means medical care, services or Treatment or course of Treatment which is ordered, prescribed and/or provided by a Physician to diagnose or treat an Injury or Illness, including:

1. Confinement, Inpatient or Outpatient services or procedures; and
2. Drugs, supplies, equipment, or devices.

The fact that a Treatment was ordered or provided by a Physician does not, of itself, mean that the Treatment will be determined to be Medically Necessary.

Urgent Care means medical, surgical, Hospital and related health care services and testing which are not Emergency Services, but which are determined by Us in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention. **Urgent Care does not include care that could have been foreseen before leaving the immediate area where the Covered Person ordinarily receives and/or is scheduled to receive services.** Such care includes but is not limited to: (1) dialysis; (2) scheduled medical Treatments or therapy; or (3) care received after a Physician's recommendation that the Covered Person should not travel due to any medical condition.

SECTION 2 – WHEN COVERAGE TAKES EFFECT AND TERMINATES

Eligibility for Coverage

To be eligible for this Policy, Policyowner and Dependents:

1. Must be a United States citizen or national or must be lawfully present in the United States;
2. Cannot be incarcerated (in prison; does not apply if You are awaiting disposition of charges); and
3. Must reside within Our service area. Persons residing outside the service area for more than ninety (90) consecutive days within a twelve (12) month period are ineligible.

The Policy can be written as a Child-Only Policy for individuals who are less than twenty-one (21) years of age.

Effective Dates of Eligibility Determinations

We will use the following guidelines to establish Your Policy Effective Date:

1. The initial open enrollment period begins November 15, 2014 and extends through February 15, 2015.
2. The annual open enrollment period for plan years beginning on or after January 1, 2016 begins October 15 and extends through December 7 of the preceding Calendar Year. During that period, generally, if You select a plan and remit payment to Us on or before December 7, Your Policy Effective Date will be the following January 1.
3. Certain special enrollment situations may result in a mid-plan-year eligibility redetermination that varies from the above open enrollment periods. See the Special Enrollments Periods section for more details.

Policyowner

This Policy is issued to the Policyowner upon application and initial Premium payment for this Policy. Your insurance coverage under this Policy is effective on the Policy Effective Date.

Eligible Dependents

Dependents eligible for insurance under this Policy are:

1. Your lawful spouse or domestic partner; and
2. Your Dependent Children, which include:
    a. Your natural children;
    b. Your adopted children;
    c. Your step-children provided You are married to the parent of the child;
    d. A child for whom You are the legal guardian substantiated by a court order; and
    e. A child who is the subject of an administrative or court order and for whom You must provide coverage based on such administrative or court order.

Eligibility Audit

The University of Arizona Health Plans-University Healthcare Marketplace may audit Your documentation to determine whether a Covered Dependent continues to be eligible according to this Policy's requirements. This audit may occur either randomly or in response to uncertainty concerning Dependent eligibility. We reserve the right to request information needed to determine an individual's eligibility for participation in the Plan, but not more frequently than annually.

Continued Coverage for Handicapped Children

A Covered Dependent Child, who's insurance under this Policy would otherwise terminate solely due to the attainment of age twenty-six (26) (the limiting age), will continue to be a Covered Dependent Child while such Covered Dependent Child is and continues to be both:

1. Incapable of self-sustaining employment by reason of intellectual disability or physical disability; and
2. Chiefly dependent upon You for support and maintenance.

Proof of the intellectual disability or physical disability, and dependency must be furnished to Us by You within thirty-one (31) days of the Covered Dependent Child's attainment of the limiting age and subsequently as may be required by Us, with the cost of such proof paid by You. However, We may not require such proof more frequently than annually after the two-year (2-year) period following the Covered Dependent Child's attainment of the limiting age.

When Coverage Becomes Effective for Your Dependents
You must enroll Your Dependents for insurance under this Policy in order for them to be covered under this Policy. Eligible Dependents, who are listed on Your application for this Policy, will be insured under this Policy on the Policy Effective Date. Eligible Dependents who are enrolled after the Policy Effective Date may be insured under this Policy as provided under the Newly Eligible Dependent Children and Newly Eligible Dependent Spouse/Domestic Partner provisions.

If notification of the newly eligible Dependent is received:

1. Between the first (1st) and the fifteenth (15th) day of any month, We will enroll the Dependent for coverage effective on the first day of the following month; or
2. Between the sixteenth (16th) and the last day of any month, We will enroll the Dependent for coverage effective on the first (1st) day of the second (2nd) following month.

Newly Eligible Dependent Children
A newly Eligible Dependent child of a Subscriber (or Subscriber's spouse) is covered for the first thirty-one (31) days following birth. To be covered beyond the thirty-one (31) day period, you must notify Us and make payment of any additional Premium required for the newly Eligible Dependent's coverage under this Policy. We will notify You of any additional Premium required for the newly enrolled child. Such notification and Premium payment must be given within thirty-one (31) days of acquiring the newly Eligible Dependent. If the notification and appropriate payment is not received, the newly Eligible Dependent will not be eligible for any benefits beyond the thirty-one (31) days following the date of birth, date of adoption, or placement for adoption.

We will enroll Your newborn child, or adopted child, or a child placed with You for adoption, for coverage under this Policy effective on:

1. The date of birth;
2. The date of adoption; or
3. The placement for adoption.

Newly Eligible Dependent Spouse/Domestic Partner
If You acquire a new eligible Dependent due to:

1. Marriage; or
2. The establishment of a Domestic Partnership; or
3. A qualified individual, who is Your spouse or Domestic Partner, loses minimum essential coverage under another health plan, as provided under Special Enrollment Periods;

We will enroll the new Dependent for coverage under this Policy effective on the first day of the following month.

Loss of minimum essential coverage does not include termination or loss due to:

1. Failure to pay Premiums on a timely basis, including COBRA Premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission as specified in the Federal PPACA regulation.

Special Enrollment Periods
We will allow qualified individuals and enrollees to enroll in or change from one (1) Policy to another as a result of the following triggering events:

1. A qualified individual or Dependent loses minimum essential coverage;
2. A qualified individual gains a Dependent or becomes a Dependent through: (a) marriage; (b) birth; (c) adoption; or (d) placement for adoption;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status; or
4. A qualified individual or enrollee gains access to a new Policy as a result of a permanent move.

Termination of Insurance
Policy Termination by The Company
This Policy will terminate at 11:59 p.m. local time at Your place of residence on the earliest of:

1. The end of the period for which no Premium is paid in full, subject to the Grace Period (refer to Section 3);
2. The date You request to terminate this Policy in Your written notification to Us to terminate this Policy or such

reasonable amount of time for Us to process such request;
3. The date You enroll for Medicare;
4. The date You are no longer eligible for this Policy; or
5. The date of Your death.

Nonrenewal or Discontinuance of this Policy by The Company

This Policy will be renewed or continued at Your option. However, We may nonrenew or discontinue this Policy only if:

1. You fail to pay Premiums in accordance with the terms of this Policy, or if We do not receive timely Premium payments;
2. You have performed an act or practice that constitutes fraud or have made an intentional misrepresentation of a material fact under the terms of this Policy;
3. We cease to offer coverage in the individual market in accordance with applicable Federal and Arizona State law; or
4. You no longer live, reside, or work in the service area of Our HMO Network used under this Policy.

We will not discontinue offering a particular type of individual health insurance coverage We offer in the individual market unless We discontinue such coverage in accordance with applicable Arizona State and Federal laws and unless:

1. We give notice to each covered individual provided coverage of this Policy type in the individual market of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage;
2. We offer to each individual in the individual market provided coverage of this Policy type the option to purchase any other individual health coverage currently being offered by Us to individuals in the individual market; and
3. In exercising the option to discontinue coverage of this Policy type and in offering the option of coverage under subparagraph 2 above, We act uniformly, without regard to the claims experience of individuals or any health status-related factor of individuals who may become eligible for the coverage.

We will not discontinue offering all health insurance coverage in the individual market unless in accordance with applicable Arizona State and Federal laws and unless:

1. We provide notice of discontinuation to the Commissioner of Insurance and each covered individual at least one hundred eighty (180) days prior to the date of the discontinuation of coverage; and
2. All health insurance issued or delivered for issuance in Arizona in the individual market is discontinued and coverage under the health insurance coverage in the individual market is not renewed.

If We discontinue offering all health insurance coverage in the individual market as stated in the above paragraph, We will not provide for the issuance of any health insurance coverage in the individual market during the five-year (5-year) period beginning on the date of the discontinuation of the last health insurance coverage not renewed.

Rescissions

We reserve the right to rescind this Policy if You used fraud or intentional misrepresentation of material fact to obtain this Policy or if You have performed an act or practice that constitutes fraud or have made an intentional misrepresentation of a material fact under the terms of this Policy. A rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect.

Termination of Covered Dependents

A Covered Dependent's coverage will terminate at 11:59 p.m. at Your place of residence on the earliest of:

1. The last day of the period for which Premium is not paid, subject to the Grace Period;
2. The Premium due date following the date a Covered Dependent Child ceases to be an Eligible Dependent as defined in this Policy;
3. The date Your coverage terminates, subject to Dependent Continuation provision in this section;
4. The date We receive Your written request to terminate, or such reasonable amount of time for Us to process such request to terminate Dependent coverage for Your spouse or domestic partner, and/or Dependent Children;
5. The day before the date on which the Covered Dependent attains twenty-six (26) years of age, except as provided under the Handicapped Child provision.;
6. The date the Covered Dependent enrolls for Medicare; or
7. The date of death of the Covered Dependent.

Also, refer to Termination of Coverage for Handicapped Child provision regarding additional termination provisions for handicapped children.

Termination of Coverage for Handicapped Child

In addition to the termination provisions indicated above, insurance coverage for a Covered Dependent Child who is a handicapped child age twenty-six (26) and over will end on the earliest of:

1. The date the Dependent marries;
2. The date the Dependent obtains self-sustaining employment;
3. The date the Dependent ceases to be handicapped;
4. The date the Dependent ceases to be Dependent upon You for support and maintenance;
5. Sixty (60) days after a written request for proof of handicap, if proof is not provided within such 60-day period; or
6. The date We receive Your written request to terminate, or such reasonable amount of time for Us to process such request to terminate Dependent coverage for Your Dependent Children.

Suspension of Coverage During Military Service

If a Covered Person enters into active duty status for the military or naval service of the United States or any other country, coverage will be suspended as of the first date of active duty status. We request that You notify Us within thirty-one (31) days of the first date of active duty status; however, coverage will be suspended regardless of receipt of notification. When We receive notification of the active duty status, any required adjustment of Premium will be made, including refund of Premium if necessary.

Upon termination of active duty status, the Covered Person may request a resumption of coverage if the Covered Person:

1. Meets the eligibility requirements for this Policy as provided in the Eligible Dependents provision in this Section 2;
2. Makes the request for resumption of coverage in writing to Us within sixty (60) days of his or her termination of active duty status; and
3. Pays any required Premium.

Coverage under this Policy will resume on the date immediately following Our receipt and verification of the above requirements.

Continuation Coverage For Dependents

If coverage terminates under this Policy for a Covered Dependent due to:

1. Your death; or
2. Your divorce, or annulment or dissolution of marriage or domestic partnership, or legal separation from Your Covered Dependent spouse or domestic partner; or
3. A Covered Dependent Child attaining age twenty-six (26), except as provided under the Termination of Coverage for Handicapped Child provision;

the Covered Dependent spouse or domestic partner, and Covered Dependent Child may elect to continue coverage under this Policy. The spouse or domestic partner may also elect to continue coverage for Covered Dependent children under age twenty-six (26) for whom the spouse or domestic partner has the responsibility for care and support.

Notice of this election must be received by Us within sixty (60) days of the event. No evidence of insurability will be required. Premium for the continued coverage must be paid within sixty (60) days after the election is made. Premium will be based on Our rates in effect at the time of the continuation coverage.

SECTION 3 – PREMIUMS

Payment of Premium
All Premiums, any charges or fees for this Policy (hereinafter referred to as "Premium") must be paid to Us. The Premium for this Policy is shown in the Schedule of Benefits. If You do not pay Premiums when due, this Policy will terminate subject to the Grace Period. The Premium Due Date is shown in the Schedule of Benefits.

Grace Period
After the first due Premium payment, if a Premium is not paid on or before the date it is due, it may be paid during the next thirty (30) days. These thirty (30) days are called the Grace Period. Coverage under this Policy will remain in force during the Grace Period. During the Grace Period, We will continue to pay claims incurred for Covered Medical Expenses. If payment is not received for all outstanding Premiums by the end of the Grace Period, this Policy will be terminated effective at 11:59 p.m. on the last day of the Grace Period.

We will not terminate this Policy until We have mailed or delivered to You at Your last-known address shown in Our records a written notice notifying You of the delinquency, in addition to any billing statement, stating the date this Policy's termination will become effective.

Premium Rate Changes
Subject to rate requirements mandated by Federal regulations governing this Policy and any applicable rate requirements of the State of Arizona where this Policy is issued, We may change the rates for this Policy on any Policy Anniversary Date of this Policy. However, the rates may be changed sooner if a Premium increase is necessitated by a Arizona State or Federal law, court decision, or rule adopted by an agency of competent jurisdiction of the State or Federal government. Any rate change will be made only when We change the rates for all policies in the same rate class on the same form as this Policy that are issued in the State of Arizona.

We will give You at least forty-five (45) days prior written notice before the Effective Date of any rate change. The rates will never be changed due to a change in Your age or health. Such notice will be mailed to Your last known address as shown in Our records. If We fail to provide the notice as stated in this provision, this Policy will remain in effect at the existing rate with the existing benefits until: (1) the full notice period has expired; or (2) the Effective Date of the replacement coverage is obtained by You, whichever occurs first.

Premium Refund
In the event of termination of this Policy or Your death, We will refund any portion of the unearned Premium.

Reinstatement
If all outstanding Premiums are not paid within the Grace Period, and this Policy is terminated for non-payment of Premiums, You will not be permitted to unilaterally reinstate this Policy through the submission of Premium after the date on which this Policy has been terminated. The Policyowner must reapply for coverage either during a qualifying Special Enrollment Period or during Open Enrollment. The same coverage may not be available. You will be subject to applicable Deductibles and Out-of-Pocket Maximums required under the new plan.

SECTION 4 – HOW THE HMO WORKS

Membership Card
You will receive Your identification card from Us after Your enrollment. If You do not receive Your identification card or if You need to obtain medical or prescription services before Your card arrives, contact Our Customer Care Department so that they can coordinate Your care and direct Your Primary Care Physician or Participating Pharmacy.

Customer Care
If You have a question about services, providers, benefits, how to use this Policy, or concerns regarding the quality of care or access to care that You have experienced, You should call Our Customer Care Department at the number given on page 2, Important Information. The hearing impaired may contact Our Customer Care Department through Our toll-free TTY number, [711]. Customer Care can answer many questions over the telephone.

How to Receive Services
You will be able to select Your Primary Care Physician from The University of Arizona Health Plans-University Healthcare Marketplace directory of Participating providers listed as general practitioners, family practitioners, internists, Obstetricians/Gynecologists, and Pediatricians. Each of Your Covered Dependents may also select a Primary Care Physician. If You do not select a Primary Care Physician at the time of enrollment, the Plan will designate a Primary Care Physician for You and You will be notified of the name of the designated Primary Care Physician. This designation will remain in effect until You notify Us of Your selection of a different Primary Care Physician. All Covered Benefits must be provided by or arranged through Your Primary Care Physician, except for the following: (1) services received during a Participating Provider Specialist visit (some Specialists require a referral, see Specialist Visits in Section 5); or (2) obstetrical/gynecological (OB/GYN) services provided by a Participating Obstetrician/Gynecologist; or (3) a Participating Family Practice Physician, Mental Health and Substance Abuse services covered under this Policy when provided by Participating Providers, or Urgent Care or Emergency Services, when Medically Necessary. Your choice of Physician is an important one as he or she will:

1. Help You decide on actions to maintain and improve Your total health;
2. Coordinate and direct all of Your medical care needs;
3. Work with You to arrange Your referrals to specialty Physicians, Hospitals and all other health services, including requesting any Prior Authorization You will need;
4. Prescribe those lab tests, x-rays and services You require;
5. If You request it, assist You in obtaining any needed prior approval for Mental Health and Substance Abuse services. See the Mental Health and Substance Abuse Services benefit in Section 5; and,
6. Assist You in applying for admission into a Hospice program through a Participating Hospice agency when necessary.

The Physician-Patient relationship You and Your Primary Care Physician establish is very important. The best effort of Your Primary Care Physician will be used to ensure that all Medically Necessary and appropriate professional services are provided to You in a manner compatible with Your wishes. Your Primary Care Physician will advise You if he or she believes that there is no professionally acceptable alternative to a recommended Treatment or procedure. If Your Primary Care Physician recommends procedures or Treatments which You refuse, or You and Your Primary Care Physician fail to establish a satisfactory relationship, You may select a different Primary Care Physician. Customer Care can assist You with this selection.

To ensure access to services, each Covered Person must select a Participating Primary Care Physician. If You do not select a Primary Care Physician at the time of enrollment, The University of Arizona Health Plans-University Healthcare Marketplace will designate a Primary Care Physician for You, and You will be notified of the name of the designated Primary Care Physician. This designation will remain in effect until You notify The University of Arizona Health Plans-University Healthcare Marketplace of Your selection of a different Primary Care Physician. You may designate a Pediatrician as the Primary Care Physician for Your child.

The University of Arizona Health Plans-University Healthcare Marketplace contracts with a variety of providers to ensure that a full panel of Specialists, facilities, and other health care professionals are available to provide for Your health care needs and to help Your Primary Care Physician manage the utilization of Your health plan benefits by ensuring that referrals are directed to providers who are contracted with Us. Although self-referrals to certain Participating Provider Specialists are allowed (see Section 5 Specialist Visits), The University of Arizona Health Plans-University Healthcare Marketplace encourages You to receive

specialty services through a referral from Your Primary Care Physician. To obtain a referral for specialty services, You must first contact Your Primary Care Physician. If the Primary Care Physician determines that specialty services are Medically Necessary, the Physician will complete a referral form and request necessary authorization. Your Primary Care Physician will designate the Participating Provider from whom You will receive services. When no Participating Provider is available to perform the Medically Necessary service, the Primary Care Physician will refer You to a Non-Participating Provider after obtaining authorization. This authorization procedure is handled for You by Your Primary Care Physician. **Note:** When You receive a referral from Your Primary Care Physician to obtain services from a Specialist, You are responsible for the Specialist Provider's services Copayment and/or Coinsurance.

Because Your Physician has set aside time for Your appointments in a busy schedule, You need to notify the office at least twenty-four (24) hours prior to Your appointment if You are unable to keep the appointment. This Policy applies to appointments with or arranged by Your Primary Care Physician and self-arranged appointments to a Specialist, other Provider, or for OB/GYN services. Such cancellation will allow the office staff to offer that time slot to another Patient who needs to see the Physician. Some offices may advise You that You will be charged a fee for missed appointments unless You give twenty-four-hour (24-hour) advance notice.

Obstetrical/Gynecological (OB/GYN) Physician Services

A female Covered Person may arrange for Obstetrical and/or Gynecological (OB/GYN) services by an Obstetrician/Gynecologist or a Family Practice Physician who is not her designated Primary Care Physician. A referral from the female Covered Person's Primary Care Physician is not needed. However, the Obstetrician/Gynecologist or Family Practice Physician must be a Participating Provider for services to be covered.

Mental Health and Substance Abuse Services

The University of Arizona Health Plans-University Healthcare Marketplace has contracted to deliver Mental Health and Substance Abuse services through a unique network of Mental Health Participating Providers. All non-Emergency Mental Health and Substance Abuse services, except for Specialist visits, should be arranged through Your Primary Care Physician. Covered Persons are not required to arrange for Mental Health and Substance Abuse services through their Primary Care Physician, except for referrals to a Psychiatrist or as specified in Section 5.

All Mental Health and Substance Abuse services, except for Emergency or Urgent Care services as indicated in this Policy, must be provided by a Participating Provider. Participating Providers are indicated in The University of Arizona Health Plans-University Healthcare Marketplace Provider Directory. Covered Persons may contact Customer Care directly for information on, and to select a Participating Provider by calling the toll free number on page 2. Your Primary Care Physician may also contact the Plan to obtain information re¬garding Participating Providers for You. **Note:** Specialist Visits for Mental Health and Substance Abuse services received from a Provider who does not participate in the Participating Provider network will not be covered, except as stated herein, and all charges for these services will be the Member's responsibility. This limitation does not apply with respect to Emergency Services or Urgent Care Services.

Emergency Services

Covered Persons who reasonably believe that they have an Emergency medical or Mental Health condi-tion which requires an Emergency response are encouraged to appropriately use the 911 Emergency response system where available. It is important that You do the following in an Emergency:

1. Obtain care immediately.
2. You, Your Provider, a member of Your family, or Your other designated representative must contact Your Primary Care Physician no later than twenty-four (24) hours after the onset of the Emergency, or as soon as it is medically possible to provide notice.
3. Obtain any follow-up care as recommended. Follow-up care is any care provided after the initial Emergency room visit, and it must be provided or authorized by Your Primary Care Physician.

For a complete description of the Emergency Services benefit see Section 5. For applicable Copayments, see the Schedule of Benefits. Note: If You receive non-authorized services in a situation that The University of Arizona Health Plans-University Healthcare Marketplace determines was not a situation in which a reasonable person would believe that an Emergency condition existed, You will be responsible for the costs of those services.

Urgent Care Services
If You require Urgent Care for a condition that could reasonably be treated in Your Primary Care Physician's office or in an Urgent Care clinic (i.e., care for a condition that is not such that the absence of immediate medical attention could reasonably be expected to result in placing Your health in: (1) serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part), You must first call Your Primary Care Physician. However, You may go directly to an Urgent Care clinic when Your Primary Care Physician is unavailable.

The University of Arizona Health Plans-University Healthcare Marketplace provides coverage for You and Your Covered Dependents for Urgent Care needs when You or Your Covered Dependents are temporarily traveling outside of Your Primary Care Physician Network service area. **Note:** No coverage is provided while traveling outside of the United States. The Covered Person can receive Urgent Care services from any Urgent Care Provider. Follow-up care must be coordinated with the Covered Person's Primary Care Physician. The University of Arizona Health Plans-University Healthcare Marketplace may direct the Covered Person who is the Patient to receive the follow-up services from his or her Primary Care Physician. Prior Authorization is required for care that involves surgical procedures or an Inpatient stay. All other requirements pertaining to Covered Benefits apply.

Copayment and Coinsurance
Copayment (or Copay) and Coinsurance are the amounts of covered costs for each type of service for which the Covered Person has a financial responsibility. The Covered Person must first meet the Deductible amount before We will begin making payment for Covered Benefits except for Preventive Care Services for the appropriate age, gender and location of the Covered Person obtained from a Participating Provider. The amount of Copayment and Coinsurance varies by benefit category and benefit plan. Refer to the Schedule of Benefits for Copayment and Coinsurance requirements.

Copayments and Coinsurance may not be applied to Preventive Health Care Services. Please Note: No benefits will be payable for Preventive Health Care Services provided by a Non-Participating Provider.

Independent Contractors
Participating Providers are neither agents nor employees of the University of Arizona Health Plans-University Healthcare Marketplace but are independent contractors. The University of Arizona Health Plans-University Healthcare Marketplace conducts a process of credentialing and certification of all Physicians who participate in Our HMO Network. However, in no instance shall We be liable for the negligence, wrongful acts or omissions of any person receiving or providing services, including any Physician, Hospital, or other Provider or their employees.

IT IS IMPORTANT TO KNOW THAT THIS POLICY PROVIDES SERVICES THROUGH THE UNIVERSITY OF ARIZONA HEALTH PLANS-UNIVERSITY HEALTHCARE MARKETPLACE HMO NETWORK, BUT THE CONTINUED PARTICIPATION IN THE HMO NETWORK BY ANY ONE PHYSICIAN, HOSPITAL OR OTHER PROVIDER CANNOT BE GUARANTEED. THEREFORE, IT IS IMPORTANT FOR THE COVERED PERSON TO CHECK TO SEE IF THE PROVIDER IS AN ACTIVE PARTICIPATING PROVIDER IN THE UNIVERSITY OF ARIZONA HEALTH PLANS-UNIVERSITY HEALTHCARE MARKETPLACE HMO NETWORK.

SECTION 5 – COVERED BENEFITS

Payment of Benefits
This Policy will pay Covered Medical Expenses for the following Covered Benefits when they are provided by the Primary Care Physician or other referred Participating Provider.

Payment of Covered Medical Expenses will be:
1. Based on the Allowable Fee; and
2. Subject to the Deductible, Coinsurance, Copayments, and Annual Out-of-Pocket Maximum stated in the Schedule of Benefits, unless otherwise stated in the Schedule of Benefits or this Section for specified Covered Benefits.

Exceptions
Benefits Eligible for Payment
Benefits will be eligible for payment if Covered Medical Expenses are:

1. Incurred for Covered Benefits while the Covered Person is insured under this Policy; and
2. The Treatment for which the Covered Medical Expenses are incurred is:
   a. The result of an Illness or Injury; and
   b. Medically Necessary, unless the Covered Benefit is for educational purposes only, as provided under this Policy; and
   c. Prescribed or treated by the Primary Care Physician or other Participating Provider as provided under this Policy;
   d. Prior-authorization is obtained from Us by the Covered Person or Provider, for those Covered Benefits that require Prior Authorization as specified in this Policy; and
   e. Meets Our Medical Policy.

Covered Benefits provided under this Policy are subject to the exclusions, limitations and all terms and conditions specified in this Policy.

All non-Emergency services within the HMO Network must be provided by a Participating Provider. No coverage is provided for non-Emergency services rendered outside of the HMO Network, unless the service is Prior-Authorized by Us.

Allergy Testing
The University of Arizona Health Plans-University Healthcare Marketplace considers specific allergy testing and allergy immunotherapy Medically Necessary for Covered Persons with clinically significant allergic symptoms when performed by or under the direct supervision of a Physician for the purpose of establishing a diagnosis of allergy disease. Allergy testing coverage is based on practice parameters and recommendations of: (1) the American College of Allergy, Asthma, and Immunology (ACAAI); (2) the American Academy of Allergy, Asthma, and Immunology (AAAAI); and (3) the Joint Council of Allergy, Asthma and Immunology (JCAAI). Prior Authorization is required.

Allergen immunotherapy by intradermal or subcutaneous injection is covered when administered by a Participating Provider for the Treatment of patients demonstrating hypersensitivity to specific antigens that cannot be managed by medications or avoidance.

No coverage will be provided for the following:

1. Tests for allergies that are considered experimental or investigational and/or those in investigational stages; and
2. Allergy re-testing. Allergy re-testing is not considered Medically Necessary.

Ambulance Service
Coverage is provided for local ground transportation, or air and/or water transportation when ground transportation is not available or appropriate, provided by a licensed ambulance service to or from the nearest Hospital with the appropriate staff and facilities to treat the Emergency Medical Condition of the Covered Person. Ambulance service for a non-Emergency Medical Condition must be Prior Authorized by the Covered Person's Primary Care Physician or other Participating Provider who has been referred to treat the Covered Person, and the Utilization Review Management Program.

Autism Spectrum Disorders
Coverage is provided for applied behavioral analysis therapy for the Treatment of the Autism Spectrum Disorders. Prior Authorization is required.

Autism Spectrum Disorders means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

1. Autistic Disorder;
2. Asperger's Disorder; or
3. Pervasive Developmental Disorder not otherwise specified.

Behavioral Therapy means interactive therapies derived from evidence based research, including applied behavior analysis, which includes: (1) discrete trial training; (2) pivotal response training; (3) intensive intervention programs; and (4) early intensive behavioral intervention.

No coverage will be provided for the following:

1. Sensory Integration;
2. LOVASS Therapy; and
3. Music Therapy.

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

Bariatric Surgery
Coverage is provided for the following bariatric Surgery procedures:

1. Open roux-en-y gastric bypass (RYGBP);
2. Laparoscopic roux-en-y gastric bypass (RYGBP);
3. Laparoscopic adjustable gastric banding (LAGB);
4. Open biliopancreatic diversion with duodenal switch (BPD/DS); and
5. Laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS);

If the Covered Person meets all the following criteria:

1. The Covered Person must have a body-mass index (BMI) greater than thirty-five (35);
2. The Covered Person has at least one (1) co-morbidity related to obesity; and
3. The Covered Person previously has been unsuccessful with medical Treatment for obesity.

The following medical information must be documented in the Covered Person's Patient medical record:

1. Active participation within the last two (2) years in one (1) Physician–supervised weight-management program for a minimum of six (6) months without significant gaps. The weight-management program must include monthly documentation of all of the following components:
    a. Weight;
    b. Current dietary program; and
    c. Physical activity (e.g., exercise program).
2. In addition, the procedure must be performed at an approved Center of Excellence facility that is credentialed by the University of Arizona Health Plans-University Healthcare Marketplace to perform bariatric Surgery.
3. The Covered Person must: (a) be eighteen (18) years of age or older; or (b) have reached full expected skeletal growth.

If Treatment was directly paid or covered by another health plan, Medically Necessary adjustments will be covered.

Excluded Services
No benefits will be paid for the following bariatric procedures:

1. Open vertical banded gastroplasty;
2. Laparoscopic vertical banded gastroplasty;
3. Open sleeve gastrectomy;

4. Laparoscopic sleeve gastrectomy; and
5. Open adjustable gastric banding.

Prior Authorization is required for bariatric Surgery.

Breast Reconstruction and Breast Prostheses

Coverage is provided for the following services and supplies after a mastectomy:

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.

Cancer Clinical Trials

Coverage is provided for Medically Appropriate covered Patient Costs that are directly associated with a Cancer Clinical Trial that is offered in the State of Arizona and in which the Covered Person 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 (1) of the following: (a) one (1) 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 University Health Marketplace Plan at the rates that are established by the University Health Marketplace Plan and that are not more than the level of reimbursement applicable to other similar services provided by the health care providers with the University Health Marketplace HMO 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 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.

Pursuant to the Patient informed consent document, no party is liable for damages associated with the Treatment provided during any phase of a Cancer Clinical Trial.

Coverage provided under this Policy for Cancer Clinical Trials will not supplant any portion of the Clinical Trial that is customarily paid for by: (1) government; (2) biotechnical; (3) pharmaceutical or medical device industry sources.

For the purposes of this specific Covered Benefit and benefit, the following definitions apply:

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.

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.

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.

Patient means the Covered Person.

Patient Cost means any fee or expense that is covered under this Policy and that is for a service or Treatment that would be required if the Patient were receiving usual and customary care.

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

Chiropractic Care Services

Chiropractic Care Services are provided under this Policy. Chiropractic Care Services include only nonsurgical and noninvasive Treatment of neck and back pain through physiotherapy, musculoskeletal manipulation and other physical corrections of musculoskeletal conditions within the scope of the chiropractic practice.

Musculoskeletal means any function of the musculoskeletal system that is integrated with neurological function and is expressed by biological regulatory mechanisms.

No benefits will be provided for:

1. Services of a Chiropractor which are not within his or her scope of practice, as defined by State law;
2. Charges for care not provided in an office setting;
3. Maintenance or preventive Treatment consisting of routine, long term or Non-Medically Appropriate care provided to prevent reoccurrences or to maintain the Covered Person's current status;
4. Vitamin therapy.
5. Services provided by a Non-Participating Provider.
6. Manipulation or Treatment under anesthesia or for anesthesia services.

Chiropractic Care Services are limited to twenty (20) visits per Covered Person per Calendar Year, as shown in the Schedule of Benefits.

Cosmetic Surgery

Cosmetic Surgery is covered under this Policy in limited circumstances for:

1. Reconstructive Surgery that constitutes necessary care and Treatment of medically diagnosed services required for the prompt repair of accidental Injury; and
2. Congenital defects and birth abnormalities for Eligible Dependent children.

Prior Authorization is required.

Continuing or Follow-Up Treatment

Continuing or follow-up Treatment by Non-Participating Providers will be transferred to the Covered Person's Primary Care Physician for management of the continuing or follow-up Treatment. Coverage is provided for continuing or follow-up Treatment by Non-Participating Providers out of the Service Area only if such continuing or follow-up Treatment is Prior Authorized by Our Utilization Review Management Program. The following outlines the requirements for such continuing or follow-up Treatment.

Continuing and Follow-Up Treatment by a Provider from Another Health Plan

Coverage is provided for continuation or follow-up Treatment by the Non-Participating Provider of a newly Covered Person when We receive his or her written request to continue an active course of Treatment with Non-Participating Provider during a transitional period after the Covered Person's Effective Date of coverage under this Policy. Such continuation or follow-up Treatment will be provided if both of the following apply:

1. The Covered Person has either:
   a. A life threatening disease or condition, in which case the transitional period is not more than thirty (30) days after the Covered Person's Effective Date of coverage under this Policy.
   b. Entered the third trimester of pregnancy on the Effective Date of coverage under this Policy, in which case the transitional period includes the delivery and any care up to six (6) weeks after the delivery that is related to the delivery.
2. The Covered Person's Non-Participating Provider agrees in writing to do all of the following:
   a. Except for Copayment, Coinsurance or Deductible amounts, accept as payment in full reimbursement from Us at the rates (benefits amounts) that are established by Us and that are not more than the level of reimbursement applicable to similar services provided by Participating Providers within Our HMO Network.
   b. Comply with Our quality assurance and Utilization Review Management Program requirements and provide to Us any necessary medical information related to the care.
   c. Comply with Our policies and procedures including procedures relating to: (1) referrals and obtaining Prior Authorization; (2) claims handling and Treatment plan approval by Us.

Continuing and Follow-Up Treatment by a Former Participating Provider

If while insured under this Policy, the Participating Provider of the Covered Person is terminated by Us from Our HMO Network, except for reasons of medical incompetence or unprofessional conduct, on written request by the Covered Person to Us to continue an active course of Treatment with that former Participating Provider during a transitional period after the date of the former Participating Provider's disaffiliation from Our HMO Network, if both of the following apply:

1. The Covered Person has either:
   a. A life threatening disease or condition, in which case the transitional period is not more than thirty (30) days after the date of the former Participating Provider's disaffiliation from Our HMO Network.
   b. Entered the third trimester of pregnancy on the date of the former Participating Provider's disaffiliation, in which case the transition period includes the delivery and any care up to six (6) weeks after the delivery that is related to the delivery.
2. The Covered Person's former Participating Provider agrees in writing to do all of the following:
   a. Except for Copayment, Coinsurance or Deductible amounts, continue to accept as payment in full reimbursement from Us at the rates applicable before the beginning of the transitional period.
   b. Comply with Our quality assurance and utilization review requirements and provide to Us any necessary medical information related to the care.
   c. Comply with Our policies and procedures including: (1) procedures relating to referrals and obtaining Prior Authorization; and (2) claims handling and Treatment plan approval by Us.

This section does not extend to a health care Provider who is not a Participating Provider of Our HMO Network any contractual rights or remedies beyond those rights or remedies related to and necessary for the provision of Covered Benefits to the specific Covered Person during the required transitional period.

Health Care Provider means any Physician who is licensed in the State of Arizona pursuant to Title 32, Chapter 13 and/or Chapter 17.

Dental Confinements/Anesthesia
Coverage is provided for facility and anesthesia services for Hospitalization in connection with dental or oral Surgery if the confinement has been Prior Authorized because of a hazardous medical condition. Such conditions include: (1) heart problems; (2) diabetes; (3) hemophilia; (4) dental extractions due to cancer related conditions; (5) the probability of allergic reaction (or any other condition that could increase the danger of anesthesia). All facility services must be provided by a Participating Provider.

Dental Services – Accident Only
Coverage is provided for dental services for the Medically Necessary Treatment of:

1. A fractured jaw; or
2. An Injury to Sound Natural Teeth;

incurred due to an Accidental Injury. Benefits are payable for the services of a Physician, Dentist, or Dental Surgeon in the Treatment of such Accidental Injuries. Prior Authorization is required for services to qualify as a Covered Benefit.

For the Accidental Injury to sound natural teeth, the continuous course of Treatment must be started within six (6) months of the date of the Accident.

Sound Natural Teeth means natural teeth that: (1) are free of active clinical decay, (2) have at least 50% bony support; and (3) are functional in the arch.

This Policy will not pay for services for the repair of teeth which are damaged as the result of biting and chewing.

Diagnostic Testing, Laboratory and Radiology Services
Coverage is provided by Participating Providers for diagnostic testing which includes the following:

1. Radiological procedures, including: (a) x-rays and diagnostic imaging; (b) Computed Tomography (CT or CAT) scans; (c) Positron Emission Tomography (PET) scans; (d) Magnetic Resonance Imaging (MRI); and (e) multi-dimensional imaging. These radiological procedures require Prior Authorization.
2. Laboratory Tests and Services. These benefits will be provided in accordance with the requirements of the Affordable Care Act or applicable State law or regulations. Genetic testing requires Prior Authorization. Genetic testing is covered for certain conditions when the Covered Person has risk factors such as family history or specific symptoms. The genetic testing must be: (a) expected to lead to increased or altered monitoring for early detection of disease; (b) a Treatment plan or other therapeutic intervention; and (c) determined to be Medically Necessary and appropriate in accordance with Our policies,
3. Other diagnostic procedures.

Durable Medical Equipment
Coverage is provided for the purchase or rental of Durable Medical Equipment and prosthetics when: (1) ordered or prescribed by a Primary Care Physician or other Participating Physician; and (2) provided by a Participating vendor. The determination to either purchase or rent equipment expected to cost one thousand dollars ($1,000) or more will be made by the Utilization Review Management Program. Prior Authorization is required when: (1) cost for durable medical equipment exceeds three hundred dollars ($300); or (2) consumable medical equipment exceeds one hundred dollars ($100).

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 Primary Care Physician or other Participation Provider for which referral has been made.
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 (1) 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: (1) crutches; (2) Hospital beds; (3) wheel chairs; (4) respirators; and (5) 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: (a) bathtub chairs; (b) safety grab bars; (c) stair gliders or elevators; (d) over-the-bed tables; (e) saunas or exercise equipment; (f) Environmental control equipment, such as: (i) air purifiers; (ii) humidifiers and electrostatic machines; (f) Institutional equipment, such as air fluidized beds and diathermy machines; (g) Elastic stockings and wigs; (h) equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, (i)braces and splints; (i) items, such as: (i) auto tilt chairs; (ii) paraffin bath units; and (iii) whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective; (j) items which under normal use would constitute a fixture to real property, such as: (i) lifts; (ii) ramps; (iii) railings; and (iv) grab bars; and (k) hearing aid batteries (except those for cochlear implants) and chargers;
3. Repair or replacement due to misuse or damage; or
4. Replacement when lost.

Emergency Services

Coverage is provided for Emergency services provided in the Emergency room of a Participating Hospital or a Non-Participating Hospital, if the Non-Participating Hospital is the nearest Hospital to treat an accidental Injury or an Emergency Medical Condition requiring Emergency care for the Covered Person. Emergency Services include:

1. At least a screening examination to determine whether an Emergency exists; and
2. Care through stabilization for an Emergency situation.

No Prior Authorization is required for Emergency Services; however, the Covered Person must notify his or her Primary Care Physician within forty-eight (48) hours or as soon as reasonably possible of the Emergency Service.

If the Covered Person receives Emergency Services outside the Service Area, the Covered Person must notify the Utilization Review Management Program as soon as reasonably possible; refer to Section 6, Utilization Review Management Program. We may arrange to have the Covered Person transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

Also, refer to Urgent Care Services.

External Prosthetic Appliances

Coverage is provided for the initial purchase and fitting of external prosthetic devices which are:

1. Used as a replacement or substitute for a missing body part; and
2. Necessary for the alleviation or correction of Illness, Injury or congenital defect.

External prosthetic appliances will include: (1) artificial arms and legs; and (2) terminal devices such as a hand or hook.

Replacement of external prosthetic appliances is covered only if necessitated by normal anatomical growth or as a result of wear and tear.

The following are specifically excluded:

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

Family Planning Services (Contraception and Voluntary Sterilization)

Coverage is provided for 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 (tubal ligation).

Note: Vasectomy is covered under Outpatient Facility and Professional Services.

Foot Orthotics

Coverage is provided for the following foot orthotics for Treatment of diabetes:

1. Custom-molded shoes constructed over a positive model of the Covered Person'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
2. have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

Habilitative Coverage

Coverage will be provided for habilitative care services when the Covered Person requires help to keep, learn or improve skills and functioning for daily living due to a medically diagnosed condition. These services include, but are not limited to: (1) physical and occupational therapy; (2) speech-language pathology; and (3) other services for people with disabilities. These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Participating Physician. Prior Authorization is required.

Hearing Aids

Coverage is provided for hearing aid services. Benefits are limited to one (1) hearing exam per Calendar Year and one (1) hearing aid per ear, per Calendar Year. The following services are covered:

1. New or replacement hearing aids no longer under warranty (Prior Authorization is required);
2. Cleaning or repair;
3. Batteries for cochlear implants.

Home Health Services

Coverage is provided for Home Health Services limited to a maximum of forty-two (42) visits per Covered Person per Calendar Year when the following criteria are met:

1. The Primary Care Physician must have determined a medical need for home health care and developed a plan of care that is reviewed at thirty-day (30-day) intervals by the Primary Care Physician.
2. The care described in the plan of care must be for: (a) intermittent skilled nursing; (b) therapy; or (c) speech services.
3. The Covered Person must be homebound unless services are determined to be Medically Necessary by the Utilization Review Management Program.
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 (4) hours of services. Home Health Services do not include services of a person who is a member of the Covered Person's family or who normally resides in the Covered Person's home. Subject to all the provisions above, physical, occupational, and speech therapy provided in the home are subject to sixty (60) visits per Covered Person per Calendar Year and are included in the overall Outpatient Rehabilitative Therapy limitation of sixty (60) visits per Calendar Year. Therefore, a combined total of sixty (60) days per Calendar Year will be provided for: (1) physical, occupational, and speech therapy provided in the home in connection with Home Health Services; and (2) Outpatient Rehabilitative Therapy services. Refer to Rehabilitative Therapy Services in this Section.

Prior Authorization is required for Home Health Services.

Hospice Services

Coverage is provided for Hospice care services when provided:

1. Under an approved Hospice care program; and
2. To a Covered Person 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: (1) Inpatient Care; (2) Outpatient services; (3) professional services of a Physician; (4) services of: (a) a psychologist; (b) social worker or family counselor for individual and family counseling; and (c) Home Health Services.

Hospice care services do not include the following:

1. Services of a person who is a member of the Covered Person's family or who normally resides in the Covered Person's house;
2. Services and supplies for curative or life prolonging procedures;
3. Services and supplies for which any other benefits are payable under this Policy;
4. Services and supplies that are primarily to aid the Covered Person 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:

1. A Participating Hospital;
2. A Participating Skilled Nursing Facility or a similar institution;
3. A Participating Home Health Care Agency;
4. A Participating Hospice facility or any other licensed facility or agency under a Medicare-approved Hospice care program.

A Hospice care program is:

1. A coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
2. A program that provides palliative and supportive medical, nursing, and other health services through home or Inpatient Care during the Illness; and
3. A program for persons who have a terminal Illness and for the families of those persons.

A Hospice facility:

1. Is a Participating institution or portion of a facility which primarily provides care for terminally ill patients;
2. Is a Medicare-approved Hospice care facility;
3. Meets standards established by this Policy; and
4. Fulfills all licensing requirements of the State or locality in which it operates.

Prior Authorization is required for Hospice services.

Infertility Services

Coverage is provided for diagnostic services rendered for infertility evaluation. Any medical Treatment and/or prescription related to infertility once diagnosed are excluded by this Policy.

Inpatient Hospital Services

Coverage is provided for Inpatient Hospital Services. Such services are provided for the 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:

1. Semi-private room and board;
2. Care and services in an intensive care unit (ICU);
3. Drugs and medications;
4. Biologicals;
5. Fluids;
6. Blood and blood products;
7. Chemotherapy;
8. Special diets;
9. Dressings and casts;
10. General nursing care;

11. Use of operating room and related facilities;
12. Laboratory and radiology services;
13. Other diagnostic and therapeutic services;
14. Anesthesia and associated services;
15. Inhalation therapy;
16. Radiation therapy;
17. Admit kit; and
18. Other services which are customarily provided in acute care Hospitals.

Inpatient Hospital Services also include services provided in a Birthing Center.

Prior Authorization is required for Inpatient Hospital services. If the Covered Person is admitted to the Hospital due to Emergency, notification to Utilization Review Management Program is required within 48 hours of admission, or when reasonably possible.

Inpatient Services at Other Participating Health Care Facilities
Coverage is provided for: (1) semi-private room and board; (2) skilled and general nursing services; (3) Physician visits; (4) physiotherapy; (5) speech therapy; (6) occupational therapy; (7) x-rays; and (8) administration of drugs, medications, biologicals and fluids. Prior Authorization is required.

Insulin Pumps and Supplies
Coverage is provided for insulin pumps and insulin pump supplies when ordered by a Participating Provider and obtained through a Participating durable medical equipment supplier. The Covered Person may contact Our Customer Care department to obtain supplier contact information.

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

Maternity Care Services
Coverage is provided for Maternity care services including medical, surgical and Hospital care: (1) during the term of pregnancy; (2) upon delivery and during the postpartum period for normal delivery; (3) cesarean section; (4) spontaneous abortion (miscarriage); (5) complications of pregnancy; and (6) maternal risk.

Coverage for a mother and her newly born child will be available for:
1. A minimum of forty-eight (48) hours of Inpatient Care following a vaginal delivery; and
2. A minimum of ninety-six (96) hours of Inpatient Care following a cesarean section.

Any decision to shorten the period of Inpatient Care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

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

Prior Authorization will be required if a decision is made to lengthen the time of Inpatient stay to more than the above required period.

Under Federal law, benefits may not be restricted for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Participating Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, under Federal law, Covered Physicians are not required to obtain Prior Authorization

from the Utilization Review Management Program for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Prenatal and Postnatal Care. Office visits for Prenatal and Postnatal Care are covered if services are obtained by a Participating Provider.

Medical Foods / Metabolic Supplements and Gastric Disorder Formula
Coverage is provided for:

1. Medical foods;
2. Metabolic supplements; and
3. Gastric Disorder Formula;

to treat inherited metabolic disorders or a permanent disease/non-functioning condition in which the Covered Person is unable to sustain weight and strength commensurate with the Covered Person's overall health status.

Inherited metabolic disorders triggering medical food coverage are:

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

Inherited Metabolic Disorder means: (1) a disease caused by an inherited abnormality of body chemistry; and (2) includes a disease tested under the newborn screening program as prescribed by Arizona statute.

We will pay at least fifty percent (50%) of the cost of Medical Foods for Inherited Metabolic Disorder.

Gastric Disorder Formula Benefit
Coverage will be provided for amino acid-based formula that is ordered by a Participating Provider who is a Physician or a Registered Nurse Practitioner; if:

1. The Covered Person has been diagnosed with a Gastric Disorder;
2. The Covered Person is under the continuous supervision of a Participating Provider who is a Physician or a Registered Nurse Practitioner; and
3. There is risk of a mental or physical impairment without the use of the formula.

We will pay at least seventy-five percent (75%) of the cost of the formula for Medical Foods required by eosinophilic gastrointestinal disorder.

Medical Foods means modified low protein foods and metabolic formula.

Metabolic Formula means foods that are all of the following:

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

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

1. Formulated to be consumed or administered internally under the supervision of a Participating Provider who is a Medical Doctor or Doctor of Osteopathy.

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

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

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

Medical Supplies

Coverage is provided for medical supplies which include Medically Appropriate supplies which may be considered disposable; however, they are required for the Covered Person in a course of Treatment for a specific medical condition. Supplies must be obtained from a Participating Provider. Over-the-counter supplies, such as Band-Aids and gauze are not covered.

Mental Health and Substance Abuse Services

Coverage is provided for Mental Health Services and Substance Abuse Services. Such services may be provided in a Participating General Hospital or Participating Specialty Hospital that provides services especially for persons with Mental Health and Substance Abuse conditions. Prior Authorization is required for Mental Health Services and Substance Abuse Services provided on Inpatient basis.

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

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

Inpatient Mental Health Services

Coverage is provided for Inpatient Mental Health Services rendered by a Participating Hospital for the Treatment and evaluation of Mental Health during an Inpatient admission. Prior Authorization is required.

Outpatient Mental Health Services

Coverage is provided for Outpatient Mental Health Services rendered by Participating Providers who are qualified and properly licensed or certified according to State or local laws to provide Mental Health Treatment when such Treatment is provided on an Outpatient basis in an individual, group or structured group therapy program. Covered Benefits include, but are not limited to: (1) Outpatient Treatment of conditions such as: (a) anxiety or depression which interferes with daily functioning; (b) emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; (c) neuropsychological testing; (d) emotional reactions associated with marital problems or divorce; (e) child/adolescent problems of conduct or poor impulse control; (f) affective disorders; (g) suicidal or homicidal threats or acts; (h) eating disorders; or (i) acute exacerbation of: (aa) chronic Mental Health conditions (crisis intervention and relapse prevention); (bb) Outpatient testing/assessment; and (cc) medication management when provided in conjunction with a consultation.

Outpatient Substance Abuse Rehabilitation Services

Coverage is provided for Outpatient Substance Abuse rehabilitation services which include the diagnosis and Treatment of abuse or addiction to alcohol and/or drugs, including Outpatient rehabilitation in an individual, group, structured group or intensive Outpatient structured therapy program.

Intensive Outpatient structured therapy programs consist of distinct levels or phases of Treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient structured therapy programs provide nine (9) or more hours of individual, family and/or group therapy in one (1) week.

Inpatient (Residential) Substance Abuse Treatment

Coverage is provided for Inpatient Substance Abuse Treatment Services. Such services are provided for the Treatment of conditions that cannot be adequately treated on an ambulatory basis or in another Participating Mental Health Care Facility. Inpatient Substance Abuse Treatment Services include:

1. Semi-private room and board;
2. Prescribed drugs and medications;
3. General nursing care;
4. Other diagnostic and therapeutic services;
5. Admit kit; and
6. Other services which are customarily provided in an Inpatient Substance Abuse Treatment facility; and
7. Any other services required by: (a) the Affordable Care Act; (b) the Mental Health Parity and Addiction Equity Act.

Prior Authorization is required.

Substance Abuse Detoxification Services

Coverage is provided for Substance Abuse detoxification services which include detoxification and related medical ancillary services when required for the diagnosis and Treatment of:

1. Addiction to alcohol and/or drugs; and
2. Medication management;

when provided in conjunction with a consultation. The Utilization Review Management Program will decide, based on the Medical Necessity of each situation, whether such services will be provided in an Inpatient or Outpatient setting. Inpatient detoxification coverage is limited to two (2) Treatments per year and a lifetime maximum of five (5) Treatments.

Excluded Mental Health and Substance Abuse Services

The following are specifically excluded from this Mental Health and Substance Abuse Services benefit:

1. Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
2. Treatment of Chronic Conditions not subject to favorable modification according to generally accepted standards of medical practice;
3. Developmental disorders, including but not limited to:
   a. Developmental reading disorders;
   b. Developmental arithmetic disorders;
   c. Developmental language disorders; or
   d. articulation disorders.
4. Counseling for activities of an educational nature;
5. Counseling for borderline intellectual functioning;
6. Counseling for occupational problems;
7. Counseling related to consciousness raising;
8. Vocational or religious counseling;
9. IQ testing;
10. Residential Treatment; (unless associated with chemical or alcohol dependency as described in the Inpatient (Residential) Substance Abuse Treatment provision);
11. Marriage counseling;
12. Custodial care, including but not limited to geriatric day care;
13. Psychological testing on children requested by or for a school system;
14. Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; and
15. Biofeedback is not covered for reasons other than pain management.

Nutritional Evaluation
Nutritional evaluation and counseling from a Participating Provider is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to: (1) Morbid obesity; (2) Diabetes; (3) Cardiovascular disease; (4) Hypertension; (5) Kidney disease; (6) Eating disorders; (7) Gastrointestinal disorders; (8) Food allergies; and (9) Hyperlipidemia.

All other services for the purpose of diet control and weight reduction are not covered unless required by a specifically identified condition of disease etiology. Services not covered include but are not limited to: (1) gastric Surgery; (2) intra oral wiring; (3) gastric balloons; (4) dietary formulae; (5) hypnosis; (6) cosmetics; and (7) health and beauty aids. Prior Authorization is required.

Obstetrical and Gynecological Services
Obstetrical and gynecological services are covered when provided by a qualified Participating Provider for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions. No Prior Authorization or referral is required for such visit.

Organ Transplant Services
Coverage is provided for human organ and tissue transplant services at designated facilities throughout the United States. Prior Authorization is required, and this coverage is subject to the following conditions and limitations. Due to the specialized medical care required for transplants, the HMO Participating Provider Network for this specific service may not be the same as the medical network in which the Covered Person enrolled.

These benefits are only available when the Covered Person is the recipient of an organ transplant. No benefits are available where the Covered Person is an organ donor for a recipient, unless the Covered Person and the recipient are family members and are both insured under this Policy at the time transplant services are being provided to such recipient.

Organ transplant services include the recipient's: (1) medical, surgical and Hospital services; (2) Inpatient immunosuppressive medications; and (3) costs for organ procurement. Transplant services are covered only if they are required to perform human to human organ or tissue transplants, such as: (1) Allogeneic bone marrow/stem cell; (2) Autologous bone marrow/stem cell; (3) Cornea; (4) Heart; (5) Heart/Lung; (6) Kidney; (7) Kidney/Pancreas; (8) Liver; (9) Lung; (10) Pancreas; (11) Small Bowel/Liver; or (12) Kidney/Liver.

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

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs will consist of Surgery necessary for: (1) organ removal; (2) organ transportation; and (3) Hospitalization and Surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

Organ Transplant Travel Services
Coverage is provided for travel expenses incurred by the Covered Person in connection with a pre-approved organ/tissue transplant subject to the following conditions and limitations.

1. Travel expenses are limited to ten thousand dollars ($10,000).
2. Organ transplant travel benefits are not available for cornea transplants, unless a member is Prior Authorized for a corneal transplant and there is no contracted HMO Network Provider to perform such procedure.
3. Benefits for transportation, lodging and food are available only for the recipient of a pre-approved organ/tissue transplant from a transplant facility.

The term recipient is defined to include the Covered Person receiving authorized transplant related services during any of the following: (1) Evaluation; (2) Candidacy; (3) Transplant event; or (4) Post-transplant care.

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

1. Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
2. Transportation to and from the transplant site in a personal vehicle will be reimbursed at thirty-seven and one-half cents ($0.375) per mile when the transplant site is more than sixty (60) miles one (1) way from the Covered Person's home.
3. Lodging while at, or traveling to and from the transplant site;
4. Food while at, or traveling to and from the transplant site.

In addition to the Covered Person being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one (1) companion to accompany the Covered Person. The term companion includes: (1) the Covered Person's spouse or domestic partner, or other member of the Covered Person's family; (2) the Covered Person's legal guardian; or (3) any person not related to the Covered Person, but actively involved as the Covered Person's caregiver.

Transplant Travel guidelines can be obtained by contacting Our Utilization Review Management Program.

Orthognathic Surgery

Coverage is provided for Orthognathic Treatment and Surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) if approved as Medically Necessary by the Utilization Review Management Program. Prior Authorization is required.

Ostomy Supplies

Coverage is provided for Ostomy supplies which are Medically Appropriate for care and cleaning of a temporary or permanent ostomy. Covered supplies include, but are not limited to: (1) pouches; (2) face plates and belts; (3) irrigation sleeves; (4) bags and catheters; (5) skin barriers; (6) gauze; (7) adhesive, adhesive remover, deodorant, pouch covers, and other supplies as appropriate. Subject to Prior Authorization and the Durable Medical Equipment supplies dollar limits; refer to the Durable Medical Equipment benefit.

Outpatient Facility Services

Coverage is provided for Outpatient Facility Services for Covered Benefits provided on an Outpatient basis, including, but not limited to:

1. Diagnostic and/or Treatment services;
2. Administered drugs;
3. Medications;
4. Fluids;
5. Biologicals;
6. Blood and blood products;
7. Inhalation therapy; and
8. Procedures which can be appropriately provided on an Outpatient basis, including: (a) certain surgical procedures; (b) anesthesia; (c) recovery room services; (d) assistance and advice on follow-up care.

If the Covered Person requires specialty care or a Hospital admission, he or she should contact the Utilization Review Management Program to obtain necessary authorizations for care or Hospitalization.

Oxygen and the Oxygen Delivery System

Coverage is provided for oxygen that is routinely used on an Outpatient basis. Oxygen Services and Supplies are not covered outside of the Service Area, except on an Emergency basis.

Pediatric Services

Coverage will be provided for Pediatric preventive care services for Covered Dependent Children under age nineteen (19). Benefits include, but are not limited to: (1) appropriate immunizations as defined by Standards of Child Health Care issued by the American Academy of Pediatrics or other guidelines required by the State; (2) developmental assessments, which includes

Physician visits for child health supervision services; (3) laboratory services; and (4) any other care and services mandated by the Patient Protection and Affordable Care Act.

Pediatric Vision Care Program
Coverage will be provided for vision care services for Covered Dependent Children under age nineteen (19). A directory listing of the Participating Providers can be obtained from the Our website, or You can contact Customer Care by telephone or mail; the contact information is shown on page 2.

Benefits will be provided for the Covered Benefits shown in the Schedule of Benefits for the stated frequency of services. The frequency of service for each Covered Benefit is once every twelve (12) months, unless otherwise stated in the Schedule of Benefits.

The Covered Person is covered for one (1) pair of eyeglasses during any Calendar Year. Benefits payable under this Pediatric Vision Care Program benefit are subject to the terms, conditions, exclusions, limitations outlined for this Covered Benefit and this Policy.

Eye Examinations
Benefits will be provided for one (1) eye examination for each eligible Covered Dependent Child during the Calendar Year.

Vision Care Materials: Eyeglass Lenses, Coatings, and Frames
Benefits will be provided for:

1. Eyeglass lenses;
2. Eyeglass coatings; and
3. Eyeglass frames;

as shown in the Schedule of Benefits.

Payment of Benefits
Benefits will be paid as shown in the Schedule of Benefits.

Exclusions and Limitations
The following exclusions and limitations apply only to this Pediatric Vision Care benefit. No coverage will be provided under this Vision Care benefit for:
1. Services provided by a Non-Participating Provider.
2. The purchase of two (2) pairs of glasses instead of bifocals. Only one (1) pair of glasses are payable under this Vision Care benefit per Calendar Year.
3. Replacement of lenses, frames or contacts.
4. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ± .50 diopter power).
5. Replacement of lenses and frames furnished under This Plan which are lost or broken except at the normal intervals when services are otherwise available.
6. Medical or surgical Treatment of the eyes.
7. Corrective vision Treatment of an Experimental Nature.
8. Costs for services and/or materials above the benefits payable for the Covered Vision Care services.
9. Services or materials not indicated as Covered Vision Care benefit.

Physician and Other Health Professional Services
Coverage will be provided for Physician and other Health Professional Services. Such services include:

1. Diagnostic and Treatment services provided by Participating Physicians and Other Participating Health Professionals;
2. Office visits;
3. Periodic health assessments;
4. Well-Baby and Well-Child Care and routine immunizations provided in accordance with accepted medical practices;
5. Hospital care;
6. Consultation;
7. Second surgical opinion; and

8. Surgical procedures.

Other Health Professional Services include those services provided by an individual other than a Physician, and 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.

Prescription Drugs Benefit
Generic and Brand-Named Prescription Drugs are covered under this Policy, as provided in this Benefit provision. All Prescription Drugs must be prescribed by a Participating Provider Physician. The Prescription Drug Benefits are provided through The University of Arizona Health Plans-University Healthcare Marketplace and administered by a Pharmacy Benefit Management (PBM) vendor, an organization which has been contracted by Us to perform these services. The Covered Person must pay a portion of Covered Prescription Drugs to receive Prescription Drug Benefits. That portion is shown in the Schedule of Benefits and described below in this provision. Prescription Drugs must be filled by Participating Pharmacies.

Copayment and Coinsurance
Copayment or Coinsurance is that portion of Covered Prescription Drugs which the Covered Person is required to pay under this benefit. In addition to the Copayments/Coinsurance outlined in the Schedule of Benefits, Covered Persons will be required to pay the difference in the medication cost of a generic medication versus a name-brand medication when the Covered Person requests the brand name drug and the prescribing Physician has indicated the generic equivalent substitution is allowable. We will exclude Narrow Therapeutic Index (NTI) drugs from these Copay penalties.

Drug Formulary Listing and Participating Pharmacy Directory
Covered Prescription Drugs are provided in the Prescription Drug Formulary for this Policy. The formulary may be obtained on Our website or by calling the Customer Care number appearing on page 2. Prescription Drugs may be obtained from a Participating Pharmacy (retail) or Participating Mail Order Pharmacy only; no coverage is provided for prescription drugs obtained from a Non-Participating Pharmacy (retail) or Non-Participating Mail Order Pharmacy. The Participating Pharmacy and Participating Mail Order Pharmacy directory listing also may be obtained on Our website or by calling the Customer Care number appearing on page 2.

Drug Formulary
Our Formulary is a list of medications that will allow You to maximize the value of Your prescription benefit. These medications, chosen by a committee of doctors and pharmacists, are lower-cost generics and brand names that are available at a lower cost than their more expensive brand-name counterparts. The Formulary is updated quarterly, and as needed throughout the year to add significant new medications as they become available. Medications that no longer offer the best therapeutic value for the plan are deleted from the Formulary. To see what medications are on the Formulary, log on to Our website or contact the Customer Care Department number appearing on page 2. You may have a copy sent to You. Sharing this information with Your Participating Provider helps ensure that You are getting the medications You need, and saving money for You.

The Prescription Drugs provided under this Policy are based on the Drug Formulary for this Policy. Therefore, only those prescription drugs listed in such Drug Formulary will be covered under this Policy.

Prescription Drugs do not require Prior Authorization unless they are so indicated in the Formulary. If the Covered Person does not obtain Prior Authorization for a Prescription Drug listed in the in the formulary as requiring Prior Authorization, the Covered Person must submit a claim with supporting documentation to Our Customer Care address, which is shown on page 2, for reimbursement considerations.

Step therapy and/or quantity limits may apply to certain drugs; check the formulary for those to which these limitations may apply. Step therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

Prescription Drugs will be dispensed as follows:

1. Per prescription or refill at a retail Participating Pharmacy is limited to a maximum of a thirty-day (30-day) supply based on the FDA-approved dosage regardless of the manufacturer packaging; and
2. Per prescription or refill received from the Participating Mail Order Pharmacy is limited to a maximum of a ninety-

day (90-day) supply based on the FDA-approved dosage regardless of the manufacturer packaging. However, Self-Administered Injectable Drugs are limited to a maximum of a thirty-day (30-day) supply per prescription or refill received from the Participating Mail Order Pharmacy.

Generic Drugs

To avoid additional cost, the Covered Person should ask their prescribing Participating Provider to prescribe any available generic equivalent medications if the Covered Person and the prescribing Participating Provider feel it is appropriate.

Covered Prescription Drugs

The term Covered Prescription Drugs means:

1. A Prescription Legend Drug for which a written prescription is required. A Legend Drug is one which has on its label "Caution: Federal law prohibits dispensing without a prescription";
2. Insulin; pre-filled insulin cartridges for the blind; oral blood sugar control agents;
3. Diabetic supplies are all covered when dispensed by the Participating Mail Order Pharmacy and Participating Retail Pharmacy program including: (a) needles; (b) syringes; (c) glucose monitors and machines; (d) glucose test strips; (e) visual reading ketone strips; (f) urine test strips; (g) lancets; and (h) alcohol swaps;
4. A compound medication of which at least one (1) ingredient is a Prescription Legend Drug;
5. Tretinoin for individuals through age twenty-four (24);
6. Any other drug which, under the applicable State law, may be dispensed only upon the written prescription of a Physician;
7. Oral contraceptives or contraceptive devices, regardless of intended use, except that implantable contraceptive devices, such as Implanon or Nexplanon, are not considered Covered Prescription Drugs;
8. Prenatal vitamins, upon written prescription;
9. Growth hormones; (with prior-authorization); or
10. Injectable drugs or medicines for which a prescription is required, except injectable infertility drugs.

Exclusions

No prescription drug benefits will be payable for the following:

1. For non-legend drugs, other than those specified under ''Covered Prescription Drugs'';
2. For non-Medically Appropriate anabolic steroids;
3. Fluoride supplements;
4. Over-the-counter drugs that do not require a prescription;

Any drug used for the purpose of weight loss;

5. Prescription Drugs for cosmetic purposes, including the Treatment of alopecia (hair loss), e.g., Minoxidil, Rogaine;
6. For Treatment of erectile or sexual dysfunction (both male and female), certain drugs used for erectile dysfunction may be covered if: (a) Medically Necessary; and (b) the Covered Person receives Prior Authorization;
7. Therapeutic devices or appliances, including: (a) needles; (b) syringes; (c) support garments; and (d) other non-medicinal substances, regardless of intended use, unless otherwise specified as a Covered Benefit under this provision;
8. Diabetic infusion sets, which include: (a) a cassette; (b) needle and tubing; and (c) one (1) insulin-pump during the warranty period. Diabetic-infusion sets and accessories for insulin pumps are covered under the Durable Medical Equipment Benefit;
9. Drugs or items labeled "Caution: limited by Federal law to investigational use", or experimental drugs even though the Covered Person is charged for the item;
10. Immunization agents, biological sera, blood, or blood plasma;
11. Prescription Drugs which are to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is a Patient in a Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medications in these situations is part of the facility's charge;
12. Any Prescription Drug refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order;
13. Replacement prescription Drugs or Prescription Drugs due to loss, theft or spoilage;
14. To the extent that payment is unlawful where the person resides when expenses are incurred;
15. For charges which the person is not legally required to pay;
16. For charges which would not have been made if the person were not covered by this Prescription Drug Benefit;

17. For drugs which are not considered essential for the necessary care and Treatment of a non-occupational Injury or Illness, as determined by the Utilization Review Management Program;
18. For drugs obtained from a non-Participating Pharmacy;
19. For more than a thirty-day (30-day) supply when dispensed in any one Prescription Order through a Retail Pharmacy;
20. For more than a ninety-day (90-day) supply when dispensed in any one Prescription Order through a Participating Mail-Order Pharmacy;
21. For indications not approved by the Food and Drug Administration except as may be covered under Section 5, Clinical Cancer Trials;
22. For drugs for cosmetic purposes;
23. For tretinoin for individuals age twenty-five (25) and over;
24. For administration of any drug; may be covered as a medical benefit;
25. For prescriptions which an eligible person is entitled to receive without charge from any workers' compensation or similar law or any public program;
26. For nutritional or dietary supplements, or anorexiants;
27. For prescription vitamins other than prenatal vitamins, upon written prescription;
28. For all infertility drugs; or
29. Prescription medications that have over-the-counter (OTC) equivalents.

If Prescription Drugs are purchased at a retail Participating Provider Pharmacy, the Covered Person must present his or her Identification Card (ID) at the time of purchase and pay the required Prescription Drug Deductible and/or Copayment or Coinsurance as shown in the Schedule of Benefits.

If Prescription Drugs are purchased through the Participating Mail Order Pharmacy, the Covered Person must provide the Participating Mail Order Pharmacy with the completed order form, Deductible and/or Copayment or Coinsurance amount as shown in the Schedule of Benefits, and the signed Physician prescription.

Prescription Medications Prior Authorization
For the purposes of Covered Person 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. This Policy administers the Prior Authorization process for prescription medications.

Prior Authorization (PA) may be initiated by the Participating Pharmacy, the Physician, or the Covered Person by calling Our Customer Care Department or submitting a Prior Authorization request form. The Participating Pharmacy may call after being prompted by a medication denial stating "Prior Authorization Required". The Participating Pharmacy may also pass the information on to the Covered Person's Physician or to the Covered Person and require the Covered Person to follow-up.

To initiate a Prior Authorization for pharmaceutical drug approval, the Participating Pharmacy, the Covered Person's Physician or the Covered Person must contact Our Customer Care Department and advise them of the request for pharmaceutical drug Prior Authorization. Determinations may take up to 72 hours from the Customer Care Department's receipt of the completed form, not including weekends and holidays.

If the Prior Authorization request is APPROVED, Customer Care Department calls the person who initiated the request and enters an override into the PBM processing system for a limited period of time. The Participating Pharmacy will then process the Covered Person's prescription.

If the Prior Authorization request is DENIED, the Customer Care Department 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, refer to Section 10, Grievances and Appeals.

The criteria for the Prior Authorization program are based on nationally recognized guidelines; FDA approved indications and accepted standards of practice. Each specific guideline has been reviewed and approved by the Health Plan Pharmacy and Therapeutics (P and T) Committee for appropriateness.

Prior Authorization is required for prescription medications designated as requiring Prior Authorization or medications not listed on the formulary.

Medication(s) included in medication management programs, including but not limited to, an amount or quantity that can be used within a set timeframe or an age limitation, may be subject to Prior Authorization. Medication management programs are subject to change and are maintained and updated as medications are FDA approved within the defined therapeutic class and as clinical evidence requires. Medications subjected to Prior Authorization resulting from medication management programs include, but are not limited to certain medications listed below:
1. Topical Anti-acne products after the age of twenty-four (24);
2. Medications for Attention Deficit Hyperactivity Disorder/ Narcolepsy after the age of nineteen 19;
3. Oral Antiemetics beyond defined quantity limitations;
4. Medications to treat insomnia beyond defined quantity limitations; and
5. Medications used to treat migraine headaches beyond defined quantity limitations.

Specialty Medication
A certain class of medications will be managed through the Pharmacy Benefit Management Vendor's Specialty Pharmacy Program. Medications that may be included in this program: (1) are used to treat chronic or complex health conditions; (2) may be difficult to administer; (3) may have limited availability; and/or (4) may require special storage and handling. Medications included in the PBM Specialty Pharmacy Program require Prior Authorization.

Preventive Health Care Services Benefit
Preventive Health Care Services for health care screenings or preventive purposes submitted with a routine diagnosis will be covered at 100% of the Allowable Fee. This means that these Benefits are not subject to the Deductible, Coinsurance, Copayments, or Annual Out-of-Pocket Maximum when services are provided by a Participating Provider. No coverage is provided for Preventive Care Services that are provided by Non-Participating Providers.

Preventive Health Care Services include, but are not limited to:

1. Services that have an "A" or "B" rating* in the United States Preventive Services Task Force's current recommendations; and
2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention; and
3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care and Screenings for Infants, Children, Adolescents and Women;
4. Current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to November 2009;
5. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years, who have a 30-pack-per-year smoking history and currently smoke or have quit within the last 15 years. Screening should be discontinued once a person has not smoked from 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery;
6. Screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation; and
7. Any other Preventive Health Care Services required by the Patient Protection and Affordable Care Act.

The following are some of the services provided under this Preventive Health Care Services Benefit. Coverage will be provided in accordance with the requirements of the Patient Protection and Affordable Care Act:

1. Abdominal Aortic Aneurysm. Coverage will be provided for one-time screening for men of specified ages who have ever smoked, as required by the Patient Protection and Affordable Care Act.
2. Autism Screening. Coverage will be provided for Covered Dependent Children age eighteen (18) to twenty-four (24) months, as required by the Patient Protection and Affordable Care Act.
3. Blood Pressure Screening. Screening will be provided for all adults. Blood pressure screening will be covered for Covered Dependent Children ages: (a) zero (0) to eleven (11) months; (b) one (1) to four (4) years; (c) five (5) to ten (10) years; (d) eleven (11) to fourteen (14) years; and (e) fifteen (15) to seventeen (17) years. Screenings will be provided as required by the Patient Protection and Affordable Care Act.
4. Breast Pump. Coverage is provided for the purchase of a manual breast pump, if requested within six (6) months

from the date of the birth of the child. Benefits are limited to one (1) manual breast pump and breast pump supplies per female member, per Calendar Year. Purchase of Hospital grade breast pumps and Hospital grade breast pump supplies is excluded.

5. Cancer Screenings. Coverage for cancer screenings includes, but is not limited to: (a) Breast Cancer Screenings (Single baseline screening for women ages 35 - 39; screening every 1 year for women age 40 and over); (b) Colorectal Cancer Screenings (for adults over age 50); (c) Prostate Cancer Screenings; and (d) any other cancer screenings required by the Patient Protection and Affordable Care Act.

6. Cholesterol Screening. Coverage for cholesterol screening will be provided for adults of certain ages or adults who are at high risk, as required by the Patient Protection and Affordable Care Act.

7. Congenital Hypothyroidism Screening. Coverage will be provided for congenital hypothyroidism screening for newborns, as required by the Patient Protection and Affordable Care Act.

8. Counseling Services. Coverage for counseling will be provided on such topics as: (a) tobacco use; (b) losing weight/obesity; (c) eating healthfully; (d) treating depression; (e) reducing alcohol use; (f) Breast Cancer Genetic Test Counseling (BRCA); (g) sexually transmitted diseases/infections; (h) breastfeeding/lactation; (i) domestic/interpersonal violence; (j) HIV; and any other counseling services mandated by the Patient Protection and Affordable Care Act.

9. Diabetes Management and Supplies. Coverage will be provided for Diabetes Self-Management, Equipment and Supplies. Benefits will be payable for Outpatient self-management training and education for the Treatment of diabetes in accordance with the Patient Protection and Affordable Care Act. Any education must be provided by a Participating Provider with expertise in diabetes.

Generally, benefits will be provided for **diabetic equipment and supplies,** including: (1) insulin; (2) syringes; (3) injection aids; (4) devices for self-monitoring of glucose levels (including those for the visually impaired); (5) test strips; (6) visual reading and urine test strips; (7) one (1) insulin pump for each warranty period; (8) accessories to insulin pumps; (9) one (1) prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States Food and Drug Administration; (10) glucagon Emergency kits; and (11) any other supply or equipment required by the Affordable Care Act.

10. Flu and Pneumonia Vaccinations.

11. Healthy Pregnancy Counseling. Coverage will include, but not limited to, counseling, screening, and vaccines.

12. Immunizations. Vaccines for adults-doses, recommended ages, and recommended populations vary. Coverage includes, but is not limited to, the following immunizations: (a) Hepatitis A; (b) Hepatitis B; (c) Herpes Zoster; (d) Human Papillomavirus; (e) Influenza (flu shot); (f) Measles; (g) Mumps; (h) Rubella; (i) Meningococcal; (j) Tetanus; (k) Diphtheria; (l) Pertussis; and (m) Varicella.

13. Routine Eye Exam (Adult): Coverage will be provided for routine eye screenings (excluding refractive exams) as part of an annual physical/well-check to determine the need for vision correction.

14. Type 2 Diabetes Screening. Coverage will be provided for adults with high blood pressure, as required in Patient Protection and Affordable Care Act.

15. Well-Baby and Well-Child Care Visits. Coverage will be provided for regular well-baby and well-child care visits, as required in the Patient Protection and Affordable Care Act.

16. Women's Preventive Care Coverage. Coverage provided consistent with requirements provided for under the Patient Protection and Affordable Care Act. Coverage includes, but is not limited to, the following:

- **a. Anemia.** Coverage will be provided for screening on a routine basis for pregnant women.
- **b. Bacteriuria.** Coverage will be provided for urinary tract or other infection screening for pregnant women.
- **c. Cervical Cancer Screening.** Coverage will be provided for cervical cancer screening.
- **d. Gestational Diabetes Screening.** Coverage will be provided for gestational diabetes screening for women twenty-four (24) to twenty-eight (28) weeks pregnant and those women who are at high risk of developing gestational diabetes.
- **e. Osteoporosis Screening.** Coverage will be provided for women over the age of sixty (60), depending on risk factor.

For more detailed information on Preventive Care Services, contact Our Customer Care Department.

Radiation Therapy
Coverage is provided for Radiation therapy and other therapeutic radiological procedures.

Rehabilitative Therapy
Coverage will be provided for rehabilitative care services when the Covered Person needs help to keep, get back or improve skills and functioning for daily living that have been lost or impaired because the Covered Person was sick, hurt or disabled. These services will include, but are not limited to: (1) physical and occupational therapy; (2) speech-language pathology; and (3) cardiac rehabilitation and pulmonary rehabilitation therapy.

These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by the Participating Physician.

Outpatient rehabilitative therapy is limited to sixty (60) visits per Covered Person per Calendar Year, and includes any coverage provided under Home Health Services for physical, speech, occupational therapy in this Policy. Therefore, a combined total of sixty (60) days per Calendar Year will be provided for: (1) physical, occupational, and speech therapy provided in the home in connection with Home Health Services; and (2) Outpatient Rehabilitative Therapy services. Refer to the Home Health Care Services benefit.

The following limitations apply to rehabilitative therapy:

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

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

Skilled Nursing Facility
Subject to all of the provisions provided under the Inpatient Hospital Services benefit. Medically Necessary skilled nursing services, including subacute care, will be covered when provided in a Skilled Nursing Facility and when Prior Authorized. This benefit is limited to ninety (90) days during any Calendar Year except when services are received through a Hospice program provided by a Participating Hospice Agency under the Hospice Services benefit in this Policy. Custodial care is not covered. Prior Authorization is required.

Specialist Visits
The Covered Person's Primary Care Physician is responsible for coordinating all of his or her health care needs and can best direct the Covered Person for required specialty services. The Primary Care Physician will generally refer the Covered Person to a Participating Provider Specialist or Participating Non-Physician health care practitioner, but the Covered Person can be referred by his/her Primary Care Physician outside of the University of Arizona Health Plans-University Healthcare Marketplace HMO Network if: (1) Medically Necessary; and (2) the type of Specialist or non-Physician health care practitioner needed is not available within the University of Arizona Health Plans-University Healthcare Marketplace HMO Network. Prior Authorization for a Primary Care Physician's referral to a Specialist outside of Our HMO Network is required. The Covered Person's Primary Care Physician will request any necessary Prior Authorization from The University of Arizona Health Plans-University Healthcare Marketplace. The Participating Provider Specialist or non-Physician health care practitioner will provide a complete report to the Covered Person's Primary Care Physician so that the Covered Person's medical record is complete.

The following specialties require a referral:

1. Dermatologist;
2. Pain Management Specialist/Anesthesiologist;
3. Plastic surgeon;

4. Podiatrist; and
5. Psychologist and/or Psychiatrist;

Surgical Services
Coverage is provided for Medically Necessary surgical procedures performed on an Inpatient or Outpatient basis when performed by a Participating Provider in a Participating Hospital or a Participating surgical facility. Prior authorization is required for all surgeries.

Temporomandibular Joint (TMJ) Disorder
Coverage is provided for Covered Benefits and supplies which are necessary to treat TMJ disorder which is a result of: (1) an Accident; (2) Trauma; (3) a congenital defect; (4) a developmental defect; or (5) a pathology.

Benefits include diagnosis and Treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate Treatment for TMJ, including intra-oral splints that stabilize the jaw joint. Prior Authorization is required.

Urgent Care Services
Coverage is provided for Urgent Care Services provided in a Hospital's Emergency room or an Urgent Care facility. The Covered Person should take all reasonable steps to contact his or her Primary Care Physician for direction and must receive care from a Participating Provider, unless otherwise authorized by Our Utilization Review Management Program. If the Covered Person is traveling outside of Our HMO Network's Service Area in which he or she is enrolled, the Covered Person should, whenever possible, contact the Utilization Review Management Program or his or her Primary Care Physician for direction and authorization prior to receiving services.

SECTION 6 – UTILIZATION REVIEW MANAGEMENT PROGRAM

Our Utilization Review Management Program provides for Prospective Utilization Review to assure that certain prescribed Treatments, care, services, supplies and elective procedures are Medically Necessary and appropriate.

Prospective Utilization Review requires that Your contracted In-Network Provider obtain Prior Authorization for certain non-prescription drug prescribed Treatments, services, supplies and elective procedures before they are rendered. Your Provider must contact the Utilization Review Management Program to obtain the Prior Authorizations. The Utilization Review Management Program contact information is shown on page 2.

How To Use The Utilization Review Program

To use the Utilization Review Management Program, the Covered Person need only to call the toll-free Customer Care telephone number listed on page 2. The Covered Person may have his or her representative place the call. A representative may be the Participating Physician, the Covered Facility, or his or her authorized representative (e.g., family member). The Utilization Review Management Program representative will give the individual who calls a reference number to verify that the call has been received and a file started.

The individual who calls the Utilization Review Management Program representative will need to provide the following information:

1. The name and Member ID Number of the Covered Person for whom Treatment has been prescribed and requires Prior Authorization (prior approval);
2. The Policyowner's name and this Policy's Policy Number which is shown in the Schedule of Benefits.
3. The name and telephone number of the attending Physician;
4. The name of the Participating Facility where the Covered Person will be admitted, if applicable;
5. The proposed date of admission, if applicable; and
6. The proposed Treatment, service, supply or elective procedure.

PLEASE NOTE: Authorization by the Utilization Review Management Program representative does not: (1) verify a Covered Person's eligibility for coverage under this Policy; and (2) guarantee that benefits will be paid for: (a) proposed Treatments; (b) services; (c) supplies; or (d) elective procedures. Covered Medical Expenses will be made for a Covered Person only in accordance with all the terms and conditions of this Policy.

Utilization Review Management does not include:

1. Routine claim administration; or
2. Determination that does not include determinations of Medical Necessity or appropriateness.

Prior Authorization

Prior Authorization is required for any planned Inpatient admission, including admissions to: (a) a Hospital; (b) Chemical Dependency Treatment Center; (c) Mental Illness Treatment Center; (d) Chemical Dependency; (e) psychiatric residential Treatment facility; (f) intensive Outpatient programs; or (g) other medical procedures or services, (or as may be noted for a Covered Benefit), as soon as the Participating Provider recommends or schedules to allow the Utilization Review Management Program to begin working with the Covered Person on the benefit management for the service. Prior Authorization is required by contacting the Utilization Review Management Program in writing or by telephone.

Medical Treatments Requiring Prior Authorization

Prior authorization must be obtained for:

3. Benefits that specify that Prior Authorization is required; and
4. Procedures listed in the Prior Authorization Medical Treatments List.

We will not request information from a health care professional that does not apply to the medical condition at issue for the purposes of determining whether to approve or deny a Prior Authorization request.

Prior Authorization Medical Treatment List

The following medical Treatments require Prior Authorization:

1. Brachytherapy
2. Capsule endoscopy
3. Cardiac nuclear medicine scans
4. Chiropractic services (after initial consultation)
5. Cochlear implants
6. Cognitive function testing, psychological testing, and behavioral assessment
7. Computed Tomography Angiograms (CTA) and Magnetic Resonance Angiograms (MRA)
8. Durable medical equipment (DME), including prosthetics, orthotics and corrective appliances greater than three hundred dollars ($300), or one hundred dollars ($100) for consumables.
9. Health education services
10. Home health care
11. Home infusion services
12. Hospice services (Inpatient and Outpatient)
13. Hyperbaric oxygen therapy services
14. Implantable medications and devices
15. Inpatient rehabilitation admissions
16. Intima media thickness testing (IMT)
17. Intraoperative electrophysiological monitoring
18. Joint Replacements
19. Magnetoencephalography (MEG)
20. Magnetic Resonance Imaging (MRI)
21. Medical coverage of dental services
22. Mental health/Substance Abuse services -
23. Neuropsychological testing
24. Occupational therapy, including evaluation
25. Outpatient facility or office surgeries and procedures
    a. Abortion
    b. Arthrodesis
    c. Breast Surgery
    d. Cardiac Septum defects
    e. Cardiac Septum defect closure
    f. Circumcision (non-newborn)
    g. Gastric restrictive procedures
    h. Grafts
    i. Jaw surgeries, including TMJ
    j. Oculoplastic procedures
    k. Ophthalmological Surgery
    l. Oral Surgery
    m. Salivary gland procedures
    n. Spinal surgeries
    o. Sympathectomy
    p. Umbilical hernia repair (members less than one (1) year old)
    q. Uvulopalatopharyngoplasty
    r. Vein Surgery
26. Pain management services
27. Physical therapy, including evaluation
28. Plastic Surgery and related procedures (Medically Necessary)
29. Proton beam therapy
30. Positron-emission tomography (PET) scans
31. Skilled nursing facility admissions
32. Sleep studies
33. Speech therapy, including evaluation

34. Telemedicine services
35. Three-dimension imaging
36. Transplants, including initial evaluation and donor testing
37. Transportation (non-urgent)

Utilization Review for Mental Health Treatment
When Utilization Review is conducted for Mental Health Treatment, the Utilization Review Management Program Manager will only request information that is relevant to the determination of Medical Necessity and/or Medically Appropriate care.

When a Utilization Review requires disclosure of personal information regarding the Patient or client, including:
1. Personal and family history; or
2. Current and past diagnosis of a mental disorder;

the identity of that individual will be concealed from anyone having access to that information in order that the Patient or client may remain anonymous.

Confidentiality of Medical Records
Our Utilization Review Management Program will:
1. Maintain Patient information as confidential in accordance with applicable Federal and State laws;
2. Use Patient information solely for the purposes of: (a) utilization review; (b) quality assurance; (c) discharge planning; and (d) catastrophic case management; and
3. Disclose Patient information only as allowed by the Health Insurance Portability and Accountability Act of 1996.

You may obtain a copy of Our Notice of Privacy Practices by contacting Our Customer Care Department or by going online to Our website. Summary data are not confidential if the data do not provide sufficient information to allow identification of individual patients.

Also, refer to the Grievances and Appeals provision in Section 10.

Determinations Made on Appeal or Reconsideration
A Utilization Review determination that is:
1. Made on appeal or reconsideration; and
2. Adverse to a Patient or to an affected health care Provider;

may not be made on a question relating to the necessity or appropriateness of a health care Treatment without prior written findings, evaluation, and concurrence in the Adverse Determination by a health care professional trained in the relevant area of health care. Copies of the written findings, evaluation, and concurrence will be provided to the Patient upon his or her written request to Our Utilization Review Management Program within thirty (30) days of determination.

A determination made on appeal or reconsideration that health care Treatment rendered or to be rendered are medically inappropriate may not be made unless the health care professional performing the utilization review has made a reasonable attempt to consult with the Covered Person's attending Participating Provider concerning the necessity or appropriateness of the health care Treatment.

SECTION 7 – EXCLUSIONS AND LIMITATIONS

No benefits will be paid for the following:

1. Care for health conditions that are required by State or local law to be treated in a public facility.
2. Care for military service disabilities treatable through governmental services if the Covered Person is legally entitled to such Treatment and facilities are reasonably available.
3. Treatment of an Illness or Injury which is due to war, declared or undeclared.
4. Charges for which the Covered Person is: (a) not obligated to pay; or (b) not billed or would not have been billed except that he or she was covered under this Policy.
5. Assistance in the activities of daily living, including, but not limited to: (a) eating; (b) bathing; (c) dressing; or (d) other custodial or self-care activities; (e) homemaker services; and (f) services primarily for: (1) rest; or (2) domiciliary or convalescent care.
6. Any Services and Supplies which are: (a) experimental; (b) investigational; or (c) unproven. These services may be related to: (a) medical; (b) surgical; (c) diagnostic; (d) psychiatric; (e) Substance Abuse; or (f) other health care: (1) technologies; (2) supplies; (3) Treatments; (4) procedures; (5) drug therapies; or (6) devices that are determined under this Policy to be:
   a. Not approved by the U.S. Food and Drug Administration (FDA): (1) to be lawfully marketed for the proposed use; and (2) not recognized for the Treatment of the particular indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in Medical Literature. M**edical Literature** means scientific studies published in a peer-reviewed national professional medical journal;
   b. The subject of review or approval by an Institutional Review Board for the proposed use;
   c. The subject of an ongoing Clinical Trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the Cancer Clinical Trials provision of this Policy under Covered Benefits and Supplies); or
   d. Not demonstrated, through existing peer reviewed literature to be safe and effective for treating or diagnosing the condition or Illness for which its use is proposed.
7. Cosmetic Surgery or surgical procedures primarily for the purpose of altering appearance, except for necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities. The exclusions include: (a) surgical excision or reformation of any sagging skin on any part of the body, including: (1) the eyelids; (2) face; (3) neck; (4) abdomen; (5) arms; (6) legs; or (7) buttocks; and (b) services performed in connection with: (1) the enlargement; (2) reduction; (3) implantation; or (4) change in appearance of portion of the body, including: (i) breast; (ii) face; (iii) lips; (iv) jaw; (v) chin; (vi) nose; (vii) ears; or (viii) genital; (ix) hair transplantation; (x) chemical face peels or abrasion of the skin; (xi) electrolysis depilation; or (xii) any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function such as Surgery required to repair bodily damage a person receives from an Injury.Non-life threatening complications of a non-covered cosmetic Surgery are not covered. This includes, but is not limited to subsequent Surgery for: (a) reversal; (b) revision; or (c) repair related to the procedure.
8. Dental Treatment of the teeth, gums or structures directly supporting the teeth, including: (a) Dental x-rays; (b) examinations; (c) repairs; (d) Orthodontics including braces; (e) Periodontics; (f) casts; splints; and (g) services for Dental malocclusion, for any condition. However, charges made for services or supplies for a continuous course of Dental Treatment started within six (6) months of an accidental Injury to Sound Natural Teeth are covered. Sound Natural Teeth are: (a) natural teeth that are free of active clinical decay; (b) have at least fifty percent (50%) bony support; and (c) are functional in the arch.
9. The following bariatric procedures are excluded: (a) open vertical banded gastroplasty; (b) laparoscopic vertical banded gastroplasty; (c) open sleeve gastrectomy; (d) laparoscopic sleeve gastrectomy; and (e) open adjustable gastric banding.
10. Unless otherwise included as: (a) a covered expense; (b) reports; (c) evaluations; (d) physical examinations; or (e) Hospitalization not required for health reasons including, but not limited to: (1) employment; (2) insurance or government licenses; and (3) court ordered, forensic, or custodial evaluations.
11. Court ordered Treatment or Hospitalization.
12. Reversal of: (a) voluntary sterilization procedures; and (b) voluntary termination of pregnancy.
13. Transsexual Surgery including: (a) medical or psychological counseling; and (b) hormonal therapy in preparation for, or subsequent to, any such Surgery.

14. Treatment of: (a) erectile dysfunction; and (b) sexual dysfunction.
15. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this Policy.
16. Non-medical ancillary services including, but not limited to: (a) vocational rehabilitation; (b) behavioral training; (c) sleep therapy; (d) employment counseling; (e) driving safety; and (f) services, training or educational therapy for: (1) learning disabilities; (2) developmental delays; and (3) mental retardation.
17. Therapy to improve general physical condition including, but not limited to, routine long term care.
18. Consumable medical supplies, including but not limited to:
    a. bandages and other disposable medical supplies; and
    b. skin preparations and test strips;
    except as specified in the Inpatient Hospital Services, Outpatient Facility Services, Home Health Services, Diabetic Services and Supplies, or Breast Reconstruction, Ostomy Supplies and Breast Prostheses benefit provisions in this Policy.
19. Private Hospital rooms and/or private duty nursing are only available during Inpatient stays and determined to be Medically Appropriate under this Policy. Private duty nursing is available only in an Inpatient setting when skilled nursing is not available from the facility. Custodial Nursing is not covered under this Policy.
20. Personal or comfort items such as: (a) television; (b) telephone; (c) newborn infant photographs: (d) complimentary meals; (e) birth announcements; and (f) other articles which are not for the specific Treatment of Illness or Injury.
21. The following services are excluded: (a) foot orthotics; (b) corrective orthopedic shoes, and (c) arch supports unless provided under other provisions in this Policy that provides for diabetic services and supplies.
22. The following services and supplies are excluded: (a) elastic/compression stockings; (b) garter belts; (c) corsets; (d) dentures; (c) wigs; (d) hair pieces; (e) hair transplants; and (f) Treatment of alopecia or hair loss.
23. Except as provided for Pediatric Vision Care in this Policy, no coverage will be provided for: (a) eyeglass lenses and frames and contact lenses (except for the first pair of contacts for Treatment of keratoconus or post-cataract Surgery); (b) routine refraction; and (c) eye exercises and surgical Treatment for the correction of a refractive error, including radial keratotomy.
24. Treatment by acupuncture.
25. Except as otherwise provided under this Policy, all of the following are excluded: (a) non-prescription drugs; and (b) investigational and experimental drugs.
26. Unless Medically Necessary, routine foot care, including: (a) the paring and removing of corns and calluses; or (b) trimming of nails.
27. Membership costs or fees associated with: (a) health clubs; and (b) weight loss programs.
28. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Appropriate to determine the existence of a gender-linked genetic disorder.
29. Services rendered by a Midwife for the purpose of home delivery.
30. Genetic testing and therapy including germ line and somatic unless determined Medically Appropriate by the Plan for the purpose of making Treatment decisions.
31. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in Our opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to Surgery.
32. Blood administration for the purpose of general improvement in physical condition.
33. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks, except as otherwise referenced as covered in this Policy.
34. Cosmetics, dietary supplements, nutritional formula (except for Treatment of malabsorption syndromes), and health and beauty aids.
35. Expenses incurred for or in connection with an Injury or Illness arising out of, or in the course of, any employment for wage or profit.
36. Phase 3 Cardiac Rehabilitation.
37. Massage therapy, health spas, mineral baths, or saunas.
38. Coverage for any services incurred prior to the Effective Date of the Policy for the Covered Person or after the termination date of the Policy for the Covered Person.
39. Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military service-connected Illness or Injury.
40. To the extent that payment is unlawful where the Covered Person resides when the expenses are incurred.

41. To the extent of the exclusions imposed by any certification requirement.
42. Charges for supplies, care, Treatment or Surgery which is not considered essential for the necessary care and Treatment of an Injury or Illness, as determined by Our Utilization Review Management Program.
43. Charges made by an assistant surgeon or co-surgeon in excess of Our HMO Network contracted rate.
44. Charges made by any Participating Provider who is a member of the Covered Person's family.
45. Manipulations under anesthesia. This does not include: (a) reductions of fractures; and/or (b) dislocations done under anesthesia.
46. Surgery for correction of Hyperhidrosis.
47. Biofeedback except for Mental Health and Substance Abuse only for pain management.
48. Any medical Treatment and/or prescription related to infertility once diagnosed.
49. The following Autism Spectrum Disorder services are excluded: (a) Sensory Integration; (b) LOVAAS Therapy; and (c) Music Therapy.
50. Purchase or rental of durable medical equipment and prosthetics are not covered when due to misuse, damage and replacement when lost.
51. Breast pumps and supplies for male members.
52. Costs for services while traveling outside the United States.

Circumstances Beyond Our Control

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

SECTION 8 – COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when a Covered Person has health care coverage under more than one (1) Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary Plan must pay benefits in accordance with its Policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Definitions

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or Treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

(1) Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other Federal governmental plan, as permitted by law.

(2) Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; specified disease or specified Accident coverage; limited benefit health coverage, as defined by State law; school Accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other Federal governmental plans, unless permitted by law.

Each contract for coverage under A (1) or A (2) is a separate Plan. If a Plan has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one (1) COB provision to certain benefits, such as Dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one (1) Plan.

When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

D. Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

(1) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one (1) of the Plans provides coverage for private Hospital room expenses.

(2) If a person is covered by two (2) or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(3) If a person is covered by two (2) or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(4) If a person is covered by one (1) Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
(5) The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions; precertification of admissions; and Participating Preferred Provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that has contracted with, or are employed by, the Plan, and that excludes coverage for services provided by other providers, except in cases of Emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the Calendar Year excluding any temporary visitation.

Order of the Benefit Determination Rules
When a person is covered by two (2) or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(1) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an employee, member, Policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two (2) Plans is reversed so that the Plan covering the person as an employee, member, Policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
(2) Dependent Child Covered Under More Than One (1) Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one (1) Plan the order of benefits is determined as follows:

a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

b. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one (1) of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is

primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
iii. If a court decree states that the parents have joint custody without specifying that one (1) parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Plan covering the Custodial parent;
2. The Plan covering the spouse of the Custodial parent;
3. The Plan covering the non-Custodial parent; and then
4. The Plan covering the spouse of the non-Custodial parent.

c. For a Dependent child covered under more than one (1) Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee, Retired, or Laid-off Employee. The Plan that covers a person as an Active Employee, that is, an employee who is neither laid-off nor retired, is the Primary Plan. The Plan covering that same person as a Retired or Laid-off employee is the Secondary Plan. The same would hold true if a person is a Dependent of an Active Employee and that same person is a Dependent of a Retired or Laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by Arizona State or other Federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or Arizona State or other Federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, Policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two (2) or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan; COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one (1) or more of the persons We have paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 9 – CLAIM PROVISIONS

No claims have to be submitted by the Covered Person when services are provided by a Participating Provider. However, the Covered Person will need to submit a claim to Our Claims Administrator for reimbursement considerations when the Covered Person receives services from a Non-Participating Provider for Emergency Services provided by a Non-Participating Provider.

Notice of Claim
Written notice of claim must be given to Us within twenty (20) days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by, or on behalf of, the Covered Person to Us at Our Customer Care Department at the address shown on page 2 of this Policy, or to any of Our authorized agents, with information sufficient to identify the Covered Person, will be deemed notice to Us.

Claim Forms
We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished to the claimant within fifteen (15) days after the giving of such notice, the claimant will be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss
Written proof of loss must be given to Us at Our Customer Care Department at the address shown on page 2 of this Policy within ninety (90) days of the date of loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

Timely Payment of Claims
Benefits payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss. If We do not pay the claim within thirty (30) days after We receive acceptable proof of loss which contains all information necessary for claim adjudication, We will pay interest at the legal rate from the date the claim is received by Us; the Legal rate will be rate specified by Arizona law. Interest will be calculated on the amount We are legally obligated to pay in accordance with the terms and conditions of this Policy.

Payment of Claims
We will pay benefits to You, unless the claim payment has been assigned to the Non-Participating Provider for the Emergency care services provided.

Required Claim Responsibilities by The Company
We, upon receiving notification of a claim, will, within ten (10) working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment will be made in Our claim file and dated. Notification given to any of Our authorized agents will be notification to Us.

We, upon receipt of any inquiry from the Arizona Department of Insurance respecting a claim, will, within fifteen (15) working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry.

An appropriate reply will be made within ten (10) working days on all other pertinent communications from a claimant which reasonably suggests that a response is expected.

We, upon receiving notification of claim, will promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with this Policy's conditions and Our reasonable requirements. Compliance with this Paragraph within ten (10) working days of notification of a claim will constitute compliance as required under this provision.

Standards for Prompt Investigation of Claims
We will complete investigation of a claim within thirty (30) days after notification of claim, unless such investigation cannot reasonably be completed within such time.

Standards for prompt, fair and equitable settlements are as follows:

1. Notice of acceptance or denial of claim.
   a. Within fifteen (15) working days after Our receipt of properly executed proofs of loss, the first party claimant will be advised of the acceptance or denial of the claim by Us. We will not deny a claim on the grounds of a specific Policy provision, condition, or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and Our claim file will contain a copy of the denial.
   b. If We need more time to determine whether a first party claim should be accepted or denied, We will also notify the first party claimant within fifteen (15) working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, We will, forty-five (45) days from the date of the initial notification and every forty-five (45) days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.
2. If a claim is denied for reasons other than those described in Subparagraph (a) above, and is made by any other means than writing, an appropriate notation will be made in Our claim file.
3. We will not fail to settle first party claims on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by this Policy's provisions.
4. We will not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or this Policy's time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's right. Such notice will be given to first party claimants thirty (30) days and to third party claimants sixty (60) days before the date on which such time limit may expire.
5. We will not make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

Claims and Services Review
The University of Arizona Health Plans-University Healthcare Marketplace reserves the right to review all claims and services to determine if any exclusions or other limitations apply. The University of Arizona Health Plans-University Healthcare Marketplace may use the services: (1) Physician consultants; (2) peer review committees of professional societies or Hospitals; and (3) other consultants to evaluate claims.

Claims Procedures
A Claim is any request for a Policy benefit or benefits made for a Covered Person in accordance with this Policy's claims procedure. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a Claim under these procedures.

The initial benefit claim determination notice will be included in the Covered Person's explanation of benefits (EOB) or in a letter from Us. Written notification will be provided whether or not the decision is adverse.

The Covered Person becomes a Claimant when the Covered Person makes a request for a benefit or benefits in accordance with this Policy's claims procedures.

An Authorized Representative may act on behalf of a Claimant with respect to a benefit claim or appeal under these claims procedures. Claimants should complete and submit an Appointment of Authorized Representative form in order to appoint an authorized representative. For post-service claims, no person (including a treating health care professional) will be recognized as an authorized representative until We receive an Appointment of Authorized Representative form signed by the Claimant. For other claims, We will recognize a health care professional with knowledge of the Claimant's medical condition as the Claimant's authorized representative unless the Claimant provides specific written direction otherwise.

An Appointment of Authorized Representative form may be obtained from, and completed forms must be submitted to Our Customer Care Department at the address listed on page 2. An assignment for purposes of payment does not constitute

appointment of an authorized representative under these claims procedures. Once an authorized representative is appointed, We will direct all information, notification, etc., regarding the claim to the authorized representative. The Claimant will be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise.

Any reference in these claims procedures to Claimant is intended to include the authorized representative of such Claimant appointed in compliance with the above procedures.

SECTION 10 – GRIEVANCES AND APPEALS

Grievances

We have established a Grievance process for You to address concerns for Yourself and Your Covered Dependents. Grievances are any complaints or disputes expressing dissatisfaction with the manner in which We or delegated entities provide health care services, except the appealing of an action, regardless of whether any remedial action can be taken. Grievances may include complaints such as the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure or item, the quality of care received, quality of service received, aspects of interpersonal relationships, Copay amounts, or failure to respect Your rights.

You must file a grievance within ninety (90) days of the grievance event by phone, fax or email as shown below:
Customer Care – [855-231-9236]
Email – [grievance@uahealth.com]
Fax – [866-465-8340]

Our Customer Care Department representative will make every effort to resolve the issue. If more time is needed, to resolve the matter, Our Customer Care Department representative will notify the Covered Person of the need for additional time to respond. Your case will be forwarded to the Grievance and Appeals Department for investigation and resolution. Standard Grievances are resolved within 30 days after receipt of Your or Your representative's request to file a grievance with the Grievance and Appeals Department

You may also file a written complaint at the mailing address of Our Grievance and Appeals Department:
The University of Arizona Health Plans-University Healthcare Marketplace
[Attn: Grievance and Appeals Manager
2701 E. Elvira Rd.
Tucson, AZ 85756
grievance@uahealth.com
866-465-8340 (fax)]

You or Your representative should include the following information in Your request:

1. Your name;
2. Your ID number;
3. Date of occurrence;
4. Type of occurrence;
5. Detail of events to the best of Your knowledge;
6. Contact information.

A staff member from the Grievance and Appeals Department will provide a written response to the grievance after a completed investigation. The resolution will be sent to You or Your representative no later than thirty (30) days.

Grievance and Appeals data will be maintained for quality improvement purposes. Appeal rights do not apply to grievances.

Your Right to Appeal

Adverse Benefit Determination means a determination by Us that a requested service or claim for service is not a Covered Benefit or is not Medically Necessary under this Policy plan if that determination results in a denial or nonpayment of the service or claim. You have a right to appeal an Adverse Benefit Determination, including a rescission. An appeal is a review of Adverse Benefit Determinations taken by Us. Actions include:

1. Denial or limited authorization of a requested service, including the type or level of service;
2. Reduction, suspension, or termination of a previously authorized service; and
3. Denial, in whole or part, of payment for a service.

If You disagree with an Adverse Benefit Determination made by Us, You (or Your authorized representative) may appeal the decision. The type of appeal depends upon the Adverse Benefit Determination made by Us. There are two (2) types of appeals:

1. Standard appeals, including appeals of denied claims;

2. Expedited Appeals.

Standard Appeals Process

Standard Appeals are used when You do not qualify for an Expedited Appeal, and applies to denial of non-urgent requests for services, including Prior Authorizations, or denial of claims payments for services. In the case of appeals on service or pre-service issues which would jeopardize the Covered Person's life, health, or ability to regain maximum function, an expedited appeal may be requested of Us. See Expedited Appeals below.

Informal Reconsideration

You must make a request for Informal Reconsideration within two (2) years of the date of denial of requested service or date of denial of claims payment. You may call, write or fax Your complaint to as the Grievance and Appeals Department via the contact information shown below. We will mail to You and Your treating Provider a written acknowledgment of Your request within five (5) business days. We may request additional information, including any pertinent medical records, necessary for Us to make a decision regarding Your Informal Reconsideration.

The University of Arizona Health Plans-University Healthcare Marketplace
[Attn: Grievance and Appeals Manager
2701 E. Elvira Rd.
Tucson, AZ 85756
grievance@uahealth.com
866-465-8340 (fax)]

We will make a decision within thirty (30) days and will mail You and Your treating Provider a written notice of Our decision, including the criteria used and the clinical reasons for the decision. At any time during the Informal Reconsideration process, We may, at Our option, initiate an Independent External Review process through the Arizona Department of Insurance. If We do so, We will mail You and Your treating Provider a written notice of Our decision to initiate an Independent External Review. If Our decision is to uphold Our Adverse Benefit Determination, You may proceed with a Formal Appeal.

In the event that We uphold Our decision for Adverse Benefit Determination, You have sixty (60) days to file a Formal Appeal. You may file a formal appeal by submitting a written request to Our Grievances and Appeals Department. Providing the following information will ensure timely and accurate processing of Your request:

1. All requests for appeals must be in writing.
2. Submit any supplemental documents to be considered during the appeals process.
3. State the reason(s) for the appeal. If multiple appeals are sent to Us in a single mailing, each request (whether claim or service) must be individually identified and a reason for the appeal request for that item provided.
4. Allow reasonable access to documents, records, and other information relevant to the Adverse Benefit Determination.

A Formal Appeal will be treated as received by Our Grievances and Appeals Department in a properly stamped envelope addressed to the below name and address. The postmark on any such envelope will be proof of the date of mailing. Written appeals must be sent to Our Grievance and Appeals Department:

The University of Arizona Health Plans-University Healthcare Marketplace
[Attn: Grievance and Appeals Manager
2701 E. Elvira Rd.
Tucson, AZ 85756
grievance@uahealth.com
866-465-8340 (fax)]

We will mail to You and Your treating Provider a written acknowledgement of Your request for appeal within five (5) business days. We will review all information submitted during the appeals process. We may request additional information, including any pertinent medical records, necessary for Us to make a decision regarding Your formal appeal. For appeals of denied services a decision will be made within thirty (30) days. For appeals of denied claims, a decision will be made within sixty (60) days. We will notify You in writing of Our decision and include the criteria used and the clinical reasons for Our decision, unless We request an Independent External Review. At any time during the Formal Appeals process, We may, at Our option,

initiate an Independent External Review process through the Arizona Department of Insurance. If Our decision is to uphold Our Adverse Benefit Determination, You may request an Independent External Review.

Independent External Review
You cannot file a request for Independent External Review until You have completed Informal Reconsideration, Formal Appeal, or Expedited Medical Review (see below).

In the event that We uphold Our decision for Adverse Benefit Determination, You have four months to file a request for an Independent External Review. You may request an Independent External Review by submitting a written request to Our Grievances and Appeals Department. Within five (5) business days, We will forward Your request, a copy of this Policy, and all supporting documentation used to make Our decision to the Arizona Department of Insurance.

For appeals involving cases of Medical Necessity, the Arizona Department of Insurance will select an Independent Review Organization (IRO) at no charge to You. You will be notified by the Arizona Department of Insurance of the decision within thirty-one (31) business days.

For appeals of cases of denials of coverage, including claims denials, the Arizona Department of Insurance will render a decision within fifteen (15) business days. If the Arizona Department of Insurance is unable to make a determination, they will select and Independent Review Organization (IRO) to make the determination. You will be notified in writing of the decision by the Arizona Department of Insurance within forty-one (41) business days.

Expedited Appeals Process
Expedited Medical Review
In cases where Your treating Provider believes that We have denied coverage of urgently needed services that have not yet been provided, he or she may file a request for an Expedited Medical Review. Urgently needed services are those services that delaying could cause a significant negative change in Your medical condition. In order to request an Expedited Medical Review, Your treating Provider must request the review, must certify in writing to Us that delaying the requested service(s) would result in significant negative medical changes to You, and provide any supporting documentation leading him/her to that conclusion. Information should include:

1. The identity of the Claimant; A specific medical condition or symptom; A specific Treatment, service, or product for which approval is requested; and
2. Any reasons why the appeal should be processed on a more expedited basis.

These requests can be submitted to Our Grievance and Appeals Department as shown below. All necessary information including documents, record, notes or other information to be considered as part of this record should be submitted with the request for an expedited medical review. Upon receipt of the written request by Your treating Provider, We will respond with a decision within one (1) business day. We will notify You and Your treating Provider by telephone and will also mail You and Your treating Provider a copy of the decision.

The University of Arizona Health Plans-University Healthcare Marketplace
[Attn: Grievance and Appeals Manager
2701 E. Elvira Rd.
Tucson, AZ 85756
grievance@uahealth.com
866-465-8340 (fax)]

Expedited Appeal
If You wish to appeal Our decision of Expedited Medical Review, upon receiving the notice of denial of the Expedited Medical Review, whether by telephone or by mail, Your treating Provider must immediately request an Expedited Appeal. Your treating Provider must submit a written notice of appeal of the denial of service along with any additional supporting documentation or justification supporting his or her request for service. We will make a decision regarding the Expedited Appeal request within three (3) business days and will notify You and Your treating Provider of Our decision by telephone and by mail. At any time during the expedited appeals process, We may, at Our option, initiate an Independent External Review process through the Arizona Department of Insurance.

Expedited Independent External Review
You cannot file a request for an Expedited Independent External Review until You have completed an Expedited Medical Review and Expedited Formal Appeal.

In the event that We uphold Our decision for denial of service of an urgently needed service, You have five (5) business days to file a request for an Expedited Independent External Review. You may request an Expedited Independent External Review by submitting a written request and any supporting documentation or justification to Our Grievances and Appeals Department. Within one (1) business day, We will forward Your request, a copy of this Policy, and all supporting documentation used to make Our decision to the Arizona Department of Insurance. We will also mail You and Your treating Provider an acknowledgement of Your request for Expedited Independent External Review. The Arizona Department of Insurance will select an Independent Review Organization (IRO) at no charge to You.

For Expedited Independent External Reviews involving cases of Medical Necessity, the Covered Person and his or her treating Provider will be notified by the Arizona Department of Insurance of the decision within ten (10) business days. For cases based on the denial of coverage, the Arizona Department of Insurance will render a decision within seven (7) business days.

NOTE: We cannot be required to pay for services or for a claim for services that are excluded from coverage by this Policy.

Access to Documents. The Claimant will, on request, be given reasonable access to all documents, records or other information contained in the case file of the Claimant's request for review during the appeals process

Submission of Comments. A Claimant has the right to submit documents, written comments, or other information in support of an appeal.

Evidence Consideration. The review of the appeal will take into account all evidence, testimony, new and additional records, documents or other information the Claimant submitted relating to the appeal, without regard to whether such information was submitted or considered in making the initial Adverse Benefit Determination. The appellant is afforded the opportunity to submit additional documentation, records, information or any other items they deem relevant in making an informed decision to Us before a decision is made on the appeal by this Policy plan.

Medical Professionals. In the event that a service or claim is denied on the grounds of medical judgment, Our Appeals and Grievances Department will consult with a health professional with appropriate training and experience.

SECTION 11 – GENERAL PROVISIONS

Entire Contract; Changes
This Policy, including the application, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by an executive officer of The Company and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this Policy or to waive any of its provisions.

We will provide You with at least sixty (60) days advance notice of any material change to this Policy before it becomes effective.

Misstatement of Age
If the age of the Covered Person has been misstated, all amounts payable under this Policy will be such as the Premium paid if the Covered Person would have purchased at the correct age.

Representations
All statements and descriptions in any application for this Policy or in negotiations for it, by or on Your behalf, will be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements will not prevent a recovery under this Policy unless:

1. Fraudulent.
2. Material either to the acceptance of the risk, or to the hazard assumed by Us.
3. We, in good faith, would either not have issued this Policy, or would not have issued this Policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to Us as required either by the application for this Policy or otherwise.

Time Limit on Certain Defenses
After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability (as defined in this Policy) commencing after the expiration of such two-year (2-year) period.

Legal Actions
No action of law or equity will be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of 2 years after the written proof of loss is required to be furnished.

Conformity with Arizona Statutes
The provisions of this Policy conform to the requirements of Arizona law and control over any conflicting statutes of any State in which You reside on or after the Effective Date of this Policy.

Obtaining Language Assistance
Our Customer Care Department is staffed by English and Spanish speakers who are here to help You get the medical care You need. You can call Our Customer Care Department at the number given on page 2. If You speak another language other than English or Spanish, call Our Customer Care Department and We will help get an interpreter to assist with the phone call.

Reimbursement for Covered Services
If You have paid for a service that is a covered benefit and You were eligible to receive the service, please contact Our Customer Care Department at the number given on page 2. We will contact the Provider of service to request they submit a claim so We can pay the Provider for the services rendered. We will also request that the Provider reimburse You for the service.

Assessment of New Technologies and Inclusion in Benefits
The University of Arizona Health Plans – University Healthcare Marketplace regularly evaluates the effectiveness of new technologies and new uses of current technologies. Our medical staff, along with contracted providers with appropriate medical expertise, reviews such technologies as part of the Technology Assessment Committee. This committee reviews published

Medical Literature and evidence based assessments of these technologies and determines the potential value to Our covered members. Technologies used for the diagnosis or Treatment of diseases are reviewed when they are approved for use by regulatory agencies or when providers request authorization for use of a new technology for any of Our covered members.

Care After Hours

If Your life is in immediate danger, call 911. If Your doctor is unable to see You, or the office is not open, Urgent Care is an excellent option. If You need help finding Urgent Care in Our network, contact Our Customer Care Department. Urgent Care is a great place to get medical help because they usually have extended hours, Specialists for common problems, and can see You quickly.

INDIVIDUAL COMPREHENSIVE HMO INSURANCE POLICY
GUARANTEED RENEWABLE