



Healthcare Group of Arizona & Mercy Healthcare Group MEMBER HANDBOOK EVIDENCE of COVERAGE

Effective September 1, 2009

Healthstyles™ Benefit Plans

**Healthcare Group of Arizona
10851 North Black Canyon Highway, Suite 830
Phoenix, Arizona 85029**

**602.417.6755 Maricopa County
800.247.2289 (Outside Maricopa County)
www.hcgaz.com**

The Member Handbook contains the explanation of the member's coverage. Members should familiarize themselves with the Handbook and refer to it to determine their coverage and how to access their benefits. In the event that there is any difference between the information contained in the Member Handbook and the Group Service Agreement (GSA), the information contained in the GSA is controlling over any information in the Member Handbook. In the event there is any difference between the GSA in English and the GSA in Spanish, the GSA in English supersedes the GSA Spanish translation.

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Welcome to Healthcare Group of Arizona

Introduction

Welcome to Healthcare Group of Arizona! We value you as a partner in our ever-important mission.

For twenty years, Healthcare Group of Arizona (HCG) has provided healthcare coverage to uninsured sole proprietors, small business employers (2 to 50 employees) and political subdivisions of the State of Arizona. The Healthcare Group mission is: “To reduce the number of uninsured Arizonans by providing innovative healthcare coverage options to uninsured small businesses, ensuring them access to quality healthcare so that they can maintain healthy lifestyles.”

Healthcare Group contracts with HCG Health Plans. HMO benefits are available, depending on location, through Mercy Healthcare Group. Together with this HCG Plan, Healthcare Group strives to accomplish its mission.

Health Plans and benefit options may change with sixty (60) days notice. Healthcare Group is a state-sponsored program and the State Legislature may enact legislation which requires changes to the benefits, benefit options, terms and conditions of HCG coverage without notice. Healthcare Group is a state-sponsored program to provide health care to uninsured Arizona businesses. All treatment provided under Healthcare Group is limited to the state of Arizona except emergencies within the United States. Healthcare Group coverage is not intended to be used outside the state of Arizona except for emergencies.

What is this document?

This is your Member Handbook, which contains the explanation of your coverage. The Members should familiarize themselves with the Handbook and refer to it to determine coverage and how to access benefits. In the event that there is any difference between the information contained in the Member Handbook and the GSA, the information contained in the GSA is controlling over any information in the Member Handbook. In the event there is any difference between the GSA in English and the GSA in Spanish, the GSA in English supersedes the GSA in Spanish.

Understanding Your Health Plan Benefit Options and Health Plan

Each Member covered under this Plan is entitled to receive the benefits and covered services described in this document. One of the first things the Member should do is to review the list of Healthcare Group Plan Contracted Providers for the Healthcare Group Plan in which the Member is enrolled. These are the doctors and facilities that have contracted with HCG Plans to provide covered services to the Member.

Health plan benefits and benefit options may change with sixty (60) days notice unless the change is caused by a legislative action by the Arizona Legislature which does not allow a sixty (60) day notice. For more information about your Plan and covered benefits, you should refer to Section XI. “Covered Services” as well as the Benefit Plan Summary for your Plan.

Member Identification Card

HCGA will provide all members a Member Identification card (Member ID card) that contains information about the chosen benefit plan option and HCG Health Plan. If a complete enrollment application is received by the fifteenth (15th) of the preceding month, Members will receive their Member ID card within two (2) weeks after the effective date of coverage. If the enrollment application is received after the fifteenth (15th) of the month, Members will receive their Member ID cards within three (3) weeks after the effective date of coverage. If a Member ID card is not received within these timeframes, please call HCG at 602.417.6755 or 800.247.2289 (outside Maricopa County). If the personal information on the Member ID card is incorrect or changes, please contact HCG Customer Service at 602.417.6755 or 800.247.2289 (outside Maricopa County). If the Member loses the Member ID card, call HCGA at 602.417.6755 and request a replacement Member ID card. One replacement Member ID card will be provided without charge.

If the Member needs services prior to receiving the replacement card, the Member should have the Provider call HCGA to verify coverage and eligibility. The Member ID card alone is not proof of enrollment or coverage. The Provider may call HCG to verify the Member’s current enrollment status. If the Member needs

to see a Provider before receiving a Member ID card, the Member should ask the Provider to call HCGA or the HCG Plan Member Service Department to verify current enrollment and coverage.

Benefit Plan Summary

The Benefit Plan Summary is a grid containing information about the benefit option plan that was selected. The Benefit Plan Summary provides the Deductible Options, Out-of-Network Benefits, Lifetime Maximum, Co-payments and Coinsurance for Primary and Preventive Care, Hospitalization, Outpatient Care, Reproductive Care, Support and Ancillary Care, and Prescription Drugs. Refer to the Benefit Plan Summary to determine what benefits are available under the chosen benefit plan option and what the out-of-pocket costs will be.

Benefits may be subject to change which might not be reflected in the Benefit Plan Summary. For the most current benefits, contact Healthcare Group at 602.417.6755 or 800.247.2289 (outside Maricopa County) or visit www.hcgaz.com.

Provider Directory

Each HCG Plan offers a large network of contracted providers and is required to maintain a current provider listing on its Web site. The most current online version of the Provider Directory for your HCG Health Plan may be accessed through the HCG Web site at www.hcgaz.com or your HCG Health Plan's Web site. HCG will not send a Provider Directory, but a directory may be requested from the HCG Plan by calling the member services number on the back of the Member ID card.

SECTION I: ELIGIBILITY

Eligibility

Healthcare Group of Arizona Administration (HCGA) determines the eligibility of the Employer Group and the prospective employee Subscribers in accordance with the requirements in the GSA.

Audit of Eligibility

HCG may, from time to time throughout the duration of Enrollment, with or without cause, require the Employer Group or any employee Subscriber or that employee Subscriber's enrolled dependents to produce documentation that verifies the eligibility of that group or person. Failure to produce the requested documentation by the date due may result in termination of coverage.

Employee Eligibility

To be eligible for HCG coverage, an employee of an eligible Employer Group or Sole Proprietor must meet **all** of the following requirements upon enrollment. The employee must:

- be employed by an eligible enrolled Employer actively conducting business within the State of Arizona and earning and being paid at least the minimum wage for the State of Arizona twice a month, no more than 16 days apart.
- reside in the State of Arizona for twelve (12) months of every calendar year. Exceptions may be made for an employee who meets all other eligibility requirements, works for an eligible enrolled Arizona business, lives in a state that borders Arizona and who has access to an HCG network. HCGA reserves the right to require proof of residence and duration of residence at any time.
- reside full-time and actively conduct business at least 20 hours per week within the State of Arizona if a sole proprietor in order to be enrolled in HCG. A sole proprietor without employees who was not enrolled as a group of one on September 27, 2008 is not eligible to enroll as a Group of One
- work at least twenty (20) hours per week for an eligible enrolled Employer. HCGA reserves the right to require documentation of hours worked at any time.
- meet any eligible enrolled Employer's waiting period for health insurance benefits eligibility. (Waiting periods may only be changed for the entire Employer Group at the time of group re-enrollment and must apply equally to all eligible employees).
- not have had prior healthcare coverage terminated by HCG or any other insurance carrier for misrepresentation, fraud, or threatening or violent behavior.
- submit all requested and required eligibility documentation including, but not limited to, "Employee

Enrollment/Change Form”, “Member Health History Form” and “Certificate of Creditable Coverage” (if applicable).

On an **annual basis** and at other times at the discretion of HCG, the Employer shall be required to certify employee eligibility on forms provided by HCGA in addition to any other documentation requested by HCG. The Employer may also be required at any time to provide proof that an employee is working at least twenty (20) hours per week on a continuous basis when requested by HCGA.

If Employee or Sole Proprietor Fails to Work at Least Twenty (20) Hours per Week for Ninety Days HCG Coverage will be Terminated

To be eligible to enroll in HCG coverage, the employee must work at least twenty (20) hours per week. It is the Employer’s responsibility to notify HCG in writing if the individual is not employed for twenty (20) hours per week for any period longer than ninety (90) days. HCGA reserves the right to request proof of the employment of any employee with or without cause at any time during enrollment.

Family Medical Leave Act (FMLA) applies to groups of fifty (50) or more employees. In the event the Employee is not subject to FMLA, an Employee of that Employer Group who is not employed at least twenty (20) hours per week for any period longer than ninety (90) days will have coverage terminated. The Employee will then be eligible to re-enroll at the next Employer’s Open Enrollment if the Employee meets the eligibility requirements at that time.

Employee Dependent Eligibility

A person becomes a Dependent of an eligible enrolled Subscriber through marriage to the Subscriber, birth to the Subscriber, placement for adoption or adoption by the Subscriber and legal guardianship. It is the Subscriber's responsibility to provide required supporting documentation for the addition of Dependents prior to the Dependent’s enrollment. In the case of misrepresentation and/or fraud in the enrollment of a Dependent coverage may be terminated and any services paid for an ineligible Dependent will be recovered from the Subscriber.

“Child” means a Subscriber’s unmarried, unemancipated natural or adopted child under the age of nineteen (19) including a:

- natural child,
- stepchild living in the Subscriber’s household at least fifty (50%) percent of the time pursuant to a court order for the Subscriber's spouse,
- minor child legally placed for adoption with the Subscriber,
- minor child legally adopted by the Subscriber,
- minor child for whom a Subscriber has a legal obligation of support pursuant to a “Qualified Medical Child Support Order (QMCSO)” or
- child for whom the Subscriber has a legal obligation as a permanent legal guardian or with permanent custody by Court Order.

Spouse Eligibility

To be eligible for HCG coverage as a spouse of an eligible enrolled Subscriber, the person must be the legal husband or wife of a Subscriber who has entered into a marriage recognized as valid by the State of Arizona. The Subscriber may be required to provide a Certificate of Marriage at the time of enrollment of the spouse Dependent. The spouse must have the same legal residence within the State of Arizona as the Subscriber.

Natural Minor Child Dependent in Household of Subscriber

To be eligible for HCG coverage as the natural minor child of the Subscriber living in the household of the Subscriber, the minor child must be unmarried, unemancipated and living full time in the household of the Subscriber unless the child is a full-time student in an accredited secondary educational institution. The newborn Dependent child of the Subscriber must be enrolled within thirty-one (31) days of the birth date to ensure coverage from the date of birth. After notification to HCGA, a certified copy of the birth certificate showing the Subscriber to be a parent must be provided within sixty (60) days from birth. If the newborn is not enrolled within thirty-one (31) days following birth and/or a copy of the birth certificate is not received

within sixty (60) days, the newborn coverage will be terminated retroactive to the original effective date and no services will be paid for the child.

Stepchild Eligibility

To be eligible for HCG coverage as a stepchild of the Subscriber, the minor child must be the natural child of the Subscriber's spouse dependent. The Subscriber's spouse must have a court order for sole or shared placement of the minor child and the minor child must reside in the Subscriber's legal residence at least fifty (50%) percent of the time. A copy of the court order must be provided to HCG at the time of enrollment and HCG must be notified and provided a copy of any changes in that order which affect placement of the stepchild.

Employee Minor Dependent by Adoption

When a minor child is legally placed with the Subscriber, the Subscriber must submit to HCGA Form ICPC-100A which legally places the child with the Subscriber. The minor child placed for adoption with the Subscriber should be enrolled with the legal name at the time of enrollment. When the Subscriber receives the final adoption decree, the enrolled name should be changed to the legal name of the child in the final adoption decree.

Student Dependent Eligibility

In order to be eligible for coverage as a student Dependent of an eligible enrolled Subscriber, a Dependent child from the age of nineteen (19) through the age of twenty-three (23) must:

- be registered and attending classes full-time at an Accredited Secondary Educational Institution located within the United States,
- be dependent upon the Subscriber for more than fifty percent (50%) of the Dependent's economic support as defined by the Internal Revenue Code, **and**
- provide an Accredited Secondary Educational Institution's verification of full-time student status for every semester for which the student Dependent has HCG coverage.

HCG reserves the right to require the submission of a transcript for every semester for which the student Dependent is enrolled.

A Dependent through the age of nineteen (19) who continues to reside in the parent's residence and continues to be enrolled in high school is **eligible** for student Dependent coverage.

Dependent student verification notices are sent to all Dependents from the age of nineteen (19) years through the age of twenty-three (23) and must be completed by the Accredited Secondary Educational Institution to certify that the student Dependent is attending the institution on a full-time basis and the number of semester hours the student Dependent is attending classes. The certification must be returned to HCG by the required date or the student Dependent's coverage will be terminated effective at 11:59 p.m. on the last day of the month for which premium was paid and for which the certification was due.

If an Accredited Secondary Education Institution does not offer semester hours or semester-length courses, the Subscriber or Subscriber's student Dependent must request and submit to HCG in a timely manner an affidavit from the Registrar of the Institution certifying that the student Dependent is a full-time student at that Institution.

Proof of the student Dependent's full time attendance at an Accredited Secondary Educational Institution is required to be provided for **every semester** for which the student Dependent is enrolled as a student Dependent. The Subscriber is required to notify HCGA with the date for which the student Dependent is no longer a full-time student. Failure to provide the required notification will result in retroactive termination to the date when full-time student eligibility status ended and the Subscriber will owe HCG for any services provided during any period for which the Dependent was ineligible as a student Dependent. The Student Dependent is ineligible to enroll in HCG for any semester for which the Student Dependent is not enrolled as a full-time student for any reason.

The Subscriber is required to notify HCGA in writing when the Dependent is enrolled as a student Dependent from the age of nineteen (19) through twenty-three (23). If the Subscriber does not provide the required

notice, the student Dependent coverage may be retroactively terminated to the last eligible semester and the Subscriber will owe HCGA for any services paid for at any ineligible period of coverage for the student Dependent.

Full-time student Dependents who attend school outside of the HCG Health Plan's Service Area are limited to Emergency Services when outside the Service Area. Emergency services are only covered within the United States. All other services must be received within the HCG service area. Any other out-of-network services must be prior authorized. Full-time student Dependents are encouraged to use mail order pharmacy if there is access to a secure mailbox.

Disabled Dependent Eligibility

A Subscriber's Dependent who is nineteen (19), unmarried, under the legal guardianship of the Subscriber and was permanently and continuously disabled and incapable of self-support by reason of mental or physical handicap prior to attaining the age of nineteen (19) may be covered as a Subscriber's Dependent. Proof of dependency must be provided to HCG within thirty-one (31) days of the Dependent reaching the age of nineteen (19) or within thirty-one (31) days of the Dependent becoming eligible by reason of disability.

Proof of disability must be verified by the Dependent's treating physician and such other documentation that HCG may require. HCG reserves the right to require an independent examination for the verification of a Dependent's disability by a physician chosen by HCG. The cost of the independent verification of the Dependent's disability will be paid by HCG.

HCG Coverage for the Subscriber's disabled Dependent will continue as long as the enrolled Dependent is disabled unless HCG coverage terminates in accordance with other terms of the GSA. HCGA may request proof of continuing disability every two (2) years or at such other times as reasonably required by HCGA.

Eligibility Under the Health Coverage Tax Credit Program (HCTC)

Individuals and their Dependents who are eligible under Trade Adjustment Assistance (TAA), Trade Impacted Workers or Pension Benefit Guaranty Corporation (PBGC) in the State of Arizona are eligible to enroll in HCG. The IRS determines eligibility under the HCTC program. HCG is registered with the Internal Revenue Service (IRS) as a qualified health plan under all of these programs.

Once the Subscriber is no longer eligible or enrolled in the HCTC program, the dependents of the Subscriber are no longer eligible to be enrolled in the HCTC program. The dependents are not eligible for HCG non-COBRA continuation coverage as a result of the loss of HCTC coverage.

When an HCTC eligible Subscriber is no longer eligible to participate in the HCTC program or voluntarily terminates HCG coverage, all enrolled Dependents of the Subscriber are also terminated from HCG coverage. Neither the Subscriber nor the Dependents of the HCTC eligible Subscribers are eligible for HCG non-COBRA continuation coverage as a result of the loss of HCTC coverage.

For more information about eligibility under the HCTC program, call the HCTC Customer Contact Center at 866.628.4282 or visit the IRS Web site at www.irs.gov/individuals/ and enter search term HCTC.

Eligibility Under a Medical Child Support Order

"Medical Child Support Order" means any judgment, decree or order which provides for health benefit coverage to a child of a participant of a plan which is made pursuant to a State domestic relations law and a law relating to medical child support described in section 1908 of the Social Security Act [42 U.S.C. 1396g-1](as added by section 13822 of the Omnibus Budget Reconciliation Act of 1933) with respect to a group health plan. The judgment, decree or order must be issued by a court of competent jurisdiction or issued through an administrative process established under State law that has the force and effect of law under applicable State law.

The "alternative participant" referred to in a medical child support order means any child of a participant in the Plan who is recognized under a medical child support order as having a right to enrollment under a group

health plan with respect to the participant. The term “child” includes any child adopted by, or placed for adoption with a participant of a group health plan.

When an appropriately completed Medical Child Support Order or National Medical Support Notice pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 is submitted, HCGA must, within forty (40) days after the date of the Notice, notify the State agency issuing the Notice whether coverage is available under the terms of the Plan of the participant and, if so, whether the child is covered under that Plan with the effective date of coverage or any steps taken to effectuate the coverage. HCGA must also provide a description of coverage to the custodial parent of the alternative participant and any forms or documents necessary to put the coverage into effect.

Eligibility Verification

On an annual basis and at other times at the discretion of HCGA, the Employer shall validate and certify employee eligibility on forms provided by HCGA, along with any other requested documentation for eligibility verification.

SECTION II: ENROLLMENT

Enrollment

“Enrollment” means the process in which an eligible Employee and Dependents, if any, are qualified to receive HCG services by selecting an HCG Benefit Plan and completing and submitting all necessary documentation specified by HCG under Arizona Administrative Code R9-27-302 and HCG receiving the full required premium no later than the date specified by HCGA.

An eligible Employee and Dependent may receive HCG coverage if all of the following occur:

- The eligible Employee selects an HCG Benefit Plan.
- The eligible Employee completes and submits all necessary documentation specified by HCGA including the Employee enrollment information and Health History Form.
- HCGA receives and accepts the full required premium.

Initial Enrollment

The Employer, Employee(s) and Employee’s Dependents are not considered to be enrolled in HCG until all eligibility applications and any other documentation required or requested by HCG have been received and approved by HCGA.

Upon enrollment, every eligible Subscriber is entitled to select his or her own benefit plan. All Subscriber’s Dependents must be enrolled in the same benefit plan option as the Subscriber. In order to receive services as described in this Group Service Agreement (GSA), the Employer must be current on premium payments for all enrolled Members.

Once a Subscriber has chosen and enrolled in a benefit plan option, the Subscriber must remain in that benefit plan until the Employer’s annual Open Enrollment or until a qualifying event occurs which allows an earlier termination of benefits. Members may change their benefit plans, deductible levels and Health Plan only during the Employer’s Open Enrollment.

A Member may terminate prior to the end of the twelve month enrollment ONLY for the following qualifying events:

- employment termination,
- death of the Subscriber,
- divorce from the Subscriber,
- enrollment in Spouse’s group coverage, **or**
- enrollment in a government health plan (Medicare, Medicaid).

If a newly eligible Employee chooses not to enroll or chooses not to enroll his or her Dependents during the initial enrollment period or within thirty-one (31) days of the date of Enrollment, then the Employee will be

considered a Late Enrollee. A pre-existing condition waiting period may apply to coverage for any condition determined to be a pre-existing condition. See section “Late Enrollee” for more information.

Husband and Wife Must Enroll as Family Coverage

Married couples who enroll in HCG will be enrolled with one spouse as the owner/employee and the other spouse as a Dependent unless proof of ownership or employment of both spouses is provided. A husband and wife who request to enroll in HCG as individual owners must provide proof that each spouse is a legal owner of the business. Proof of the business’ legal status for enrollment in HCG is based upon the federal and Arizona tax returns in addition to any other requested documentation.

Married business owners filing a joint federal individual return with both individuals listed as owners on the Schedule C and all other business documentation will be allowed to enroll individually as owners/employees. Spouses providing a federal tax form 1065 with both spouses filing a K-1 form showing a partnership interest in the income will be allowed to enroll each spouse as an owner/employee. Spouses who participate in a corporation or limited liability corporation as officers will each be allowed to enroll as owners/employees if the federal tax returns show that participation and the Arizona Corporation Commission filings confirm each spouse’s participation in the corporation.

Eligible Employees Married to Each Other

An eligible Employee who is married to another eligible employee may enroll as an owner/employee or as a dependent of an owner/employee but may not enroll for any coverage as both.

Annual Open Enrollment

Eligible Employees and their Dependents may be enrolled during the Employer’s annual open enrollment period.

All Employees and their Dependents who were not previously eligible, or who were previously declined coverage by HCG and become eligible to enroll may enroll upon eligibility or during the annual open enrollment period. All required forms or online enrollment and required premiums for the Employer Group for all employees and employees’ Dependent enrollments must be completed and received by HCG within the required timeframes. Any health plan or benefit plan changes will not be processed unless timely received by HCGA.

Enrollment Changes at Renewal

During the annual open enrollment period, eligible Employees are provided an opportunity to change health plans, benefit plans or deductible levels. If an eligible Employee increases his or her deductible level during the open enrollment period and continues on the same health plan, the Employee and covered Dependents must meet the new deductible level before HCG begins paying for covered services subject to the deductible. If an eligible Employee chooses to reduce the deductible level or change health plans during open enrollment, any accumulated payments applied towards the calendar year deductible level will not transfer to the new benefit option or health plan. If for any reason, an eligible Employee is permitted to change benefit plans or health plans mid-contract year, the deductible resets to zero and must be met before HCG begins paying for covered services.

Re-enrollment

Re-enrollment is when a previously enrolled Employer Group or Member returns to HCG coverage and enrolls after a gap in coverage of any length. Re-enrollment is required for all Employer Groups and Members whose HCG coverage has been terminated. An Employer Group will not be allowed to re-enroll for ninety (90) days when there is a gap in coverage for any reason. When an Employer Group or Member re-enrolls with HCG, all documentation required for the initial enrollment is also required. Re-enrollment cannot be completed until all documentation is received and required premium timely paid. All benefit limitations, deductibles and pre-existing condition exclusion periods re-set upon re-enrollment.

Reinstatement

Reinstatement refers to a reactivation of a terminated Employer Group or Member without any gap in coverage. No additional documentation is required when an Employer Group or Member is reinstated without a gap in coverage unless requested by HCGA.

Qualifying Events for Special Enrollment Periods

Employee Subscribers and their Dependents may be enrolled in existing HCG Employer Group coverage within the first thirty-one (31) days following employment after meeting the Employer's waiting period or within thirty-one (31) days following a qualifying event. An eligible Employee or eligible Dependent who experiences a qualifying event and requests enrollment within the required timeframe will have coverage effective as of the date of the qualifying event.

The following are qualifying events:

- Employees who enroll within 31 days following completion of any waiting period imposed by the Employer;
- Employees or Dependents who at the time of initial enrollment were covered under a public or private health insurance policy and who later lost their coverage due to termination of employment, loss of eligibility, reduction in number of hours of employment, termination of coverage of another health plan, the death of a spouse, divorce or legal separation from a spouse or termination of Employer contributions toward coverage;
- Employees or Dependents who request enrollment into HCG within thirty-one (31) days after the termination of creditable coverage;
- Employees who are ordered by a court or administrative order to provide health coverage for a spouse or minor child and request that coverage from HCG within thirty-one (31) days after that Order;
- An individual who becomes the Dependent of a covered Employee through marriage, birth, guardianship, adoption or placement for adoption and requests enrollment no later than thirty-one (31) days after becoming a Dependent.

If a newborn Dependent is enrolled within thirty-one (31) days of the birth and pays any premium owed and submits a copy of the birth certificate within sixty (60) days of birth, the newborn Dependent coverage will be effective the first day of the month in which the birth occurred. **If the enrollment of the newborn and payment of any required premium is not completed within thirty-one (31) days after the birth of the child and the copy of the certified birth certificate is not received within sixty (60) days after the birth of the child, HCG coverage will not pay the costs of the services rendered to the newborn from the date of birth prior to the effective date of coverage.**

Late Enrollee

A late enrollee is defined as:

- An Employee or Dependent who was eligible to enroll in HCG during the first thirty-one (31) days after the date of initial Employer Group enrollment or was eligible to enroll during Employer Group's Annual Open Enrollment period, or was eligible to enroll within thirty-one (31) days of a qualifying event and did not do so.

An Employee or Dependent who requests enrollment after the first thirty-one (31) days of the initial enrollment or after thirty-one (31) days of a qualifying event will be considered a late enrollee. Late enrollees are subject to a pre-existing condition waiting period of eighteen (18) months.

An Employee, Employee's spouse or Employee's Dependent will not be considered a late enrollee if the person:

- At the time of the initial enrollment period was covered under a public health benefit program or private health insurance policy or any other health benefit plan package, and applies for coverage within thirty-one (31) days of termination of that coverage.
- Lost coverage under a public health benefit program or any other health benefit plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce or the termination of the Employer contributions toward the coverage, and applies for HCG coverage within thirty-one (31) days of loss of coverage.

- Requests enrollment within thirty-one (31) days after the termination of creditable coverage that is provided under a COBRA continuation provision.

Late enrollees are subject to a pre-existing condition waiting period of eighteen (18) months. A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis or treatment was recommended or received in person by a licensed healthcare Provider during the six (6) month period immediately preceding the Member's effective date of coverage under HCG coverage.

Pre-existing Conditions and Pre-existing Condition Waiting Period, Health History Form and Creditable Coverage

A Member Health History Form is required to be completed as a part of the documentation for initial enrollment. The Member Health History Form is not used to determine insurability. The information provided is used to identify pre-existing conditions.

The Member Health History form must contain all medical advice, consultations or recommendations in any form, medical procedures or treatments received in person or drugs prescribed from a healthcare Provider by each Member and Dependent within the six months prior to HCG enrollment. A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, consultations or recommendations in any form, diagnosis or treatment was recommended or received by a licensed healthcare Provider during the six (6) month period immediately preceding the Member's effective date of coverage. A refill of maintenance prescriptions without a face to face encounter with a licensed healthcare Provider during the six (6) month period prior to HCG coverage is not considered a pre-existing condition.

Pre-existing conditions are identified by the Member Health History Form but HCGA and the HCG Health Plan may also request medical records for a Member or Dependent if a claim is submitted for a chronic disease which was not disclosed on the Health History Form. If there is no Creditable Coverage for the year prior to enrollment, HCG or the HCG Health Plan will request medical records for a Member or Dependent if a claim is submitted for a chronic disease, whether or not the chronic disease was identified on the Member Health History Form. If the medical records for the Member or Dependent disclose a chronic condition which was not listed on the Member Health History Form, then the Member or Dependent will receive a letter from HCGA of the HCG Health Plan which informs the person what pre-existing condition has been identified on the basis of medical records and that condition will not be covered for the period of the pre-existing waiting period. If the pre-existing condition was not disclosed on the Member Health History Form and a pre-existing condition is later determined to exist based upon a review of the Member's medical records, the Member may owe HCG reimbursement for any claims paid for that pre-existing condition.

The Medical Health History Form contains Section G, "Disclosure Statement and Signature", which requires the applicant to certify that the information provided is true. This section further provides that the application must be **updated** to include any illness or disease that has occurred between the date on the Member Health History Form and the effective date of coverage. The applicant is also put on notice that any misrepresentation or omission, whether intentional or unintentional, regarding the presence of a pre-existing condition may result in the cancellation of coverage and the Member or Dependent will be responsible for the costs incurred for any non-covered services.

Creditable Coverage

Creditable coverage for an individual may be obtained from any of the following benefit plans:

- A Group Employee Welfare Benefit Plan that provides medical care to Employees or the Employees' Dependents directly or through insurance, reimbursement or otherwise, according to the Employee Retirement Income Security Act of 1974 (ERISA).
- A Church Plan as defined by ERISA.
- A health benefits plan issued by an accountable health plans as defined in Arizona Revised Statutes §20-2301.
- Medicare, Chapter 7, subchapter XVIII of the Social Security Act.
- Medicaid, Chapter 7, subchapter XIX of the Social Security Act, other than benefits under section 1928.

- TRICARE, Title 10, Chapter 55 of the United States Code.
- A medical care program of the Indian Health Service or of a tribal organization.
- A health benefits risk pool operated by any State of the United States.
- Federal Employee Health Benefits Plan (FEHBP, a health plan offered pursuant to Title 5, Chapter 89 of the United States Code).
- A public health plan as defined by federal law.
- A health benefit plan pursuant to section 5(e) of the Peace Corps Act.
- A policy or contract, including a short-term limited duration insurance, issued on an individual basis by an insurer, a healthcare services organization, a hospital service corporation, a medical services corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under Arizona Revised Statutes §36-2901, paragraph 4, subsections (d), (e), (f) and (g).
- A policy or contract issued by a healthcare insurer or accountable health plan to a Member of a bona fide association.

Creditable coverage under any of the listed benefit plans will reduce the period of pre-existing condition waiting period if the Member

- had continuous coverage for a period of one (1) year,
- during that one (1) year period there were no breaks in coverage totaling more than thirty-one (31) days, and
- the time between the termination of the prior coverage and the Member's HCG effective date of coverage does not exceed sixty-three (63) days.

The Creditable coverage will reduce the Pre-existing Condition Waiting Period one month for every month of Creditable coverage. Any Creditable coverage occurring prior to the break in coverage over sixty-three (63) days will not be credited toward the Pre-existing Waiting Period.

Termination of Coverage and Exclusion from Enrollment or Re-enrollment

HCGA may exclude an Employer, a Subscriber or a Subscriber's Dependent from enrollment or re-enrollment if the prior coverage has been terminated for any of the following reasons:

- Clear and convincing evidence of fraud or misrepresentation material to the enrollment.
- Factors listed under A.R.S. §36-2912(P) that impacts the premium when the Member applies for coverage or obtains services.
- Committing violence or threatening to commit violence or being abusive toward the employees or agents of HCGA, an HCG Health Plan, or a Provider.
- Repeated and unreasonable demands for unnecessary or uncovered medical services.
- Failure to pay any co-payment, coinsurance or deductible.
- Violating any provision of the Member Handbook or GSA

SECTION III: PREMIUM PAYMENTS

Monthly Premium Payments

Premium rates may change with a sixty (60) day notice.

Premiums are fees that are paid to cover the basic costs of the benefits chosen. Premiums are paid on a monthly basis. Premium payments are due on the date listed in the monthly billing statement in advance of the month of coverage.

The monthly premiums for enrolled Employees and Employee's Dependent(s) are paid through the Employer. The Employer is responsible for collecting all Employee premiums and paying the entire premium amount due for the Employer Group to the HCGA by the company authorized form of payment.

SECTION IV: MEMBER CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES

Co-payment

"Co-payment" means an amount specified in the Benefit Plan Summary that a Member pays directly to a Provider at the time a covered service is provided. Members are responsible for paying all co-payments as they

are listed in the Benefit Plan Summary. Failure to pay the co-payment may result in denial of services or termination of coverage by HCGA.. **The payment of a co-payment is not applied to the deductible requirement.**

Coinsurance

“Coinsurance” means an amount specified in the Benefit Plan Summary that a Member agrees to pay to a Provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services. Members are responsible for paying all coinsurance as it is listed in the Benefit Plan Summary. Failure to pay the coinsurance may result in denial of services or termination of coverage by HCGA. **The payment of coinsurance is not applied to the deductible requirement.**

Changes in Co-payments and Coinsurance

Coinsurance and co-payments are subject to change at the time of re-enrollment or with sixty (60) days advance notice from HCGA.

Calendar Year Deductible

“Calendar year” means January 1st through December 31st of any year.

“Deductible” means a fixed annual dollar amount that a Member agrees to pay for certain covered services before the HCG Plan will pay for those covered services subject to the deductible. Deductibles are calculated on a calendar year and do not coincide with the annual open enrollment or contract year. Every January 1st the deductibles are set to zero and the Member must pay the full amount of the deductible before the HCG health plan pays for any services subject to the deductible. Co-payments and coinsurance do not apply toward satisfying the deductible. The family deductible may be met by one family Member or all of the family Members.

Members are responsible for paying all deductibles as they are listed on the Member’s benefit plan option or Benefit Plan Summary. Refer to the Benefit Plan Summary for the health plans and benefit options chosen to determine what services are subject to the deductible. Failure to pay the deductible may result in denial of services or termination of coverage. **Co-payments and coinsurance must be paid in addition to the deductible amount.** The Health Plan maintains records of the deductible met by each Member. Any questions about the deductible or the accumulated payments applied toward meeting the deductible should be directed to the Health Plan.

Members may change benefit plan options, deductible options or health plans at the Employer Group annual open enrollment period. At the Employer Group annual open enrollment the amount paid toward the deductible at the time of the open enrollment will roll over to the new enrollment period if:

- The Subscriber chooses the **same benefit plan and deductible** the Subscriber had the previous enrollment, or
- The Subscriber chooses the **same benefit plan but increases the deductible amount.**

If the Subscriber chooses to reduce the deductible level, change benefit plans or health plans at the HCG annual open enrollment, deductible balances will not roll over to the next enrollment year and will reset to zero.

For example, if a Member initially enrolls in June 2007 in a \$1,000 deductible in a UPH benefit plan option and then elects a \$2,000 deductible in the same benefit plan upon the Member’s June 2008 renewal, the amount of deductible that the Member had paid toward the \$1,000 deductible which reset on January 2008 will be applied toward the \$2,000 deductible which must be met from June 2008 through December 31, 2008 before it resets on January 2009.

On the other hand, if a Member initially enrolls in June 2007 in a \$1,000 MHG benefit plan option and then elects a \$2,000 deductible in a different health benefit plan option upon the Member’s June 2008 renewal, the amount of deductible that the Member has paid toward the \$1,000 deductible (which reset to zero on January 2008) from January 1, 2008 through May 31, 2008 will NOT be applied toward the

\$2,000 deductible for the new health benefit plan and the Member will have to pay \$2,000 in deductible from June 2008 through December 31, 2008 before HCG pays for any benefit subject to a deductible.

Note: **Family deductible is twice the individual deductible.** Please see the following Section, Family Deductible. Any combination of family members can meet the family deductible.

Family Deductible

The deductible for a family plan equals two (2) times the individual deductible regardless of family size. Until twice the individual deductible has been paid by a combination of family members or any one member, the deductible requirement has not been met for a family plan and the covered services subject to the deductible will not be paid by HCG.

The family deductible applies to Subscribers in premium rate tiers for Employee + Spouse, Employee + Family and Employee + Children.

This means that if the Employee signs up for a \$1,000 deductible plan and also signs up the Member's eligible Dependents, a deductible of \$2,000 must be paid before the Member's deductible requirement has been satisfied and HCG begins to pay for covered services. The family deductible is cumulative and can be paid by any combination of covered family members.

If, for any reason an Employee is allowed to change benefit plans outside of open enrollment, the deductible for the new plan is reset at zero and no deductible for the prior plan is carried over.

Balance Billing of Member

"Balance billing" occurs when a Provider bills a Member for any remaining balance for covered services after HCG or a HCG Health Plan makes a payment to the Provider.

The Member owes all co-payments, coinsurance and deductibles. The Member is not responsible for any other payment for covered services to the Provider (except as listed below for medical implantable devices) if the Member:

- Uses a participating Provider.
- Receives emergency care from any hospital in the United States.
- Receives prior authorization when it is required.

Note: a Member may be billed and be financially responsible for the ancillary, routine non-emergent services provided by non network providers. These services could include radiologists, anesthesiologists, pathologists and hospitalists.

A Provider or Provider's subcontractor is not allowed to charge a Member, submit a claim, demand or otherwise collect payment from a Member or person acting on behalf of a Member for any covered service **except** for the collection of co-payments, coinsurance or deductibles for covered services.

SECTION V. OTHER SOURCES OF PAYMENT FOR COVERED SERVICES

Reimbursement

If the amount of payments made by HCGA for covered services is more than it should have paid under the GSA, HCGA may recover the excess from any person or organization that may be responsible for the benefits and services provided for the covered Member.

Requirement of Member to Notify HCGA of Other Coverage

The Subscriber is required to notify HCGA if at any time a Member has other coverage or if another party or entity is legally responsible for the Member's injuries or services. If the Subscriber does not notify HCGA of other coverage, HCGA reserves the right to offset any benefits paid to recoup the cost of the services that should have been paid by the other party or entity.

Coordination of Benefits

“Coordination of Benefits” (also abbreviated as COB) is a process which determines the financial responsibility for payment when a person has group healthcare coverage under more than one plan. COB is designed to provide the maximum coverage for services at the lowest cost by avoiding duplicative or excessive payments. The objective of COB is to ensure that all of the group health plans that provide coverage to the Member pay no more than 100% of the allowable expenses for services.

Each Member is required to disclose to HCGA the existence of any other coverage, including the identity of the carrier and the group through which it is provided. This disclosure is required at the time of enrollment and at any time throughout the duration of enrollment when there is any other coverage provided to the Member by another carrier. HCGA will make a determination on which plan is primary and which plan is secondary. COB is only done with Group commercial medical coverage.

A “plan” includes any of the following types of coverage that provide benefits or services for medical care:

- Group insurance or group-type coverage whether insured or self-insured.
- Medicare or other governmental benefits, as permitted by law.

Each type of coverage in these categories will be treated as a separate plan.

A plan does **not** include:

- Individual insurance
- Medicare Supplement policies
- Medicaid (AHCCCS) or any plan when, by law, its benefits are in excess of any private insurance plan or non-governmental plan
- Medical benefits of automobile liability insurance

When two or more plans pay benefits for covered services,

- The primary plan pays or provides benefits as if the secondary plan does not exist.
- A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense under the HCG Plan. If HCG is the secondary plan, the provider that performed services **MUST** be part of the HCG Plan provider network in order for HCG to make payment. If the provider is not part of the HCG Plan provider network, HCG will make no payment.

Covered services provided under HCG do not duplicate other benefits available to the Member. HCG is never the primary payer for claims involving Workers’ Compensation, automobile liability insurance or homeowner’s insurance.

Arizona Revised Statutes 36-2912(J) provides,

“With respect to services provided by contractors to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e), a contractor is the payor of last resort and has the same lien or subrogation rights as those held by healthcare services organizations licensed pursuant to title 20, chapter 4, article 9.”

This means that Healthcare Group will always be the secondary payer or payer of last resort when the Member has other group medical coverage.

Recovery of Excess Benefits When HCG Coverage is Secondary

Based upon the Order of Benefit Determination Rules, if HCG is determined to be secondary but has provided or reimbursed for a covered service that should have been paid by the primary plan, that covered service will be considered an excess benefit. HCGA will recover the excess at its discretion.

Determination of Benefits When Medicare is a Plan

The benefits under HCG coverage are not intended to duplicate any benefits to which Members are entitled under Medicare. **The Subscriber must notify HCGA when the Subscriber or the Subscriber’s**

Dependent becomes eligible or enrolls in Medicare Part A and/or Part B coverage. If the Member is eligible for Medicare but fails to enroll, the HCG coverage will be reduced by the amount that the Member would have received from Medicare. HCGA will not reduce the benefits due any Member because of the Member's eligibility and enrollment in Medicare where federal law requires that HCGA determine its benefits for that Member without regard to the benefits available from Medicare. Additionally, HCG will not reimburse costs for services allowed by Medicare, but limited or excluded in the GSA or for services rendered by a provider not contracted with HCG.

When HCG is primary for any enrolled Member or Dependent,, HCG will be responsible for payment to the extent that services are covered under the HCG benefit option. HCG will pay as primary for a Member entitled to or enrolled in Medicare based upon End Stage Renal Disease (ESRD) for a maximum of thirty (30) months or such other term as required by Federal law. For a more complete explanation of these circumstances, refer to the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/COBGeneralInformation>.

When Medicare is primary, HCG coverage will be limited to the cost of HCG covered services not covered by Medicare and rendered by a network provider except for emergency services.

Medical Payments Insurance

If a Member is injured as a result of a motor vehicle accident and the medical expenses as a result of that accident are covered in part or in full by a medical payment provision under an automobile liability insurance policy, the Medical Payment insurance shall be primary and pay expenses first. The HCG plan will pay only in the event that the amount of Medical Payments Insurance is insufficient to pay for all of the medical expenses as a result of the accident. HCGA reserves the right to require proof that the Medical Payment insurance has been exhausted and has not paid for all of the expenses. The Member is required to cooperate with and assist HCGA in obtaining reimbursement for medical expenses incurred for the Member's injuries which were required to have been paid by the Medical Payments Insurance.

Workers' Compensation Insurance

Injuries or illnesses resulting from work-related occupational accidents or illnesses covered under Arizona Workers' Compensation laws, occupational disease laws, Employers' liability or federal, State or municipal law are not covered by the HCG plans. HCGA will not provide or arrange benefits, services or supplies required as a result of a work-related injury or illness.

To obtain benefits for a work-related injury or illness, it is the sole responsibility of the Member to pursue those rights under Arizona Workers' Compensation laws or any other applicable law. The Member must contact the Employer and submit any claims for medical services. HCG will not pay any claims for work related injuries or illnesses when the Member fails to file a claim with Workers' Compensation within the filing period required by law or fails to comply with other applicable provisions under the Arizona Workers' Compensation law.

If coverage under Workers' Compensation is optional for the Employer and it could have been elected and was not, HCG benefits will not be paid for any injury or illness that would have been covered under Workers' Compensation had the coverage been elected.

A claim that indicates that a work-related accident, injury or illness has occurred will not be considered by HCGA for payment unless a determination is received by HCGA that the workers' compensation carrier has denied the claim based upon the fact that the accident, injury or illness is not work related. Any benefits payable by HCG are subject to all of the provisions of the GSA including, but not limited to, prior authorizations.

SECTION VI. TERMINATION OF COVERAGE

Under no circumstances will a Member's coverage be terminated due to health condition or the use of covered services.

Member Termination

HCGA Termination of Member's Coverage for Fraud or Misrepresentation without Notice

The HCGA or HCG Plan may terminate a Member's coverage, without notice for clear and convincing evidence of fraud or misrepresentation material to enrollment or factors listed in A.R.S. §35-2912(P) (age, gender) that would have affected the premium when the Member applied for coverage or obtained services.

HCGA Termination of Member's Coverage With Thirty (30) Days Notice

HCGA may terminate a Member's coverage effective thirty (30) days from the date that HCG mails a written **Notice of Termination of Coverage** to the Member's last address provided to HCGA by Member for any the following reasons:

- Repeated and unreasonable demands for unnecessary medical services
- Failure to pay any co-payment, coinsurance or deductible
- Violation of a provision of the Member handbook or GSA
- Change in age or other status of the Member that is required for eligibility
- Loss of the participating HCG Health Plan in which the Employer Group is enrolled, if there is no other participating HCG Health Plan available to serve the Employer Group.
- Threats to commit or commission of violence or abusive behavior against employees or agents of HCGA, an HCG Plan, Network Providers or Out-of-Network Providers

Termination Due to Ineligibility

Coverage for the Subscriber and the Subscriber's Dependents will terminate at 11:59pm on the last day of the month in which:

- The Member no longer meets the eligibility requirements of the GSA.
- The Employer made a timely payment for the full premium.
- The Member dies.

Coverage for the Subscriber's Dependent will terminate at 11:59pm on the last day of the month in which:

- The Subscriber's spouse loses eligibility due to divorce from the Member.
- The Subscriber's Dependent loses eligibility due to marriage or emancipation.
- The Subscriber's Dependent loses eligibility due to reaching the age of nineteen (19) and not being enrolled in high school or an accredited secondary education institution or being nineteen (19) through the age of twenty-three (23) and not being a full-time student at a secondary education institution.
- The Subscriber dies.

Termination of Subscriber Coverage Only for Ineligibility or Qualifying Events

The Subscriber cannot terminate HCG coverage until the Employer Group's renewal unless the Subscriber becomes ineligible for HCG coverage or has one of the qualifying events occur and provides the required notice.

Coverage for the Subscriber will terminate at 11:59pm on the last day of the month in which one of the following occurs:

- Reduction in work hours so that the Subscriber is no longer eligible for HCG coverage,
- Involuntary termination of employment,
- Death of the Subscriber,
- Subscriber becoming eligible and enrolling in a government health plan (Medicare, Medicaid) and providing written notice of termination of HCG coverage.

Termination of Subscriber Dependent's Coverage Only for Ineligibility or Qualifying Events

The Subscriber's Dependent(s) cannot terminate HCG coverage unless the Subscriber becomes ineligible for HCG coverage or one of the qualifying events occurs and the required notice is provided.

Coverage for the Subscriber's Dependents will terminate at 11:59pm on the last day of the month in which at least one of the following occurs:

- Subscriber is no longer eligible to be enrolled HCG,
- Dependent minor child reaches the age of nineteen (19) and is not a full-time student in an Accredited Secondary Education Institution, or reaches the age of nineteen (19) and is no longer disabled.

Subscriber Termination-Voluntary and Involuntary Termination of Employment

The Employer must notify HCG **in writing** by completing and submitting to HCGA the Employee Enrollment/Termination Form within five (5) working days when an Employee's employment is terminated. Coverage for the terminated Employee will end on the last day of the month in which notification of termination is received. The Group's premium payment will be adjusted to reflect the termination upon receipt by HCG of written Notice that the Employee is no longer employed by the Employer. An employee terminated for misconduct or other cause is not eligible for non-COBRA continuation coverage.

No reductions in the premium payments will be made for the terminated Employee for the month of termination if notification of the terminated Employee is not received by HCG prior to the last day of the month.

Effective Date of Termination for Member and/or Member's Dependents

Termination of coverage will be effective at 11:59pm on the date in the termination notice unless the Member or Member's Dependent is eligible for and elects continuation coverage and pays the premium. The effective date of the termination of coverage for Employee involuntary termination of employment and Employee voluntary termination of coverage will be the last day of the month following thirty (30) days' notice to HCGA.

Certificate of Creditable Coverage

According to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable Coverage will be provided to the Member and/or the Member's Dependents by HCGA when the Member or Member's Dependent is no longer enrolled in HCG coverage. Certificates of Creditable Coverage will also be provided upon request while the Member or Member's Dependent is covered under HCG and for up to twenty-four (24) months after coverage ends under HCG coverage.

Services Provided During any Period for Which Employee Coverage is Terminated

Payment for any services received by a Member or a Member's Dependents during a period for which coverage has been terminated will be recovered from the Member or Member's Dependent individually.

Member Inpatient in Hospital on Date of Termination

HCG is not responsible for the cost of health services received by a Member after the date of termination of HCG coverage except that a Member who is an inpatient on the effective date of termination shall continue to have coverage until the HCG Plan Medical Director or designee determines that care in the hospital is no longer medically necessary for the condition for which the Member was admitted to the hospital. For coverage of a hospitalized Member to continue, HCGA must continue to receive timely paid premiums.

SECTION VII. CONTINUATION OF GROUP COVERAGE

Note: The information about COBRA related to groups that are required to provide COBRA continuation coverage is provided only for informational purposes and is not to be construed as legal advice or any guarantee of continued coverage.

Continuation of Coverage Under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, allows certain individuals the right to continue group coverage when a qualifying event for termination occurs. COBRA applies to Employers who employed at least twenty (20) full-time employees on more than fifty percent (50%) of its typical business days in the previous calendar year and to plans sponsored by State and local governments. Both full- and part-time employees are counted to determine whether a Plan is subject to COBRA. The COBRA coverage may not be conditioned upon, or discriminate on the basis of the lack of, evidence of insurability.

Note: The definition of a full-time employee for purposes of COBRA may be different from the definition

used for HCG eligibility. It is the employer's responsibility to determine if the Employer Group size is subject to COBRA.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who is not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage has the same rights under the Plan as other participants or beneficiaries covered under the Plan.

The definition of "qualified beneficiary" means "with respect to a covered employee under a group health plan, any individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—as the spouse of the covered employee, or as the Dependent child of the employee". This term also includes a child who is born to or placed for adoption with the covered employee during the period of continuation coverage. This term also includes the covered employee. This term can also include the covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before this qualifying event, is beneficiary under the plan as the spouse, surviving spouse or Dependent child of the covered employee.

COBRA Qualifying Events

The term "qualifying event" means, with respect to any covered Employee, any of the following events, which, but for the continuation coverage required, would result in the loss of coverage for the qualified beneficiary:

- The death of the covered employee.
- The termination (other than by reason of Employee's gross misconduct) of the covered employee's employment or reduction of hours.
- The divorce or legal separation of the covered Employee from the Employee's spouse.
- The covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] (Medicare).
- A Dependent child ceasing to be a Dependent child under the generally applicable requirements of the plan.
- A proceeding by the Employer in a case under Title 11 (Bankruptcy), commencing on or after July 1, 1986, from whose employment the covered employee retired at any time.
- In the case of this event, a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary (spouse of the covered employee, Dependent child of the employee or surviving spouse of the covered employee) within one year before or after the date of commencement of the proceeding.

COBRA General Notice by HCGA

It is the responsibility of HCGA at the time of commencement of coverage to provide notice to the eligible employee or employee's Dependent about the eligibility requirements and terms and conditions of continuation of coverage under COBRA if there is a qualifying event as defined in COBRA.

COBRA Qualifying Event Notice by Employer

The Employer must notify HCGA if the qualifying event is:

- Termination or reduction in hours of employment of the covered Employee,
- Death of the covered Employee,
- Covered Employee's becoming entitled to Medicare, or
- Bankruptcy of the Employer.

It is the responsibility of the Employer to notify HCGA within sixty (60) days of the date of a qualifying event and to provide HCGA with the appropriate COBRA documentation for the Employee and/or Employee's Dependents, including the election form.

COBRA Qualifying Event Notice by Employee

The Employee or other qualified beneficiary must notify HCGA if the qualifying event is:

- Divorce,
- Legal Separation, or
- A Dependent's loss of Dependent status under the Plan.

HCGA COBRA Election Notice

When HCGA receives notice of a qualifying event from the Employer or the Employee as listed above, the qualified beneficiary must be provided an Election Notice which describes the rights to continuation coverage and how to make an election within fourteen (14) days after the notice of the qualifying event is received. Notification to the spouse of the covered employee is treated as notification to all other qualified beneficiaries residing with the spouse at the time notification is made.

If the Employer terminates all Plans, COBRA does not apply and the Member is not entitled to continuation coverage.

Election of COBRA Continuation Coverage

If the Member becomes entitled to elect COBRA coverage, the Member must be given an election period of at least sixty (60) days to choose whether or not to elect the continuation coverage. The election period begins on the later date of the date the election notice is furnished or the date coverage would be lost. If the Member elects COBRA continuation coverage, no premium payment is required to be sent in with the Election Form. If the Member does not elect COBRA continuation coverage on a timely basis, the HCG coverage will terminate for the Member.

Each qualified beneficiary for the qualifying event may independently elect continuation coverage. A parent or legal guardian may elect on behalf of a minor child.

If the Member or qualified beneficiary waives coverage during an election period, the Member or qualified beneficiary may be permitted to later revoke the waiver of coverage and elect continuation coverage as long as the election is done during the election period. The Plan is only required to provide continuation coverage beginning on the date the waiver is revoked.

If the Member is already covered by Medicare or another group health plan prior to the election of COBRA continuation coverage, COBRA can be elected in addition to the other coverage. If Medicare or another group health plan is obtained after the election of COBRA continuation coverage, the COBRA coverage must be terminated.

COBRA Premium Payment

HCGA may use the services of a contractor to administer COBRA continuation coverage.

For COBRA continuation coverage, a Member usually pays a higher premium because the Member pays any Employer contribution as well as the Member's premium. A Member's contribution to the COBRA premium may be increased to one-hundred and two percent (102%) of the employee's or employee's Dependent(s) current premium under the GSA in effect at the time of the qualifying event.

The premium payment must be made no later than forty-five (45) days after the date of the election. The election date will be the date the Election Notice is postmarked if it is mailed.

If the Member does not make the first premium payment for continuation coverage in full no later than forty-five (45) days after the date of election, the Member will lose all continuation rights under the Plan. The Member is responsible for making sure that the premium amount submitted is the full amount due.

The Member must pay the COBRA premium through the Employer for the period subsequent to the date the non-COBRA coverage is terminated and no later than forty-five (45) days after the Member elects COBRA coverage. Premiums for the COBRA coverage are due from the Member and/or Member's Dependent(s) in regular monthly payments as required by the Employer.

If the COBRA premium is not received by HCGA or its contractor on or before the due date, COBRA coverage will be terminated with thirty-one (31) days written notice by HCGA or its contractor to the Employee or Employee's Dependent(s). It is the Employer's responsibility to notify the Employee or Employee's Dependent(s) in writing of the termination. Failure to pay the premium for the COBRA coverage

within the forty-five (45) day period will result in the Member or the Member's Dependent(s) losing the right to continuation coverage under COBRA.

If the COBRA premium is not paid when due but is paid during the thirty-one (31) day period prior to the termination, the Member may be required to pay for any services received during the thirty-one (31) day period and then request reimbursement from HCGA or the HCG Plan if the premium is paid before the end of the thirty-one (31) day period.

In the event that the Employee and/or Employee Dependent elects COBRA coverage, it is the responsibility of the Employer to collect the premium and pay the COBRA premium to HCGA according to the terms of the GSA.

COBRA Coverage Provided

If the Member elects COBRA continuation coverage, the coverage given must be identical to the coverage that is currently available to similarly situated active Employees and their families. Generally, this coverage will be the same coverage that the Member had immediately before the qualifying event. The qualified beneficiaries will be entitled to the same benefits, choices and services that similarly situated participants would receive. The qualified beneficiaries will also be subject to the same rules and limits that would apply to similarly situated participants such as co-payment requirements, deductibles and coverage limits. HCG Plan rules also apply for filing benefit claims and grievance and appeals.

If the Member and/or Member's Dependent(s) elect COBRA coverage, the Member and/or Member's Dependent(s) will continue to be covered by the GSA. COBRA coverage is subject to the conditions, limitations and exclusions of the GSA. HCGA and the Employer may agree to change the GSA after the Member and/or Member's Dependent(s) enroll for COBRA continuation coverage and the Member and/or Member's Dependent(s) coverage will also be subject to the changes.

Duration of COBRA Group Continuation Coverage

The duration of the COBRA continuation coverage is subject to the terms of COBRA that apply to the Member or the Member's Dependent(s).

The COBRA coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

- General rule for terminations (other than for reason of the Employee's gross misconduct) and reduced hours eighteen (18) months after the qualifying event.
- Multiple qualifying events - If a qualifying event (other than retirement) occurs during the eighteen (18) months after the date of a qualifying event, the date which is thirty-six (36) months after the date of the first qualifying event.
- Other qualifying events - In the case of other qualifying events, the date which is thirty-six (36) months after the date of the qualifying event.
- Medicare entitlement followed by a qualifying event - In the case of a qualifying event that occurs fewer than eighteen (18) months after the date the covered employee becomes entitled to Medicare benefits, the period of coverage for qualified beneficiaries other than the covered employee shall not terminate before the close of the thirty-six (36) month period beginning on the date the covered employee became entitled to Medicare.

Disability Extension of COBRA

If the Member or Member's Dependents covered under the GSA through COBRA continuation coverage is determined by the Social Security Administration to be disabled and the Employer Group is notified in a timely fashion, the Member and the Member's Dependents may be entitled to receive an additional eleven (11) months of COBRA continuation coverage. The disability would have to have started at some time before the sixtieth (60th) day of the COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of continuation coverage.

Termination of COBRA Coverage

COBRA continuation coverage can be terminated when:

- The last day of the maximum continuation coverage,
- Any required premium is not paid in full on time,
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary or the qualified beneficiary obtains coverage with another Employer Group HCG Plan and has satisfied any waiting periods for preexisting conditions under the new plan,
- A covered Employee becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage,
- The Employer ceases to provide any group health plan for its Employees, or
- Fraud is committed by the qualified beneficiary.

Employer Bankruptcy and COBRA Coverage

If the Employer files for bankruptcy under Chapter 7, the Company liquidates its assets to pay its creditors and the Company ceases to exist. It is likely that the health plan of the employer will be terminated as well. If there is no health plan, there is no COBRA coverage available. If there is another plan available, the Member may be eligible to be covered by that plan. If the Member is a Union member covered by a collective bargaining agreement, the Union member should be in contact with the Union representative.

If the Employer files for bankruptcy under Chapter 11 (reorganization), there is usually a company that will continue in business under the Court's protection while attempting to reorganize its financial affairs. A Chapter 11 bankruptcy may or may not affect the health plan. You should contact the administrator of each plan to determine if a health plan will continue to be available.

Certificate of Creditable Coverage

A Certificate of Creditable Coverage is a written verification of prior coverage from any qualified health plan that includes specific dates of enrollment.

A Certificate of Creditable Coverage will be provided by HCGA to each Member within thirty (30) days when a Member's coverage under the GSA is terminated or COBRA continuation is exhausted. The Certificate of Creditable Coverage will include the date of termination of the coverage and the period of time that the Member was covered under the GSA.

HCG Non-COBRA Continuation Coverage

Employees working for Employers with fewer than twenty (20) employees and not eligible for COBRA continuation coverage may be eligible for HCG non-COBRA continuation coverage for a maximum of three (3) months of coverage following a qualifying event. The Employees' Dependent(s) may also be eligible for HCG non-COBRA continuation coverage.

If the Employer Group business is terminated, discontinued or no longer in existence in the form as originally enrolled, no Subscriber is eligible for HCG non-COBRA continuation coverage. If the Member enrolls in HCG non-COBRA continuation coverage and the business is terminated, discontinued or no longer in existence during the period of coverage for HCG Non-COBRA Continuation coverage, the Member's HCG non-COBRA continuation coverage is terminated on the date the Employer Group is terminated. A sole proprietor without employees is not eligible for HCG non-COBRA continuation coverage when the business is terminated, discontinued or no longer in existence. HCG Non-COBRA conversion is not available to former owners of a business once the business is sold.

To qualify for HCG non-COBRA continuation coverage, the Employee and/or the Employee's Dependent(s) must:

1. Have been enrolled in a HCG Health plan for a minimum of six (6) months.
2. Work for an eligible enrolled Employer with fewer than twenty (20) full-time employees or be the

- eligible enrolled Dependent(s) of that Employee.
3. Request HCG non-COBRA continuation coverage as a result of involuntarily termination of employment (except as a result of misconduct) within the month immediately following the qualifying event. HCG will rely upon the cause of Termination provided by the Employer
 4. Continue to reside in the State of Arizona with access to a HCG Health Plan.

The Subscriber must request HCG non-COBRA continuation coverage within the month immediately following the termination of Employer Group coverage. The premiums for the HCG non-COBRA continuation coverage will be calculated at a group of one rate. There can be no gap in coverage between the Employer Group and HCG non-COBRA continuation coverage. The Member must remain in the same Health Plan or move to a benefit plan and deductible option that is available for a group of one. If the Health Plan in which the Member was enrolled is no longer available, the Member will be enrolled in the most similar benefit plan option. The Employee will be issued a new Group number for the HCG non-COBRA continuation coverage and must use the new Group number to access all covered benefits.

The premiums for the HCG non-COBRA continuation coverage must be paid by the terminated Employee or the Employee's Dependent(s) directly to HCGA.

HCG Non-COBRA Continuation Coverage Group ID Number and New Employer Group Enrollment by Same Member

Any employee who elects HCG non-COBRA continuation coverage and subsequently starts his or her own new business cannot use the HCG non-COBRA continuation coverage Group ID number for the new business. Eligibility will be determined and all requirements of a new Employer Group will have to be met as for any new Employer Group.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation coverage may also be available under HCG to you and your Dependents through your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) (38 U.S.C. 4317). The law requires that health continuation benefits continue for persons who are absent from work by reason of service in the uniformed services even if the Employer has fewer than twenty (20) Employees and is exempt from COBRA.

The benefits under USERRA may be available to you if you are absent from your employment due to service in the United States uniformed services for up to eighteen (18) months if you meet the USERRA requirements. USERRA benefits can be received concurrently with COBRA benefits. The person cannot be required to pay more than one-hundred and two percent (102%) of the full premium for the coverage. If the military service was for thirty (30) or fewer days, the person cannot be required to pay more than the normal Employee share of the premium.

Even if the Member does not elect to continue the coverage under the GSA while away for service in the military, USERRA entitles the Member to immediate reinstatement with no exclusion of pre-existing conditions (except conditions which the Department of Veteran's Affairs has determined to be service-connected) upon reemployment.

SECTION VIII. CONFIDENTIALITY OF INFORMATION

Confidentiality of Information

HCGA, HCG Plans and Participating Providers are required to comply with all Federal and Arizona statutes, rules and regulations regarding the confidentiality of information pertaining to its Members. HCGA and HCG contractors and Providers are committed to protecting the privacy of all of the Member's health information. Except as permitted by law, a Member's health information is not released unless the Member or the Member's authorized representative authorizes the release.

Release of Protected Health Information (PHI) to HCGA and HCG Plans

The Health Insurance Portability and Accountability Act (HIPAA) was enacted to set national standards for the protection of certain health information. The U.S. Department of Health and Human Services (HSS)

issued the Privacy Rule to implement the requirement of HIPAA that addresses the use and disclosure of individuals' health information – called “protected health information” –by organizations subject to the Privacy Rule. A major goal of the Privacy Rule is to assure that the individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality healthcare.

Members' confidential health information is kept secure and only made available as necessary to appropriate HCG Employees, contractors and Providers or other affiliates who have a need to know and have signed a confidentiality statement. HCG must make reasonable efforts to use, disclose and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure or request.

HCGA and HCG Plans may require access to Members' medical records and other necessary information to help coordinate and manage the Members' care and to help to decide whether to pay the Members' claims. By enrolling in HCG, the Member agrees to cooperate with HCG, HCG Plans and its Contracted Providers in obtaining medical records and other necessary information. By enrolling in HCG, the Member agrees to cooperate in the provision of this information for utilization review, chronic conditions management, quality assurance, claim adjudication, coordination of benefits, treatment, payment, healthcare operations purposes and any other lawful purpose.

Mandatory Disclosure of Protected Health Information (PHI)

HCG must disclose protected health information in only two situations:

- To individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of their protected health information, and
- To HHS when it is undertaking a compliance investigation or review or enforcement action.

Permitted Uses and Disclosure of Protected Health Information to Others

HCG and HCG Plans are permitted, but not required to, use and disclose protected health information, without an individual's authorization or consent for the following purposes or situations:

- To the individual
- Treatment, Payment and Healthcare Operations
- Opportunity to Agree or Object (circumstances clearly give the individual the opportunity to agree, acquiesce or object)
- Incident to an otherwise permitted use and disclosure
- Public Interest and Benefit Activities (required by law and public health activities such as disease control), and
- Limited data set for the purposes of research, public health or healthcare operations

Members' Rights Regarding Privacy and Protected Health Information (PHI)

A Member's protected health information will not be shared without written permission or a signed authorization except as previously explained or as required by law. A Member may give permission for other disclosures by completing the “Authorization to Disclose” form found on line at the HCG Web site at www.hcgaz.com or by requesting a form from HCGA (602.417.6755).

A Member has a right to:

- see and get copies of the Member's records for a reasonable fee,
- request to amend or correct the Member's records if there is a mistake,
- receive a reason from the plan if the request to amend or correct the Member's records is not allowed,
- get a list of disclosures made after April 13, 2004 with the exception of disclosures for treatment, payment or healthcare operations or information provided to the Member of the Member's family directly,
- restrict the uses and disclosures of the Member's information although HCGA is not required to agree to the restriction,
- revoke authorizations previously provided to HCGA although information released prior to the

- revocation is not subject to the revocation,
- designate how or where HCGA will communicate with the Member; for instance, communicate only to a particular phone number or only communicate by e-mail,
 - file a complaint if there is a disagreement about how HCGA used or disclosed the Member's information,
 - get a copy of the Privacy Notice at any time.

HCGA may change its Notice of Privacy Practices and a copy of the new notice will be sent to the Member within sixty (60) days and will be posted on the HCG Web site at www.hcgaz.com. The Member may request a copy of the Notice of Privacy Practices at any time.

The Member must contact HCGA **in writing** about Privacy Rights or to file a complaint at:

Healthcare Group of Arizona
ATTN: Privacy Officer
10851 N. Black Canyon Highway, Suite 830
Phoenix, Arizona 85029

Complaints about Privacy Rights may also be mailed or faxed to the Office for Civil Rights:

Office for Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza- Room 322
San Francisco, California 94102
415.437.8310
415.437.8311 TDD
415.437.8329 Fax

SECTION IX. GRIEVANCES, APPEALS AND REQUESTS FOR STATE FAIR HEARINGS

Informal Resolution of Dissatisfaction

HCG wants all Members to be pleased with the quality of care provided. HCG surveys show that the great majority of Members are satisfied with their coverage and services and renew year after year. If, for any reason, a Member is not satisfied with the quality of care or the level of service, the Member may call HCG Customer Service at 602.417.6755 or 800.247.2289 (outside Maricopa County).

Arizona Administrative Code

The Arizona Administrative Code (A.A.C.) provides the procedure to follow when a Member is adversely affected by an action HCGA or an HCG Contracted Provider has taken or is dissatisfied with the care received from an in or out-of-network Provider. The Member has a right to have these actions reviewed and the Arizona Administrative Code establishes the requirements for a person enrolled in HCG to file a grievance or an appeal or to request a State Fair Hearing. The pertinent sections of the A.A.C. are available on the HCG Web site at www.hcgaz.com.

Filing a Grievance with an HCG Health Plan

A grievance is defined as "an expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the enrollee's rights" (A.A.C.§R9-34-202(10)).

A grievance can be filed orally or in writing with an HCG Plan for issues related to the network of Providers, prior authorization process, medical necessity determination or dissatisfaction with the care received from an HCG Provider. A final determination on a grievance is made by the HCG Plan within 90 days and cannot be appealed to HCGA or AHCCCS, or elevated to State Fair Hearing. The Member may have an authorized representative, including a Provider, act on the Member's behalf with the Member's written consent. The Member is not entitled to a State Fair Hearing on a grievance. (A.A.C.§R9-34-209)

If a Member wants to file a grievance with an HCG Plan or with HCG, the Member can call the HCG Plan or HCG appeals unit or write to them directly at:

Mercy Healthcare Group
4350 E. Cotton Ctr. Blvd.
Building D
Phoenix, AZ 85040
602.263.3000
800.624.3879
mercyhealthcaregroup.com

Filing an Appeal With an HCG Health Plan

An appeal is defined as “a request for the review of an Action” (A.A.C.§R9-34-202(3))

An “Action” (A.A.C.§R9-34-202(2)) by a HCG Plan is:

- The denial or limited authorization of a requested service, including the type or level of service,
- The reduction, suspension, or termination of a previously authorized service,
- The denial, in whole or in part, of payment for a service,
- The failure to provide a service in a timely manner as set forth in contract,
- The failure of a contractor to act within the timeframes specified in this Article, or
- For an enrollee residing in a rural area with only one contractor, the denial of an enrollee’s request to exercise the enrollee’s right to obtain services outside the contractor’s network.

An appeal can be filed with an HCG Plan for issues related to the network of Providers, prior authorization process, medical necessity determination or dissatisfaction with the care received from an HCG Provider. The HCG Plan will issue a Notice of Action advising the Member of the Action and reason for the Action taken.

An appeal can be made either orally or in writing and must be filed within sixty (60) days after the date on the Notice of Action.

If a Member wants to file an appeal with an HCG Plan, the Member can call the HCG Plan appeals unit or write to them directly at:

Mercy Healthcare Group
4350 E. Cotton Ctr. Blvd.
Building D
Phoenix, AZ 85040
602.263.3000
800.624.3879
mercyhealthcaregroup.com

For the standard resolution of an appeal, the HCG Plan will resolve the appeal and mail a Notice of Action within fourteen (14) calendar days following the receipt of the Member’s request unless the HCG Plan requests an extension of the timeframe for an additional fourteen (14) days and provides the Member with an explanation of the reason for the decision to extend the timeframe.

If the Member’s life or health or ability to attain, maintain or regain maximum function would be seriously jeopardized by the standard timeframe the HCG Plan must make an **expedited** authorization decision as expeditiously as the Member’s health condition requires, but no later than three (3) days after the receipt of the request.

If a decision is not reached within the maximum timeframe the request will be considered to be denied on the date that the timeframe expires.

Filing an Appeal to a Notice of Action with an HCG Health Plan

The Member will be notified in the Notice of Action of the Member’s right to file an appeal from the first Notice of Action, how to request it and the circumstances under which a Member has a right to have services

continued pending the resolution of the appeal. The HCG Plan must resolve the second appeal and mail the Member a Notice of Appeal Resolution within thirty (30) days after the date the HCG Plan receives the appeal from the Notice of Action. Both the Member and the HCG Plan may request an extension of thirty (30) days if additional information is needed, the extension is in the best interest of the Member and the HCG Plan provides the Member written notice of the reason for the extension. The HCG Plan is required to extend the timeframe if the Member requests an extension.

HCG Health Plan and HCG Requirements for Grievance or Appeal Process

HCG Plans and HCG are required to provide reasonable assistance to Members in completing forms and taking other procedural steps. (A.A.C.§R9-34-210) Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free services that have adequate TTY/ITD and interpreter capability.

HCG Plans and HCG are required to acknowledge receipt of each grievance orally or in writing. HCG Plans and HCG are required to acknowledge the receipt of each appeal in writing. (A.A.C.§R9-34-210(B)) HCG Plans and HCG are also required to ensure that the individual who makes the decision on a grievance or appeal was not involved in any previous level of review or decision-making (A.A.C.§R9-34-210(C)).

HCG Plans and HCG must ensure that a healthcare professional who makes decisions on any appeal or grievance has the appropriate clinical expertise in treating the Member's condition or disease if 1) the appeal of a denial is based on lack of medical necessity, 2) a grievance is denied regarding expedited resolution of an appeal, or 3) a grievance or an appeal involves clinical issues (A.A.C.§R9-34-210(D)(1)-(3)).

HCG must make an expedited authorization decision as expeditiously as the Member's health condition requires, but no later than three (3) days after the receipt of the request for service (A.A.C.§R9-34-206(B)).

If a Service Authorization Request decision is not reached within the maximum time-frame, the authorization shall be considered to be denied on the date that the time-frame expires (A.A.C.§R9-34-206(E)).

Member's Request for a State Fair Hearing from an HCG Health Plan Notice of Appeal Resolution

A Member can ask for a State Fair Hearing based on HCG's resolution of an appeal. The request must be in writing and submitted to and received by HCG no later than thirty (30) days after the date of the Notice of Appeal Resolution (A.A.C.§R9-34-217(A)).

To request a State Fair Hearing regarding an appeal resolution determination made by HCG, a written request must be sent to HCG Plans or HCG at the following address:

Mercy Healthcare Group
4350 E. Cotton Ctr. Blvd.
Building D
Phoenix, AZ 85040
602.263.3000
800.624.3879
mercyhealthcaregroup.com

The Member's Request for a State Fair Hearing is timely if it is filed within ten (10) days after the date that the HCG Plan or HCG mails the Notice of Action or is filed by the date of the Action as indicated in the Notice of Action (A.A.C.§R9-34-(A)).

If the HCG Plan or HCG continues or reinstates the Member's services at the Member's request while the Appeal is pending, the HCG Plan or HCG must continue until one of the following occurs:

- The Member withdraws the appeal,
- Ten (10) days pass after HCG mails the Notice of Appeal to the Member, unless the Member within the ten (10) day time-frame has requested in writing a State Fair Hearing with continuation of benefits until a Director's Decision is reached,
- AHCCCS mails a Director's Decision adverse to the Member; or

- The time-period or service limits of a previously authorized service have been met.

Content of HCG Health Plan and HCG Notice of Appeal Resolution

HCG Plans and HCG are required to ensure that the written Notice of Appeal Resolution includes the results of the resolution process and the date that it was completed. (A.A.C.§R9-34-216(A))

If an appeal is not resolved completely in favor of the Member, the Notice of Appeal Resolution must contain:

- The right to request a State Fair Hearing and how to do so,
- The right to request to receive services while the State Fair Hearing is pending and how to make that request,
- The factual and legal basis for the decision, and
- That the Member will be liable for the cost of continued services if the Director's Decision upholds the Contractor's decision. (A.A.C.§R9-34-216(B))

Continuation of Services While the HCG Health Plan Appeal or State Fair Hearing is Pending

If a Member wants covered services to be continued pending the State Fair Hearing, the request to continue services must be in writing and must comply with A.A.C.§R9-34-224. (A.A.C.§R9-34-217(B)). The Member should be advised that if the State Fair Hearing is not decided in favor of the Member, the Member may be responsible for the cost of the services. HCG has no obligation to continue non-covered services paid for in error or for services excluded by the GSA or for services never authorized prior to the State Fair Hearing.

A.A.C.§R9-34-224 provides that an HCG Plan must continue the Member's services if:

- The Member files the appeal timely,
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment,
- The services were ordered by an authorized Provider,
- The original period covered by the original authorization has not expired, and
- The Member requests continuation of services. (A.A.C.§R9-34-224)

Withdrawal of a Request for a State Fair Hearing

AHCCCS is the State of Arizona Medicaid agency which administers the Healthcare Group of Arizona program. Healthcare Group is not a Medicaid program but, as a State agency, is subject to the administrative process that is followed by all State agencies. The Administrative Rules that are followed by AHCCCS, HCG, and HCG Plan can be found at A.A.C.9-34-101 through 409.

The Member may send, and AHCCCS must accept, a written request for the withdrawal of a Request for a State Fair Hearing if the written request to withdraw the State Fair Hearing is received by AHCCCS from the Member before AHCCCS mails a Notice of a State Fair Hearing.

If AHCCCS has already mailed a Notice of a State Fair Hearing, a Member must send the written request to withdraw the State Fair Hearing to the Office of Administrative Hearings (A.A.C.§R9-34-221(A), (B)).

SECTION X. GENERAL PROVISIONS

Administrative Rules and Procedures Relating to the Group Service Agreement

HCGA and HCGA Plans may adopt reasonable policies, procedures, rules and interpretations that assist in the administration of HCG coverage. By enrolling in HCG, the Member agrees to follow and comply with all policies, procedures, rules and interpretations.

Agreement By Employer Binding on all Members

By enrolling in HCG coverage, the Employer makes covered services available to enrolled Employees and their Dependents. The GSA may be amended, modified or terminated in accordance with any provision of the GSA, by mutual agreement between HCGA and the Employer without the agreement of the Employee and Employee Dependent Members. By electing or accepting covered services under the GSA, the Member agrees to obey and comply with all of the terms, conditions and provisions of the GSA.

The Employer may copy the GSA and make it available for review to each Employee.

Right to Covered Services Conditioned Upon all Information in Application, Member Health History Form and Other Documents Being True and Correct

All individuals enrolling in HCG must complete a Member Health History Form in order for the application to be considered complete. Failure to provide complete and accurate information on the Member Health History Form is cause for termination of the Member from the HCG Plan. An eligible Employee or the eligible Employee's Dependents will not be denied enrollment due to conditions described on the Member Health History Form.

Eligible Employees and their Dependent(s) warrant that all information in their Applications, Member Health History Forms and all other forms and statements is true, correct and complete. If the Employee or the Employee's Dependent(s) discovers that any information provided to the HCGA is not true, correct or complete, the Employee or the Employee's Dependent(s) must contact HCGA within three (3) working days to provide the correct information in order for the HCG coverage to remain in effect. All rights to covered services are subject to all information provided to HCGA being true, correct and complete.

If HCGA should determine that an enrolled Employee or that Employee's Dependent(s) intentionally omitted or misrepresented any material fact on any document filed for enrollment, the coverage for that Employee and that Employee's Dependent(s) shall be terminated from the original effective date. Any covered services or benefits that have been provided during the enrollment shall be repaid by the Employee to HCG.

Member Has No Right of Assignment

The Member has no right to assign any interest in the GSA without the prior written permission of the HCGA.

Clerical Errors

A clerical error on the part of HCGA or any HCG Plan shall not defeat any of the rights, privileges or covered services of any Member.

Compliance with Laws, Rules, Policies and Plan Requirements

HCGA and all Members acknowledge and agree that the GSA is administered pursuant to A.R.S. § 36-2912 et.seq. governing the HCG Plans. HCGA and the Members agree to be bound by all applicable Arizona Revised Statutes, Arizona Administrative Code, HCG Policies and Procedures and GSA contract provisions.

Entire Agreement Between the Parties

The enrollment documents, Group Service Agreement and any Endorsements and Benefit Plan Summaries are the entire agreement between the parties and supersede any prior oral or written negotiations, representations or agreements including prior GSAs. The GSA supersedes the information contained in the Member Handbook. The English version of the GSA shall take precedence over any translation into any other language.

GSA Can Only be Amended in Writing and may be Amended at Any Time

Only HCGA can amend the GSA. No other person has the authority to waive any conditions or restrictions of the GSA or bind HCG or any HCG Contractor. No change in the GSA will be valid unless contained in an amendment or an endorsement of the GSA. The GSA may be amended at any time by HCGA and the HCGA will notify the Employer in writing.

Titles are Reference Only

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

Indemnification

The Employer and each Member shall hold harmless and indemnify the State of Arizona and HCGA, their agents, officers and employees against all claims, liabilities, judgments, attorney fees, costs and expenses with respect to third parties, which may accrue against the State of Arizona or HCGA, their agents, officials, or employees arising from any Action of HCG or HCGA HCG Plan; Employer, or Member, their agents, officers, employees or of any subcontractor or any other person, firms of corporation furnishing or supplying

work, services, materials or supplies in connection with the performance of HCGA, HCG Health Plan, Employer Group's or Member's obligations under the GSA.

Misrepresentation or Fraud by Member or Employer in Application for Coverage may Result in Rescission of Coverage to Original Effective Date

Rescission is the cancellation of a contract and the return of the parties to the positions they would have occupied if the contract had not been made. If a Member commits fraud by lying, omitting or concealing information in any document submitted for the application or enrollment which would have affected the decision to provide coverage, affected the decision to decide to investigate further or affected the decision to pay claims under that coverage, the coverage may be rescinded to the original date of the coverage. If the Member has any questions on how to respond to a question in the application or application process and does not ask HCGA what response would be required, this will be interpreted as an attempt to conceal information that would have been relevant to the decision to provide coverage, pay claims or further investigate.

Fraud By Member Discovered at Any Time

If HCGA determines at any time after the effective date of a Member's coverage that a Member committed fraud or continues to commit fraud to continue enrollment in coverage, the coverage shall be invalid from the original effective date of coverage for that Member. The value of any services provided during that period will be recouped by HCG from the Member..

No Implied Waiver

Failure by a Member on one or more occasion to exercise a right under the GSA will not be interpreted as a waiver of that right or of the right to enforce that right in the future.

Independent Contractor Relationship

The relationship between HCGA and any HCG Contractor or vendor is an independent contractor relationship. Contractor physician, hospitals and other participating Providers are not agents or employees of the HCGA contractor. Nothing contained in the GSA shall be interpreted or construed as a contract of employment. Employees of contractors are not agents or employees of HCGA, and HCGA and its employees are not agents or employees of HCGA contractors.

No Discrimination

HCG, HCGA and HCG Contractors shall not discriminate against any Applicant or Member on the basis of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, gender or physical or mental disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C. §2000D, regulations promulgated under that Act or otherwise provide by law or regulation.

Relocation of Employer Group to Another County

The premiums for Healthcare Group coverage differ from county to county. The premiums calculated and paid for one county may not be the same in another county.

When a business and/or its eligible Employees and Members relocate to another county, the Employer Group is responsible to provide written notification to HCGA sixty (60) days prior to the relocation. The Employer must notify HCGA of the relocation by submitting an "Enrollment Change" form and any other forms or documents require by or requested by HCGA. The Employer must notify HCGA of the change in address, change in county and the date the relocation is to be effective.

The Employer must pay for any increase in premiums for the new county if the premium rate is higher in the new county. The new premium rate is due as of the effective date of the relocation. The Employer is also responsible for any administrative costs incurred by HCGA for the relocation including, but not limited to, new Member ID cards.

SECTION XI. COVERED SERVICES

This section describes the covered services provided by the Healthstyles Benefit Plans. Please refer to Section XI. **Exclusions** and **Limitations** for any limitations or exclusions for covered services.

Healthcare Group is a state-sponsored program to provide health care to uninsured Arizona businesses. Health plans and benefits may change with sixty (60) days notice. Healthcare Group is a state-sponsored program and the State Legislature may enact legislation which requires changes to the benefits, benefit options, terms and conditions of HCG coverage without notice. All treatment provided under Healthcare Group is limited to the state of Arizona except emergencies within the United States. **Healthcare Group coverage is not intended to be used outside the state of Arizona except for emergencies.**

The Arizona Legislature passed House Bill 2275 which effective September 27, 2008 modified A.R.S. 36-2912(I) to add (2) and provided that HCG could not pay for services provided at a noncontracting hospital except for emergency services.

House Bill 2275 states,

“The director shall...

(2) Prohibit the administration and program contractors from reimbursing a noncontracting hospital for services except for services for an emergency medical condition.”

In addition, House Bill 2275 also modified A.R.S. 36-2912 (Q) to provide,

“A health benefit plan shall not provide or offer any service benefit or coverage that is not part of the health benefit plan coverage.”

A requirement of the Benefit Option and the GSA is that all non-emergent covered services must be obtained from a facility, physician or vendor in the Health Plan’s provider network. Emergent services obtained from any US hospital Emergency Room will be covered without prior authorization but are subject to benefit exclusions and retrospective review. Any non-emergent covered service obtained from a facility, physician or vendor not in the Health Plan will not be paid unless prior authorization to use a non network provider is issued by HCGA.

All decisions regarding medical care are made by the Member and his/her Physician. There may be circumstances when a Member and his/her Physician make a determination that medical care which is not a covered service under the GSA is medically necessary and most appropriate, a facility that is not within the Plan network is the most appropriate setting for treatment, or a drug that is not on the Plan formulary is medically necessary and the most effective treatment for the Member’s condition. The decision to provide a service that is not covered, to go to a facility that is not within the plan network, or to prescribe a drug which is not contained in the Plan formulary is one for the Member and his/her physician. The decision for payment of claims for these uncovered services is determined by whether or not they are covered services under the GSA and the benefit plan summary. **Non-covered services will not be paid by the HCG Health Plans regardless of medical necessity.**

Provider Directories

The Contracted Providers may change from the time in the Provider Directory and the most current online version of the Provider Directory for your Plan can be found at www.hcgaz.com. Changes may occur to the Contracted Providers that are not reflected in the Provider Directory or on the HCG Web site, so the Member should always check with the office of the Contracted Provider to confirm that the Provider remains an HCG Contracted Provider at the time an appointment is made.

Co-payment and Coinsurance

Co-payment and coinsurance is the portion of covered costs for each type of service for which the Member has a financial responsibility. With the exceptions listed under deductibles above, you must first meet your deductible amount before HCG will begin making payment. The amount of co-payment and coinsurance varies by benefit category and benefit plan. Refer to Benefit Plan Summary for co-payment and coinsurance requirements.

First Year Dollar Cap on Medical Benefits

All new Subscribers and Subscriber's Dependents are subject to a first year, twelve (12) months of continuous coverage dollar cap on medical benefits. If there is any lapse or gap in coverage which interrupts the continuous twelve (12) months of coverage, the first year dollar cap on medical benefits resets at zero for another continuous twelve (12) months of coverage.

Lifetime Maximum

The lifetime maximum is the maximum amount that HCG will pay for all covered services combined during a Member's lifetime. Any and all payments accumulated under any and all HCG Benefit Plans are included in the lifetime maximum.

Prior Authorization for Medical Benefits

HCGA and its contracted health plans and provider networks have established processes based upon Medical Necessity to review, approve, modify or deny requests by Providers for prior authorization of the provision of some healthcare services to Members. Decisions to deny or modify requests for preauthorization of services based upon Medical Necessity are made only by licensed Physicians or other appropriately licensed qualified healthcare professionals.

Prior authorization does not guarantee payment. Payment for services also depends on other factors, including but not limited to, the Member's enrollment status on the date services are provided, medical necessity, benefit limitations and any pre-existing condition limitation that may apply. **If a prior authorization is required for a covered service but not obtained for an eligible Member, HCG will not pay for that service even if it is a covered service and medically necessary.** The Member will be financially responsible for the costs associated with services that are not covered or not prior authorized by the HCG Plan.

Prior Authorization can be requested by the Member or the Member's Physician. **It is the Member's ultimate responsibility to ensure that Prior Authorization is obtained prior to receiving any covered services.**

Prior authorization does not guarantee payment. Payment for services also depends on other factors, including but not limited to, enrollment status on the date services are provided, medical necessity, benefit limitations and any pre-existing condition limitation that may apply. The Member will be financially responsible for the costs associated with services that are not covered or prior authorized. The Member can appeal the decision on prior authorization if he or she disagrees with it.

Prior Authorization for Pharmacy Benefits and No Exception from the Formulary

Each HCG Health Plan has an approved drug formulary. Some drugs on the Health Plan formulary may require a prior authorization or step therapy before being approved. Only drugs contained on the Health Plan formulary will be covered. **No exceptions for drugs not on the Health Plan formulary will be made.**

Specialty Care and Prior Authorization of Specialty Services

As an HCG Member, any specialist in the Provider network can be accessed with a referral from the regular Provider. Please refer to Provider Directory for a list of participating specialists. The Provider Directory and the HCG Provider Directory on the Web site are updated frequently but providers can be removed from the directories without notice and the most recent directory may not reflect that change. Please call the office of the specialist and confirm that the specialist remains in the network prior to making an appointment.

If the care of a specialist is required, the HCG Plan must be contacted for an authorization. The HCG Plan may authorize an out-of-network specialist. If an out-of-network specialist is authorized, the Member is only responsible for in-network benefit deductibles, co-payments and coinsurance.

Some specialty services included in the benefit plan require prior authorization before receiving these services. Services requiring prior authorization are identified in this section and include, but are not limited to:

- Inpatient hospital services, non emergency
- Outpatient surgery

- Dental trauma
- Home healthcare
- Durable medical equipment
- Skilled Nursing Facility

Covered Benefits Calculated on a Calendar Year

Covered Benefits are calculated on a calendar year from January 1st through December 31st of every year and may not coincide with an Employer Group's contract renewal date.

Urgent Care

An Urgent Condition is a medical condition requiring prompt medically necessary covered services to prevent serious health deterioration resulting from an unforeseen illness or injury. Urgently Needed Care is care that you get for a sudden illness or injury that needs medical care immediately but is not life threatening. If the Member's regular physician is not available and the condition is not life threatening, an in-network urgent care facility should be utilized. An Urgent Care Facility cannot be used as a replacement for consultation with the PCP if the PCP is available. Referral or prior authorization is not needed for an Urgent Care facility that is in-network.

Examples of conditions appropriate for urgent care include but are not limited to: colds, flu, sore throat, ear infection, sprains.

Emergency Care In-and Out-of-State (Within the United States)

If an Emergency Medical Condition exists, call 9-1-1 or go to the nearest hospital emergency room or other facility for treatment immediately.

Referrals or prior authorization are not needed for emergency care anywhere in the United States. Members can receive emergency care from any hospital in the United States without a referral or prior authorization. If the emergency medical services are received out-of-State, the hospital does not need to be an HCG Provider. Ambulance transport services provided in response to the 911 emergency system are covered if it is reasonably believed that a medical condition requires an emergency ambulance transport service. All emergency care is subject to a review for medical necessity after the care is received.

The HCG plan must be notified within forty-eight (48) hours or as soon as reasonably possible following the receipt of emergency medical services. Following the stabilization of an emergency medical condition, if the Member is admitted to a non-Contracted hospital, the HCG plan reserves the right to transfer the stabilized Member to a Contracted hospital for subsequent medically necessary care. If a stabilized Member refuses to be transferred to a contracted hospital, the member assumes complete financial responsibility for all subsequent care received in that facility. Follow-up medical care must be provided by an HCG Contracted Provider or be prior authorized by the HCG plan.

Coverage by a non-HCG Plan Provider and Member Financial Responsibility

With the exception of emergency treatment, treatment or services received from non-contracted providers are not covered. In the event that the health plan grants an exception for a non-contracted provider to provide covered services out of network, there may be an additional amount for out-of-network services for which the Member may be financially responsible.

If services are received from a non HCG Health Plan provider, the Member may be billed directly by that provider even though the services are received at an in-network facility and the Member was not notified that the Provider was out-of-network prior to receiving the services. The Member should also be aware that some Providers may use out-of-network facilities for services such as pathology and the Member will be financially responsible for the out-of network services. The Member should ask the Provider about any out-of network services prior to having services performed. Non HCG providers may include anesthesiologists, radiologists, pathologists and hospitalists.

No Coverage Outside the United States

Treatment or services of any kind received outside the United States are not covered.

Transition of Care, Coordination of Care

HCGA and your HCG Plan will attempt to identify needs and facilitate coordination of care for Members who are impacted by changes in benefits or transitions between HCG Benefit Plans, changes in Provider networks and/or HCGA contracts. These changes could be caused by such things as a physician contract terminating or a plan being discontinued.

Members who are undergoing an active course of treatment at the time of enrollment for whom changing to a different medical Provider would be likely to cause significant risk or harm to the Member's health, increased overall cost of care or for whom it is not possible to locate a Provider willing to accept the responsibility for continuing care will need to request coordination of care from the Member's HCG Health Plan.

Under certain circumstances, a member may be able to temporarily continue to receive services. The care must be medically necessary and the non-Contracted Provider must agree to the terms and conditions of the continuing treatment. The Transition of Care must be prior authorized.

The Member is entitled to request and may be allowed Transition of Care services including, but not limited to, the following circumstances:

- Pregnancy of greater than twenty (20) weeks gestation through the post-partum follow-up.
- Currently undergoing chemotherapy or radiation therapy for treatment of cancer through the completion of current cycle.
- Members with a terminal illness and anticipated life expectancy of fewer than six (6) months.

Services are subject to the terms of the GSA related to pre-existing condition waiting periods, co-payments, coinsurance and deductibles as well as prior authorization at the time medical care is provided. It is not sufficient to prefer to receive treatment from a prior Physician or other non-Contracted Provider to qualify for transition of care approval; even for a chronic condition.

Upon receipt of a request for Transition of Care, the Member will be sent a written acknowledgement letter including the timeframe for making a decision. The Health Plan will issue a written determination within fourteen (14) days of receiving the request or within seventy-two (72) hours (expedited) if the Health Plan determines that following the fourteen (14) day timeframe would seriously jeopardize the Member's life or health or ability to attain, maintain, or regain function. Notice of the expedited determination will be given verbally within the seventy-two (72) hours and in writing not later than three (3) working days after the receipt of the request.

Transition Of Care Subject To HCG Program Limitations

House Bill 2275 (House of Representatives Forty-eighth Legislature, Second Regular Session, 2008, Senate Engrossed Version) enacted legislation effective September 27, 2008, which prohibited any Healthcare Group Health Benefit Plan from offering or providing any service, benefit or coverage that is not part of the Health Benefit Plan contract. Due to this legislative action as well as any future legislation passed which may affect Healthcare Group coverage, there may be changes in Health Plan options or limits in the geographic areas in which benefits may be offered which are not in the control of the HCGA.

When Healthcare Group is prohibited from offering a Health Plan option or has the geographic area in which benefits are allowed to be offered limited by legislation, Healthcare Group may be unable to offer any transition of care and will be unable to provide any alternative services or benefits to a Member if the prohibited benefits or geographic areas are not included in another Health Plan option in which the Member is eligible to enroll.

Case Management Services

Case Management is a collaborative process that assesses, plans, coordinates, implements and monitors an ongoing course of treatment for a Member to ensure that appropriate care is received in the most appropriate

setting to meet the Member's health and human needs. The Case Manager facilitates and advocates for the Member to obtain the services and resources that allow a cost-effective outcome and often produces alternatives to institutional care with a better patient outcome. Case Management is intended to ensure appropriate utilization of facilities and resources, avoid fragmented services and to provide continuity of services appropriate to the patient's needs over time.

Case Management services may be initiated by the HCG Medical Director, HCG Plan Medical Director, or by a request from the Member or Member's Provider.

Covered Services by Benefit Type and No Exceptions Allowed

The following covered services are described according to the category of services or treatments provided, and are summarized by benefit type. Exclusions, limitations, and/or restrictions may apply. Refer to the Benefit Plan Summary for specific information on co-payments and coinsurance. Unless otherwise noted, the coverage, exclusions and limitations described apply to all Benefit Plans described in this document. This list is a general description of treatment, services and supplies that are covered benefits. Treatment or services of any kind received outside the United States are not covered.

HCGA is prohibited by A.R.S. 36-2912(Q) from providing or offering any service, benefit or coverage that is not part of the health benefit plan contract. If a requested service is not contained in the benefit plan option in which the Member enrolled, HCGA is prohibited by statute to pay for that service regardless of medical necessity or Member's condition. The HCG program does not allow the HCGA to make exceptions to the benefits in the benefit plan options regardless of the circumstances.

Please refer to Section XII for a complete list of Exclusions and Limitations

1. AMBULANCE AND EMERGENCY MEDICAL TRANSPORTATION

Coverage: Medically necessary emergency medical ground or air ambulance services provided by a licensed ground or air ambulance service to a hospital when medical supervision or life support is necessary in transporting a Member. Air transportation is covered only when deemed medically necessary or in the event that ground transportation is unavailable. All ground or air ambulance service is limited to the United States and only transport to and from a hospital within the United States is covered.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

Limitations: Services are subject to a retrospective review for medical necessity. Services determined to be routine and non-emergent in nature will be the Member's financial responsibility.

2. CLINICAL TRIALS

Coverage: Participation in FDA approved clinical trials within the state of Arizona. Participation in clinical trials does not reduce Member benefits or make Members ineligible for medically necessary covered services.

Limitations: Services delivered in the course of participation in a clinical trial are limited to those services that would have been covered as medically necessary and were not required as part of the participation in the clinical trial.

3. COSMETIC AND RECONSTRUCTIVE SURGERY

Coverage: Correction of congenital birth defects and effects of disease, illness, or injury which cause an anatomical functional impairment if surgery is reasonably expected to correct the condition or disease; surgical services for breast reconstruction and symmetrical realignment of unaffected breast and for external prosthetic following a medically necessary mastectomy surgery, regardless of when the mastectomy was performed.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

Limitations: Requires prior authorization. Services are subject to inpatient hospital and outpatient surgery benefits.

4. DENTAL TRAUMA

Coverage: Treatment, repair or replacement of a sound and natural tooth damaged as a result of trauma suffered from an external force while this coverage was in effect.

Limitations: Requires prior authorization. Services must be completed within a 60-day period following the trauma.

5. DIABETES MEDICATION, SERVICES AND SUPPLIES

Coverage: Generic and brand name prescription drugs prescribed by a licensed provider as listed on the HCG Plan's formulary; glucometer and corresponding test strips; urine test strips; lancets; glucagon emergency kit; insulin syringes; external pumps for the administration of insulin – see limitations.

Limitations: Glucometer brands are limited to the approved monitors on the formulary. The number of test strips covered is based on the number of times per day the Member is required to test as specified by the licensed Provider's prescription and consistency with medical standards. **No exceptions will be made to the Health Plan formulary.**

External pumps for the administration of insulin are considered DME and subject to the applicable benefit limit. Only in-network DME providers and equipment claims will be paid.

6. DIALYSIS

Coverage: Dialysis treatment and training in the operation of dialysis equipment, including supplies and maintenance of dialysis equipment used in a Member's home; hospital/dialysis center services for Members with chronic renal disease. Members with chronic hemodialysis needs are required to apply for and enroll in Medicare Part A and B benefits whenever eligible.

Limitations: Requires prior authorization. Members who are covered by Medicare are subject to Medicare limitations. For chronic dialysis, application and enrollment for Medicare Parts A and B coverage must be made. Dialysis is limited to the services not covered by Title XVIII of the Social Security Act, as amended. The fact that the Member is outside the Service Area will not entitle the Member coverage for maintenance of chronic dialysis to travel.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

7. DRUGS

INJECTED AND INFUSED DRUGS IN AN OUTPATIENT SETTING

Coverage: The following types of injected and infused drugs on the Health Plan formulary are covered when dispensed by a licensed pharmacist and administered by a participating Provider in an office or outpatient setting and included in the Plan formulary:

- Antibiotics
- Chemotherapy for the treatment of cancer and medication to support the treatment of cancer
- Epidural, trigger point and peripheral nerve injection for pain management
- Glucagon emergency kit
- Immunizations
- Immunosuppressant drugs for the postoperative management of covered transplant services
- Insulin
- RhoGam

Limitations: The drugs must be included in the Plan formulary. Please refer to the HCG Web site for details on the formulary and tiers. **No exceptions will be made to the health plan formulary.**

Under all benefit plans, if covered medications are injected or infused in a physician's office, the Member is responsible for the physician office visit co-payment plus the lesser of the cost of the covered drug or the

Please refer to Section XII for a complete list of Exclusions and Limitations

associated pharmacy co-payment.

When receiving two or more covered drugs a co-payment must be paid for each.

PRESCRIPTION DRUGS

Coverage: Dispensing of generic and brand name prescription drugs listed on the HCG Plan formulary prescribed by a licensed Provider; glucometer; test strips for glucose monitors; urine testing strips; lancets; contraception medications and devices on the HCG Plan formulary.

Your HCG Plan formulary will determine the type of glucose monitor and number of test strips allowed, determined by the number of times per day the Member is required to test. Only drugs and glucometers on the HCG Plan formulary will be covered.

The formulary is subject to periodic review and change by your HCG Plan. If two or more prescriptions or refills are dispensed at the same time, a co-payment must be paid for each prescription or refill. A retail participating Provider of pharmacy services will only dispense a 31-day supply of prescription drugs unless your HCG Plan approves a greater supply or alternative Provider, such as a mail order prescription program. A higher co-payment or multiple co-payments may be required.

The plan has an approved formulary which can be found on both on the HCG Web site at www.hcgaz.com and the Web site for your HCG Plan. A copy of the formulary will be mailed to a Member upon request. Members are cautioned to call their HCG Plan to ask for coverage and coinsurance for specific drugs since the formulary may change from time to time.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

Limitations: Prescription drug coverage varies by benefit plan. See the Benefit Plan Summary for co-payments, coinsurance and specific benefit information. **Only drugs on the health plan formulary will be covered. No exceptions will be made to the health plan formulary.**

Co-payments and Coinsurance for drugs do not apply to the medical deductible.

8. DURABLE MEDICAL EQUIPMENT (DME)

Coverage: Durable Medical Equipment Coverage benefits are combined with Orthotics and Prosthetics. Check with your HCG Plan to determine if this benefit is available. Durable Medical Equipment (DME) when medically necessary prescribed by a participating physician and prior authorized. Includes, but is not limited to, canes, crutches, walkers, oxygen and standard equipment for the administration of oxygen (does not include CPAP or any sleep disorder equipment), standard manual wheelchairs and manual hospital beds obtained from a participating Provider of DME.

Benefits are available for the rental or purchase of DME prescribed by a participating Provider. Rented DME is not the property of the Member and will be returned to the rental/leasing organization when the DME is no longer necessary. If the DME is in poor condition or damaged, the Member will be responsible for all costs to replace or repair the equipment. Replacement of lost or stolen DME is not covered. HCG retains the right to determine if the DME items are leased or purchased.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

Limitations: Requires prior authorization. Certain DME items may not be deemed medically necessary even though a participating Provider prescribed the DME items. Benefit has an annual dollar limit and the benefits are combined with the annual limit for Orthotics and Prosthetics. Refer to the Benefit Plan Summary for specific benefit information.

9. EMERGENCY MEDICAL SERVICES

Coverage: Services provided after the sudden onset of an emergency medical condition manifesting itself by acute symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the absence of immediate medical attention would result in:

- Placing the patient's health in serious jeopardy, or
- Causing serious impairment to bodily functions, or
- Causing serious dysfunction of any bodily organ or part.

Emergency services are covered anywhere in the United States. If the emergency requires admission to the hospital, the co-payment is waived for that emergency room visit only. If the Member is admitted to an out-of-network hospital, the Member may be transported to a participating network hospital when medically stable.

The Member, Member's representative or Provider must notify the HCG Plan within 48 hours after emergency services are initially provided if possible.

Refer to the Benefit Plan Summary for your Plan for co-payments and coinsurance.

Limitations: Services are subject to a retrospective review for medical necessity. Services determined to be routine and non-emergent in nature will be the Member's financial responsibility.

10. FAMILY PLANNING

Coverage: Medical histories, information on family planning, physical examinations, sex education including prevention of sexually transmitted disease, contraceptive medication and devices on the formulary.

Refer to the Benefit Plan Summary for your plan for co-payment and coinsurance.

11. HOME HEALTHCARE

Coverage: Healthcare visits provided by a participating Provider that is a Medicare-certified Home health agency of the frequency, duration and level prior authorized; routine medical supplies to effectively perform therapy. Services must be limited to intermittent medically necessary care for a short period of time. Disciplines covered include skilled nursing, certified nursing assistant, physical therapy, occupational therapy, respiratory therapy and speech therapy.

A home health visit means every personal contact made by a healthcare worker in the place of the patient's residence made for the purpose of providing a covered service.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

Limitations: Requires prior authorization. Benefit is expressed in visits per calendar year and has a visit limit per calendar year. Each different discipline service is counted as one visit towards the visit maximum. Refer to the Benefit Plan Summary for specific benefit information. Home health services are not covered under all Benefit Plans.

12. HOSPICE CARE

Coverage: Services provided for Members who are diagnosed by a participating Provider with a terminal illness with a life expectancy of six months or less, based on a participating physician's evaluation; palliative and supportive medical and health services through routine home care covered services that are short-term; nursing care provided by a registered nurse or licensed practical nurse; supplementary homemaker and home health aide services. Services must be provided in a Member's place of residence by a participating hospice agency.

Please refer to Section XII for a complete list of Exclusions and Limitations

During periods of crisis, hospice care is covered for a minimum of eight (8) hours per twenty-four (24) hour day (hours do not have to be continuous) if it is predominantly nursing care by a registered nurse or licensed practical nurse that is required. Continuous hospice care is only furnished during periods of brief crisis and only as necessary to allow terminally ill Members to remain in their place of residence.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance. Refer to Group Service Agreement for clarification of the services and requirements for Hospice care.

Limitations: Requires prior authorization. The HCG Health Plan must receive written certification by a participating network physician that a Member has a terminal illness before the delivery of hospice services. The certification is applicable for a sixty (60) day period.

Admission to a hospice unit of a skilled nursing facility or inpatient hospital is covered by the corresponding benefit for that setting. Benefit has a day limit.

13. IMMUNIZATIONS

Coverage: Healthcare Group covers medically necessary immunizations as appropriate for age, history and health risk for adults and children. Immunization coverage policy is based on recommendations issued by the Advisory Committee on Immunization Practices (ACIP) and other nationally recognized organizations. ACIP is comprised of 15 experts in fields associated with immunization who provide advice and guidance to the U.S. Department of Health and Human Services and CDC on the most effective means to prevent vaccine-preventable diseases.

Immunizations must be administered by a participating provider and in accordance with the ACIP-recommended schedule. Covered immunizations include:

- *Chicken Pox Varicella Zoster for children
- Diphtheria-Pertussis-Tetanus (DPT)
- *Diphtheria, Tetanus, Pertussis
- *Hemophilus Influenza Type B(Hib)
- Hepatitis A
- Hepatitis B
- Human Papillomavirus vaccine for 11 and 12 year old females (HPV)
- Influenza
- *Measles, Mumps, Rubella (MMR)
- Meningococcal
- Pneumococcal
- *Polio (IPV)
- RhoGam
- *Rotavirus vaccine for infants and children

* Not subject to Deductible

Immunization coverage policy may be updated at the discretion of Healthcare Group on the basis of new ACIP recommendations.

Limitations: Immunizations listed above must be medically necessary and administered by a participating provider.

14. IMPLANTABLE DEVICES

Coverage: The following implantable devices when a covered benefit and medically necessary and surgically implanted: electronic heart pacemakers, heart valves, defibrillators, intraocular lens, hip and knee replacements; programming and refilling of uncovered or previously implanted devices provided the medication is included on the HCG formulary; removal of uncovered or previously implanted devices when removal becomes medically necessary (e.g., due to infection, scarring, malfunction).

Limitations: Requires prior authorization.

15. INFUSION THERAPY

Home Infusion Therapy

Coverage: Intermittent visits provided by a participating Provider which is a Medicare-certified home health or home infusion agency for the purpose of administering covered medication on the formulary; supplies and equipment to perform home infusion therapy of medications on the formulary under the direction of a participating Provider.

A visit means every personal contact made by a healthcare worker in the place of the patient's residence made for the purpose of providing a covered service.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

Limitations: Requires prior authorization. Benefit has a visit limit. Refer to the Benefit Plan Summary for specific benefit information.

Physician Office Infusion Therapy

Coverage: Administration by injection or infusion of covered medication on the HCG Plan formulary in the physician's office; infusion therapy supplies and equipment.

Limitations: In addition to the co-payment for the physician office visit, the Member is also responsible for the lesser of the cost of the covered medication or the associated pharmacy co-payment for each medication administered subject to any annual dollar limitation on amounts paid by HCG. **Requires Prior Authorization .**

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

Outpatient Freestanding Infusion Therapy Suites

Coverage: Administration by injection or infusion of covered medication on the HCG Health Plan formulary in the infusion therapy office; infusion therapy supplies and equipment.

Limitations: In addition to any co-payment for the therapy visit, the Member is also responsible for the lesser of the cost of the covered medication or the associated pharmacy co-payment for each medication administered subject to any annual dollar limitation on amounts paid by HCG. **Requires Prior Authorization.**

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

16. INPATIENT HOSPITAL SERVICES

Coverage: Semiprivate room and board except when a private room is required by medical necessity; intensive care, coronary care and other special care units; drugs, medicines and biologicals, by any route; transfusion of human red blood cells, plasma and platelets; inhalation therapy; dialysis; special diets; nutritional counseling by a registered dietician employed by the hospital; rehabilitation services; surgery; operating room charges; inpatient physician services including surgery and anesthesiology; laboratory services, x-ray and diagnostic services; oxygen; preparation and securing of blood for autologous transfusions for scheduled procedures; radiation therapy; chemotherapy for treatment of cancer; external (noninvasive) electronic stimulators; implantable devices. (there may be a dollar limit for the implantable device).

Copayment for a hospital admission is not required for a newborn but coinsurance must be paid. The newborn's hospital admission co-payment is included in the mother's hospital admission co-payment for delivery.

Please refer to Section XII for a complete list of Exclusions and Limitations

See the Benefit Plan Summary for your plan for co-payment or coinsurance.

Limitations: Requires **prior authorization**.

17. MAMMOGRAPHY SCREENING

Coverage: Mammography screening and interpretation as follows: One baseline mammogram for women aged 35-39; one mammogram screening every two years for women aged 40-49; one mammogram screening every year for women aged 50 and over. Additional screenings are covered when medically necessary, regardless of age, if approved by the HCG Health Plan Medical Director.

Limitations: Preventive and wellness services under this benefit are limited to the list of HCG approved service codes and must be billed by the primary care Provider with the appropriate diagnostic codes. Primary preventive and wellness services billed incorrectly will be subject to a Member's regular medical benefit and deductible. The list of approved preventive and wellness billing codes is available upon request from HCGA and online at www.hcgaz.com.

18. MATERNITY, PRENATAL AND NEWBORN CARE

Coverage: Diagnosis of pregnancy within the first trimester (three months) by a visit and testing; one visit per month during the first eight months (first 32 weeks) of pregnancy; visits twice a month from the eighth month to the ninth month (32nd week to 36th week) of pregnancy; weekly visits from beginning of ninth month (36th week) to delivery; RhoGam if you have Maternity benefits, postpartum visit up to 60 days post delivery; lab tests and diagnostic procedures including amniocentesis for reasons other than genetic testing; ultrasound when medically necessary; circumcision of newborns; hearing screening for newborns; inpatient admission for delivery and hospital stay of 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section, the HCG Plan Medical Director may make exceptions based upon medical necessity. Subject to exclusions, additional visits may be authorized, if medically necessary and approved by the HCG Plan Medical Director.

A co-payment for a separate hospital admission for a newborn is not required, but coinsurance is required. The newborn's hospital admission co-payment is included in the mother's hospital admission co-payment for delivery. The newborn must be enrolled with HCG within the first thirty-one (31) days of birth and a copy of the certified birth certificate provided within sixty (60) days after the birth of the child.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

Limitations: Circumcision is limited to the first thirty-one (31) days following the birth of the child and must be performed by a licensed practitioner. If the circumcision is not performed in the hospital, it will be paid within the first thirty-one (31) days following the birth as an outpatient procedure. Some benefit plans do not provide maternity coverage.

There may be a first year twelve-month maternity dollar limit. Check the Benefit Summary for the Benefit chosen to determine if there is maternity coverage and to determine if there is a first year, twelve month limit. Circumcision of the newborn is not subject to the maternity dollar limit.

Not all benefit plans include a maternity benefit – check your benefit plan summary.

19. MENTAL HEALTH AND SUBSTANCE ABUSE – INPATIENT

Coverage: No Coverage.

20. MENTAL HEALTH AND SUBSTANCE ABUSE - OUTPATIENT

Coverage: No Coverage.

21. NUTRITIONAL SUPPLEMENTS AND SUPPORT

Temporary Nutritional Support

Coverage: Temporary nutritional support administered by feeding tube into the stomach or small intestine for (thirty) 30 days or less if it is the sole source of nutrition and it is not possible by dietary adjustment and/or nutritional supplements.

Limitations: Not covered beyond thirty (30) days per calendar year for any reason.

Eosinophilic Gastrointestinal Disorder

Pursuant to A.R.S. § 36-2912.03, the prescription drug benefit will cover amino acid-based formulas for eosinophilic gastrointestinal disorder if the Member is diagnosed with an eosinophilic gastrointestinal disorder, under the continuous supervision of a physician and there is a risk of mental or physical impairment without the use of the formula.

Limitations: The formula will be covered up to seventy-five percent of the cost of the formula with a maximum annual benefit not to exceed twenty thousand dollars (\$20,000).

22. ORAL SURGERY

Coverage: Reduction or manipulation of fractures of facial bones; excision of lesions, cysts, tumors of the mandible, mouth, lip or tongue; incision of accessory sinuses, mouth, salivary glands or ducts; reconstruction or repair of the mouth or lips necessary to correct anatomical impairment caused by congenital defect.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

Limitations: Requires prior authorization.

23. ORGAN TRANSPLANT

Coverage: Coverage for kidney and cornea transplants only. No benefits will be provided for more than one organ of the same type for the lifetime of the Member. Transplant services and supplies include the covered recipient's medical, surgical and hospital services in connection with the transplant, including immunosuppressive medications on the formulary, organ procurement and one pre-transplant evaluation.

In order to be covered, the transplant and the transplant-related services and supplies must meet all of the following requirements: The transplant must be medically necessary and appropriate for the Member's medical condition, the transplant (or transplant-related service or supply) must be prior authorized, the transplant must not be experimental, investigational or unproven for the Member's condition, the Member must be the organ or tissue recipient, the Member's plan must include the transplant and the Member must be eligible for the covered service.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver (for cornea and kidney only) or live donor (for kidney only). Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if medically necessary. Immunosuppressant (anti-rejection) drugs are only covered when prescribed as part of the management of kidney transplants and only formulary drugs are covered.

Refer to the Benefit Plan Summary for your Plan for co-payments and coinsurance.

Limitations: Requires prior authorization.

24. ORTHOTICS AND PROSTHETICS

Coverage: Durable Medical Equipment Coverage benefits are combined with Orthotics and Prosthetics. Check with your HCG Plan to determine if these benefits are available. Coverage includes Orthotics and Prosthetics when medically necessary and prior authorized.

Orthotics refers to braces, splints and ankle foot supports utilized:

- for a Member with diabetic foot disease,
- to prevent a significant anatomical deformity, or
- a surgical intervention related to structural development in a child for immediate postoperative management.

Prosthetics refer to artificial limbs including the initial purchase and replacement due to physical growth for a continuously covered Member, obtained from a participating Provider when the artificial limbs are a result of injury or sickness occurring while the Member was enrolled with HCG. Artificial limbs must be adequate to provide a reasonable level of functionality for normal daily activities and not for cosmetic reasons.

Eye Prosthetics are covered due to trauma to the eye, surgical removal of the eye or a congenital defect of the eye when medically necessary. The trauma must have occurred while covered under the Plan.

Refer to the Benefit Plan Summary for your plan for co-payments and coinsurance.

Limitations: Requires prior authorization. Benefit has an annual dollar limit and is combined with the annual dollar limit for DME. Refer to the Benefit Plan Summary for specific benefit information.

25. OUTPATIENT DIAGNOSTIC SERVICES

Refer to the Benefit Plan Summary for your plan for co-payments or coinsurance.

Allergy Testing and Screening Services

Allergy screening and testing are not covered.

Cardiopulmonary Diagnostic Services

Coverage: Cardiology, Respiratory and Pulmonary diagnostic services prior-approved for the outpatient setting.

Genetic Testing

Genetic testing and/or counseling on resultant information from genetic testing is not covered except for determining whether a particular formulary drug prescribed will be effective in treating a Member's condition.

Hearing Examinations

Hearing evaluation, treatment and services, including, but not limited to, hearing aid evaluation, treatment and services are not covered except for diagnosed medical conditions with a prior authorization. Hearing aids are not covered for any reason.

Laboratory Services

Coverage: Laboratory testing and services approved for the outpatient setting.

Medical Imaging Services

Coverage: Medical imaging, including, but not limited to; MRI, PET, and CT scans.

Limitations: Requires prior authorization. For information regarding prior authorization requirements for medical imaging services, contact your HCG Health Plan.

Nuclear Medicine

Coverage: Nuclear medicine services approved for the outpatient setting.

Limitations: Requires prior authorization. For information regarding prior authorization requirements for nuclear medicine services, contact your HCG Plan.

Please refer to Section XII for a complete list of Exclusions and Limitations

Sleep Studies

Sleep disorder diagnostic tests and treatment including sleep studies are **not covered for any reason**. CPAP machine, supplies or other equipment for sleep disorder treatment are not covered.

Vision Examinations

Vision correction therapy or surgery for any cause is not covered.

X-Ray Services

Coverage: Routine x-ray and radiological services approved for the outpatient setting.

Limitations: May require prior authorization. For information regarding prior authorization requirements for medical imaging services, contact your HCG Plan.

26. OUTPATIENT SURGERY

Coverage: Operating and recovery room charges; physician services; services approved for the outpatient setting; medication relating to the covered surgery administered by any route while at the facility; supplies such as dressings applied at the time of discharge from the surgical suite; anesthesia.

The provider may use a facility or provider for services as pathology or anesthesia that is out-of-network without advising the Member. The out-of-network service or facility will not be covered. The Member should ask the Provider prior to the service if any service is out-of-network to determine the Member's liability.

See the Benefit Plan Summary for your Plan for co-payments and coinsurance.

Limitations: Requires **prior authorization**.

27. PHYSICIAN AND SPECIALIST OFFICE VISITS

Coverage: Physical exams, treatment for illness or injury, administrative of covered medications, administration of covered secondary and tertiary preventive immunizations and nutritional counseling provided by a registered dietician employed by the physician's office.

Refer to the Benefit Plan Summary for your Plan for co-payments and coinsurance.

28. PREVENTIVE and WELLNESS CARE

Coverage: Preventive and wellness care is for primary prevention services only, and limited to one annual physical each year with a primary care provider for adults and adolescents; up to six (6) well child visits each year with a primary care provider for children age four (4) and under; medically necessary covered immunizations for primary prevention (a list is available on the HCG Web site); mammography screening; one annual pap smear and interpretation; prostate, colorectal, diabetes, cholesterol and osteoporosis screening subject to age, sex, diagnosis, and service timeframe restrictions.

Exams and screenings by a specialist or to prevent complications of an already diagnosed illness or disease are not covered under the preventive and wellness benefit and are subject to a Member's standard medical benefits and deductible.

Refer to the Benefit Plan Summary for your Plan for co-payments and coinsurance.

Limitations: Preventive and wellness services under this benefit are limited to the list of HCG approved service codes and must be billed by the primary care provider with the appropriate diagnostic codes. Primary preventive and wellness services billed incorrectly will be subject to a Member's regular medical benefit and deductible. The list of approved preventive and wellness billing codes is available upon request from HCGA.

29. REHABILITATION SERVICES

Coverage: Inpatient and outpatient pulmonary rehabilitation, cardiac rehabilitation, physical, speech, and

Please refer to Section XII for a complete list of Exclusions and Limitations

occupational therapy to treat acute conditions when significant improvement can be expected in a predictable period.

Refer to the Benefit Plan Summary for your Plan for co-payments and coinsurance.

Limitations for Outpatient Rehabilitation Only: Requires prior authorization. Benefit is expressed in visits per calendar year. **Benefit has a visit limit.** Each discipline encounter is considered a separate visit. Refer to the Benefit Plan Summary for specific benefit information.

30. SKILLED NURSING FACILITY

Coverage: Admissions to a Skilled Nursing Facility, as determined by your HCG Plan Medical Director, may be utilized when medically necessary. Admissions must be temporary in nature, supported by a participating physician's treatment plan with a realistic goal leading to rehabilitation and increased ability to function.

Refer to the Benefit Plan Summary for your Plan for co-payments and coinsurance.

Limitations: Requires prior authorization. Benefit has a day limit. Refer to the Benefit Plan Summary for specific benefit information.

31. STERILIZATION PROCEDURES

Coverage: Vasectomy and tubal ligation only.

Refer to the Benefit Plan Summary for your Plan for co-payments and coinsurance.

Limitations: Co-payment and/or coinsurance are required and determined by site of care. Refer to the Benefit Plan Summary for specific information.

32. URGENT CARE

Coverage: Medically necessary urgent care services. In the event a Member experiences a non-emergency incident or medical condition that requires prompt medical attention to prevent serious health deterioration, every effort should be made to contact the Member's Primary Care provider for advice and direction.

The physician may direct the Member to an urgent care facility.

Limitations: Subject to co-payments, coinsurance. Refer to the Benefit Plan Summary for specific information.

33. OPTIONAL BENEFITS

Optional dental and vision coverage is available when an Employer enrolls or renews with HCG medical coverage. This optional coverage is separate from the medical coverage and must be purchased separately. The optional coverages cannot be discontinued independently from the Employer's or Member's medical coverage until renewal (open enrollment). An Employee must be enrolled in HCG medical coverage to enroll in dental or vision coverage.

The descriptions of the vision and dental benefit plans are available from HCGA.

SECTION XII. EXCLUSIONS AND LIMITATIONS

Pre-existing Conditions

A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received in any form by a licensed healthcare Provider during the six-month period immediately preceding the Member's enrollment date. For purposes of determining a pre-existing condition and pre-existing condition waiting periods, enrollment date means the individual's effective date of coverage, or, if earlier, the first day of the employee's eligibility waiting period. A

refill of maintenance prescriptions without a face-to-face encounter with a licensed healthcare Provider during the six-month period is not considered a pre-existing condition.

A Member Health History Form is required to be completed as a part of the documentation for enrollment. The Member Health History Form is not used to determine insurability. The information provided is used to identify pre-existing conditions as well as for the disease management and the wellness program.

The Member Health History Form must contain all medical advice, medical procedures or treatments received in any form from a healthcare Provider by each Member and Dependent within the six months prior to HCG enrollment. A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis or treatment was recommended or received in person by a licensed healthcare Provider during the six (6) month period immediately preceding the Member's effective date of coverage under the GSA.

Pre-existing conditions are identified by the Member Health History Form but a HCG Health Plan or HCGA will also request medical records for a Member or Dependent if a claim is submitted for a chronic disease which was not identified on the Health History Form. If there is no Creditable Coverage for the year prior to enrollment, HCG will request medical records for a Member or Dependent if a claim is submitted for a chronic disease, whether or not the chronic disease was identified on the Member Health History Form. If the medical records for the Member or Dependent disclose a chronic condition which was not identified on the Member Health History Form, then the Member or Dependent will receive a letter from HCGA which informs the person what pre-existing condition has been identified on the basis of medical records and that condition will not be covered for the period of the pre-existing waiting period. If the pre-existing condition was not disclosed on the Member Health History Form and a pre-existing condition is later determined to exist based upon a review of the Member's medical records, the Member may owe HCG reimbursement for any claims paid for that pre-existing condition.

The Medical Health History Form contains Section G, "Disclosure Statement and Signature", which requires the applicant to certify that the information provided is true. This section further provides that the application must be **updated** to include any illness or disease that has occurred between the date of the application and the effective date of coverage. The applicant is also put on notice that any misrepresentation or omission, whether intentional or unintentional, regarding the presence of a pre-existing condition may result in the cancellation of coverage and the Member or Dependent will be responsible for the costs incurred for any non-covered services.

Coverage for services related to a pre-existing condition or complications relating to the condition will not begin until twelve (12) consecutive months or, in the case of a late enrollee, eighteen (18) months, have elapsed from the Member's enrollment date. The length of time may be shortened or eliminated by the amount of credit given for periods of prior Creditable Healthcare Coverage. For prior coverage to apply toward this pre-existing condition waiting period, a Member's effective date of coverage with HCG must occur within 63 days (excluding the employer's eligibility waiting period or any other mandatory waiting period) of any prior creditable coverage ending. Any coverage occurring prior to a break in coverage of 63 days or more will not be credited towards the pre-existing waiting period.

Creditable Coverage includes the following:

- a person who had continuous healthcare coverage for a one year period and
- during that year had no breaks in coverage totaling more than 31 days or
- a person whose prior coverage ended within their 63 days of a Member's effective date of coverage with HCG.

Creditable Coverage for an individual may be obtained from any of the following benefit programs:

- A group health plan (insured or self-insured)
- An individual insurance policy

- Medicare
- Medicaid (AHCCCS)
- A public health plan (AHCCCS)
- TRICARE
- A health benefits risk pool
- Peace Corps
- A bona fide association
- Indian Health Services (IHS), or
- Federal Employee Health Benefits Plan (FEHBP)

Exceptions to Pre-Existing Condition Coverage

The following will not be considered pre-existing conditions:

- Newborns enrolled within 31 days of birth or adoption.
- A child placed for adoption with the Subscriber and enrolled within 31 days of placement.
- Pregnancy, family planning, and prescriptions for contraceptive medication or devices
- Refill of maintenance medications without a face to face encounter with a licensed healthcare provider.

Exclusions and Limitations:

Some limitations on certain benefits appear within the specific Covered services section. Expenses for services that exceed the covered service limitations are not covered.

The following apply to all HCG Benefit Plans unless otherwise noted, and are specifically excluded under this Group Service Agreement:

1. Acupuncture and acupressure.
2. Allergy screening and testing; allergy treatment including but not limited to, hyposensitization treatment, allergy shots, allergy serum, needles and syringes.
3. Alternative or complementary medicine, non-traditional, or alternative medical therapies, interventions or procedures not commonly accepted as part of allopathic or osteopathic curriculums; practices including but not limited to, naturopathic and homeopathic medicine, diet therapies, nutritional or lifestyle therapies, aromatherapy; massage therapy, cranial sacral manipulation.
4. Blepharoplasty without visual impairment
5. Blood and stem cell harvesting and transplants, including but not limited to autologous, allogeneic-related and allogeneic-unrelated.
6. Blood products or derivatives (synthetic), including but not limited to artificial or genetic derivatives and coagulation factors.
7. Body piercing and implant (body art) complications.
8. Bone marrow transplants are not covered.
9. Breast augmentation, implant, or reduction.
10. Care for health conditions which are required by State or local law to be treated in a public facility.
11. Charges for preparing medical reports or itemized bills.
12. Charges for services and supplies used in conjunction with a non-covered medication, service or benefit.
13. Childbirth education classes.

14. Chiropractic services for any reason.
15. Circumcisions except for newborns. Circumcision is limited to the first thirty (30) days following the birth of the child and must be performed by a licensed practitioner.
16. Clinical Trials: benefits provided solely as a requirement of the clinical trial; services that would not have been provided had the Member not selected participation in a clinical trial; services not medically necessary or in excess of benefit limits; clinical trials not approved by the FDA.
17. Cochlear implant devices and implants for any reason.
18. Cognitive and vocational therapy services related to improving cognitive functioning (i.e., higher brain function), reinforcing or re-establishing previously learned thought processes, compensatory training, sensory integrative activities, or services related to employability.
19. Comfort items, or services or devices intended for personal comfort or convenience for the Member or Member's caretaker, including but not limited to lodging and meals.
20. Complications from non-covered services.
21. Cosmetic surgery or aesthetic surgery (i.e., surgery performed primarily to enhance or improve appearance) even if such surgery will improve emotional, psychological, or mental condition or function, cosmetic surgery performed to alter an abnormal or normal structure solely to render it more aesthetically pleasing when no significant anatomical functional impairment exists; reconstructive surgery to correct abnormal structure resulting from trauma or disease when restorative function is not expected; services not prior authorized when prior authorization is required.
22. Cranial banding is not covered.
23. Dental services including dental extractions of impactions; routine dental care of teeth, gum or dental structures; services or supplies, including, but not limited to: dental implants, services for overbite, dental x-rays, supplies and appliances (including occlusion splints) and all associated expenses arising out of such dental services including hospitalizations; lost, broken or damaged appliances or dentures; braces or orthodontic appliances, services or supplies.
24. Dental trauma services not completed within a sixty (60) day period following the trauma. Dental trauma must have occurred during the period the Member is covered by the Plan.
25. Diabetes related supplies: Prefilled insulin syringes; alcohol swabs or pads; glucometers not on the HCG Plan formulary; insulin pens; miscellaneous supplies including, but not limited to, batteries, logbooks, adapters, pumps, videotapes, instruction materials and diabetes education classes.
26. Dietary and nutritional supplements, including specialized formulas, or other special foods or diets, medical foods, even if prescribed by a participating Provider. See 21 NUTRITIONAL SUPPLEMENTS AND SUPPORT.
27. Domiciliary care.
28. Drugs or medications that are not on the HCG Plan's formulary, over-the-counter medications and supplies, that do not require a prescription by federal or State law; prescriptions more than one year from date of issue of the prescription; medications that are equivalent (in strength, regardless of form) to an over-the-counter medication; drugs that are experimental or investigational; new FDA approved drugs prior to review by HCG, that have not been incorporated into the HCG Plan formulary; drugs that are not approved by the FDA; replacement of prescription drugs due to loss or theft; prescriptions for pre-existing conditions during the pre-existing condition waiting period; immunosuppressant drugs that are a part of a postoperative management of any non-covered transplant; medical foods except prescription drugs for eosinophilic gastrointestinal disorder subject to limitations, parenteral nutrition; synthetic blood products or derivatives, including but not limited to, artificial or genetic derivatives and coagulation

factors.

29. Durable medical equipment. Gym and exercise equipment; items not provided by a participating Provider of DME; hygienic equipment; more than one DME device designed to provide essentially the same functional assistance; DME repairs, replacements or adjustments required as a result of damage caused by the Member; duplicate services or supplies for any reason; additions or modifications to the home or physical environment including, but not limited to, swimming pools, therapy pools or spas, elevators and similar equipment, wheel chair ramps, lift equipment, or modifications made to accommodate any physical or mental condition; sleep apnea CPAP equipment and supplies.
30. Emergency medical services received outside of the United States and continuous or follow-up treatment after an emergency medical service by a non-contracted provider.
31. Emergency transportation determined to be non-emergency.
32. Environmental medicine, services or supplies associated with clinical ecology including, but not limited to, chemical sensitivities or toxicities from exposure to contaminants, pesticides, and herbicides
33. Erectile and sexual dysfunction diagnostic tests, services, treatment and supplies, including, but not limited to, penile implants, equipment and medications for erectile or sexual dysfunction.
34. Examination, testing and treatment for the purpose of employment, marriage, adoption, insurance application, licensing, judicial or administrative proceedings requirements or orders, medical research, sports or foreign travel.
35. Excluded or limited services which are excluded or limited by other provisions of the GSA or Member Handbook.
36. Experimental, unproven, or investigational services, treatment, devices, pharmacological regimens or drugs not approved by the FDA.
37. Eye examinations for prescriptive lenses, all types of refractive keratoplasties, and any other procedure, surgery, treatment or device for refractive correction, including but not limited to, eyeglasses and contact lenses. Eye Prosthetics are covered due to trauma to the eye, surgical removal of the eye or a congenital defect of the eye when medically necessary. The trauma must have occurred while covered under the Plan.
38. First year medical benefits are subject to a dollar cap for the first twelve (12) months of continuous coverage.
39. Food or nutritional supplements. See "Infant Specialized Formula".
40. Foot care involving trimming of nails, treatment of corns or calluses, flat feet, fallen arches, arch supports and weak feet, except when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg (below the knees)
41. Free services and supplies to the Member. Services and supplies provided free of charge to the Member are not covered.
42. Gender reassignment surgeries, transsexual treatment, treatment of gender dysphoria including gender reassignment surgeries and any related service.
43. Genetic testing and/or counseling on resultant information from genetic testing except for determining whether a particular formulary drug prescribed will be effective in treating a Member's condition.
44. Government healthcare program treatment or treatment provided by a government hospital, clinic or other facility at no charge to the Member, except as required by law.

45. Gratuitous services for items furnished for which charges are not usually made (e.g., sample medications).
46. Growth hormone therapy for any reason.
47. Hearing evaluations, treatment and services including, but not limited to, hearing aid evaluations, except for the purpose of diagnosing a medical condition with prior authorization. Hearing aids are not covered. Hearing screenings for newborns are covered.
48. Heart implants; artificial or mechanical heart devices; elective pacemaker replacements.
49. Heart transplants.
50. Home Healthcare Private duty nursing or private caregivers; custodial, domiciliary, convalescent rest or maintenance care; personal comfort items; home visits for the sole purpose of blood draws associated with laboratory tests; supplies left in the home and/or not used during the home care visit.
51. Hospice care: Curative or life-prolonging procedures or services; funeral arrangements; transportation of remains; financial and legal counseling; custodial, domiciliary, convalescent, rest or maintenance care or supplies; personal comfort items; private duty nursing; inpatient or outpatient respite care for family Members; services provided by a family Member; nutritional supplements; services exceeding benefit limits.
52. Illnesses, injuries, or medical conditions that are covered under Arizona's Workers' Compensation or Occupational Disease Laws.
53. Immunizations for the purpose of for employment, sports, or foreign travel except as provided in the GSA.
54. Immunosuppressant drugs for the postoperative management of non-covered transplants regardless of when the transplant was performed.
55. Implantable devices: Artificial heart implants; artificial or mechanical heart devices; elective pacemaker replacements; penile implants; joint replacements, except for hip and knee; implantable pumps; implantable (invasive) electronic stimulators; programming and refilling of uncovered or previously implanted devices with medication not included on the HCG Plan formulary; replacement or repair of uncovered or previously implanted devices.
56. Implants including, but not limited to, initial placements, removal and replacement of breast implants for non-medical reasons, replacement of breast prosthesis and the prosthesis itself following cosmetic breast augmentation mammoplasty.
57. Inability of HCGA or the HCG Plan to arrange for the provision of services: To the extent that a natural disaster, war, riot, civil insurrection, terrorist act, epidemic or any other emergency or similar event that is not within the control of the HCGA or the HCG Plan results in the facilities, personnel, or financial resources of the HCGA or the HCG Plan being unavailable to arrange for the provision of a basic or supplemental health service in accordance with the GSA, the HCGA or the HCG Plan shall make a good faith effort to arrange for the provision of the service, taking into account the impact of the event. In no event shall the HCGA or the HCG Plan be liable to a Member of Employer for any liabilities, cost, or expenses which may arise from the HCGA or the HCG Plan's facilities, personnel or financial resources being unavailable as a result of a natural disaster, war, riot, civil insurrection, terrorist act, epidemic or any other emergency of similar event that is not within the control of the HCGA or the HCG Plan.
58. Incarcerated, arrested, imprisoned, confined or detained Members' services for injuries or illnesses experienced while incarcerated, under arrest, imprisoned, confined or detained pursuant to federal, State or local law are not covered unless provided or authorized by an HCG Provider or emergency or urgently needed services.

59. Ineligible Dependent's medical and hospital care and costs.
60. Infant specialized formulas or other special foods or diets, medical foods for an infant or a child, even if prescribed by a participating provider except amino-acid based formula for eosinophilic gastrointestinal disorder.
61. Injectible or infusible drugs not listed on the HCG Plan formulary.
62. Infertility services including, but not limited to, infertility testing, in vitro fertilization and all other fertilization treatments including, but not limited to, retrieval, collection, fertilization, preservation, implantation or storage of sperm/eggs; services, embryo transplantation, intrauterine insemination, GIFT procedures, drugs and procedures to improve or achieve fertility (ability to conceive) or to diagnose and treat infertility (inability to conceive), voluntary reduction of multiple embryos.
63. Infusion therapy; see "Home Infusion Therapy" and "Physician Office Infusion Therapy Exclusions".
64. Infusion therapy and supplies for administering medications not on the formulary.
65. Inpatient private rooms, private nurses and other private caregivers, discharge medications or supplies. Discharge medication prescriptions must be filled with the approved pharmacy benefits manager.
66. Inpatient services that can be appropriately delivered in the outpatient/ambulatory setting.
67. Insulin syringes, pre-filled.
68. Joint replacements, except for hip and knee.
69. Keloid removal.
70. Long-term care services, custodial care, and domiciliary care, including but not limited to nursing services and respite care.
71. Massage therapy for any reason.
72. Medical foods for any reason, including but not limited to, metabolic disorders, metabolic formulas, modified low protein foods, and Parenteral Nutrition except for amino-acid based formula for eosinophilic gastrointestinal disorder.
73. Medical records, medical reports and itemized bills.
74. Medically unnecessary services.
75. Mental health services are not covered.
76. Military care by military service, military service disabilities treatable through governmental facilities for injuries received in the line of duty and military service disabilities treatable through governmental facilities if the Member is legally entitled to treatment and the facilities are available.
77. Non-covered benefits and services and the complications of any non-covered benefits and services.
78. Non-contracted provider services unless prior authorized by the HCG Plan except for emergency services.
79. Non-emergency services received by a non-contracted provider.
80. Non-medical ancillary services including, but not limited to, vocational rehabilitation, employment counseling, psychological services, physical therapy for chronic conditions or learning disability, neuropsychiatry and counseling and testing.

81. Nutritional supplements of any kind except for prenatal vitamins for pregnant females and amino acid-based formulas for eosinophilic gastrointestinal disorder if medically necessary and prescribed by a physician if the Member has been diagnosed with eosinophilic gastrointestinal disorder, is under the continuous supervision of a licensed physician and there is a risk of mental or physical impairment without the use of the formula.
82. Nutrition that is possible by dietary adjustment and/or supplements.
83. Obesity; surgical treatment for morbid obesity and services related to this surgery are not covered.
84. Occupational therapy supplies are not covered.
85. Oral surgery services not prior authorized.
86. Organ and tissue transplants except kidney and cornea. No benefits will be provided for more than one organ of the same type.
87. Orthognathic surgery is not covered.
88. Orthotics: Repairs, replacements or adjustments to artificial limb(s) required as a result of damage caused by the Member; duplicate artificial limbs or services for any reason.
89. Osteopathic manipulation therapy for any reason.
90. Outpatient personal comfort items, services not prior authorized services at non-contracted facilities, discharge medications or supplies. Discharge medication prescriptions must be filled with an approved pharmacy benefit manager.
91. Over-the-counter items, medications, and medical supplies including but not limited to dressings, tape, ace bandages, catheters, colostomy supplies, and alcohol swabs or pads, even if prescribed by a licensed medical professional.
92. Parenteral Nutritional not temporary in nature.
93. Penile implants. Erectile and sexual dysfunction diagnostic tests, services, treatment and supplies including, but not limited to, penile implants, equipment and medications for erectile or sexual dysfunction.
94. Physical therapy for the purpose of maintaining physical condition and maintenance therapy for a chronic condition.
95. Physician Office Infusion Therapy for the infusion and supplies for medications not on the HCG Plan formulary except for the treatment of cancer, synthetic blood products or derivatives including, but not limited to, artificial/genetic derivatives and coagulation factors.
96. Plastic Surgery. See Cosmetic Surgery.
97. Podiatry - Foot care involving trimming of nails, treatment of corns or calluses, flat feet, fallen arches, arch supports and weak feet, except when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg (below the knees).
98. Pregnancy termination, except when required by law to be covered.
99. Prenatal and all associated services for delivery for a surrogate mother or other parties to a surrogate agreement or arrangement.
100. Prescriptions more than one year from date-of-issue of the prescription; prescriptions for pre-existing conditions during the pre-existing exclusion period; replacement of prescription drugs due to loss or theft.
101. Private rooms, or private duty nurses or private caregivers, unless medically necessary and prior

- authorized.
102. Prosthetics: Repairs, replacements or adjustments to artificial limb(s) required as a result of damage caused by the Member; duplicate artificial limbs or services for any reason.
 103. Reconstructive surgery to correct abnormal structure resulting from trauma or disease when restorative function is not expected. Also see Cosmetic Surgery.
 104. Rehabilitation hospital or facility admission unless prior authorized.
 105. Rehabilitation therapy that is not medically necessary. See also “Physical therapy”, “Speech therapy”, “Occupational therapy”.
 106. Rhinoplasty.
 107. Sclerotherapy.
 108. Self Treatment or treatment of immediate family member. Services or supplies provided by a person who usually resides in the home or who is a member of your family; this includes your spouse, natural or adopted children, brothers, sisters and parents.
 109. Services and/or any expenses related to a medical evaluation for a non-covered service or benefit.
 110. Services for injuries incurred as a result of participating in a riot; committing, or attempting to commit a felony or assault; suicide attempt; intentionally self-inflicted injuries; intentional drug overdose; injuries incurred while under the influence of illegal drugs, alcohol, or while in police custody.
 111. Services which require prior authorization that have not been prior authorized.
 112. Services related to prenatal care, birth and delivery for a surrogate mother, regardless if the Member is the surrogate mother or one the parties to a surrogate arrangement.
 113. Services not covered in the Member’s choice of HCG benefit options; services that exceed the benefit limit.
 114. Services, treatment and/or care of any kind, including emergency, received while outside of the United States.
 115. Sexual dysfunction and erectile diagnostic tests, services, treatment and supplies including, but not limited to, penile implants, equipment and medications for erectile or sexual dysfunction.
 116. Skin lesion removal where no functional impairment or suspicion of malignancy exists unless located in areas of high friction.
 117. Sleep disorder diagnostic tests and treatment including sleep studies for any reason including, but not limited to, CPAP machine and equipment, supplies and related non-medication treatments.
 118. Smoking cessation drugs, supplies and treatment of nicotine addiction.
 119. Speech therapy for purposes other than the restoration of speech due to an illness or corrections of speech deficits related to an accident or surgical procedure, speech therapy provided by private or public schools or any government agency.
 120. Sterilization reversal for a voluntarily induced sterilization.
 121. Substance abuse treatment.
 122. Synthetic blood products and derivatives, including artificial/genetic derivatives and coagulation factors, including but not limited to, any costs for the administration of uncovered benefits, supplies or services even if billed separately.

123. Tattooing complications, including tattoo removal.
124. Temporomandibular joint (TMJ) dysfunction diagnosis and treatment, including, but not limited to, any related service or device.
125. Third Party Liability: Charges for services, treatment and diagnosis for conditions that result from an injury or accident for which there is coverage under another insurance policy or payer.
126. Transplant services and expenses related to a medical evaluation for a non-covered transplant or non-covered service.
127. Transportation services except for emergency ambulance services.
128. Treatment for a health condition for which a State or local law requires the Member to be treated in a public facility.
129. Uncovered dependents.
130. Urgent care services determined to be routine and non-urgent in nature.
131. Vein ablation unless Medically Necessary.
132. Veterans Administration Services. Except for emergency medical services, services provided in a Veterans Administration facility are not covered except as required by law.
133. Vision correction therapy or surgery for any cause or reason except for diagnosed medical conditions with prior authorization.
134. Vitamins and/or minerals taken orally, even if they are required to maintain weight or strength, except prenatal vitamins when prescribed for pregnant females.
135. Weight loss or weight gain products and services including but not limited to drugs, vitamins, minerals, food supplements, nutritional counseling. Weight loss programs including, but not limited to, drug programs, specially processed or treated medical foods. Weight loss surgery, including, but not limited to, gastric stapling or diversion and gastric bypass surgery.

SECTION XIII. DEFINITIONS

“Action”: A decision that denies or limits authorization of a requested service, including the type or level of service; reduces, suspends or terminates a previously authorized service; denies, in whole or in part, payment for a service. It also means the failure to provide a service in a timely manner as set forth in contract, or the failure to act within the time frames specified in the grievance and appeal rules.

“Accredited Educational Institution”: certified as acceptable by one of the six nationally-recognized accrediting organizations in the country.

“Administrative Fee”: means a fee charged to the Employer Group in addition to the premium payment when a premium payment is not made by the due date on the billing statement.

“Adverse Action”: A decision by HCGA that applies to eligibility determination, and to the imposition of, or increase in, a premium, co-payment or coinsurance.

“AHCCCS”: means the Arizona Healthcare Cost Containment System, which provides health services to an eligible Member through the Administration, contractors, and other arrangements.

“Allowable Expense”: The maximum reimbursement allowed for medical treatment and services that are medically necessary and covered under the terms of this Group Service Agreement.

“Alternative Medicine”: means practices not generally recognized by the medical community as standard or conventional medical approaches and used instead of standard treatments.

“Anniversary Date”: The same day and month of the initial effective date of coverage as stipulated on the signature page of the original GSA, commencing with the effective date of the issued GSA and ending at 11:59p.m. of the last day of the 12-month period.

“Appeal”: A request for review of an Action.

“Autologous transfusion”: means blood and blood components collected from an individual and intended solely for subsequent autologous transfusion or other human application to that same individual.

“Balance Billing”: means when a Provider bills a Member for any remaining balance for charges after HCG or an HCG Plan makes a payment to the Provider.

“Benefit Exception”: means an exception to a covered benefit determination by the HCG Medical Director that determines a service should be provided even though it is not a covered benefit under the Member’s plan, is subject to a pre-existing condition waiting period, is benefit exclusion or an exhausted benefit due to benefit limitations.

“Benefit Plan Summary”: is a grid containing information about the Plan that you selected.

“Biologicals”: means vaccines, cultures and other preparations made from living organisms and their products, intended for use in diagnosing, immunizing, or treating humans or animals, or in related research.

“Blood Products or Derivatives”: Man-made and synthetic blood derivatives that are available and approved for medical use.

“Business”: means employment, occupation, profession or commercial activity engaged in for gain or livelihood.

“Calendar Year Deductible”: means an annual Deductible that runs concurrent with a calendar year and resets to zero on January 1st of every year.

“Case Management”: means assessment of a person's care needs and followed by appropriate recommendations for care, monitoring and follow-up as applies to extent and quality of services to be provided.

“Certificate of Creditable Coverage”: A written verification of prior coverage from any qualified health plan that includes specific dates of enrollment.

“Chronic Condition”: means persistent or recurring condition

“Claim Determination Period”: means any part of a calendar year during which there was coverage under the GSA

“Clerical Error”: means a verbal, written or typographical error made inadvertently.

“Closed Formulary”: means a closed formulary is a provision in a pharmacy payment plan that pays only for drugs listed on a preferred list will be covered by the plan.

“COBRA Continuation Coverage”: means coverage, under a group health plan that satisfies an applicable COBRA continuation provision.

“Cochlear implant”: an implantable cochlear device for bilateral, profoundly hearing-impaired individuals who are not benefited from conventional amplification (hearing aids).

“Coinsurance”: means a predetermined percentage of the cost of a covered service as specified in the GSA that a Member must pay for the provision of that service.

“Consolidated Omnibus Budget Reconciliation Act of 1975 (COBRA)”: Title X of the Consolidated Omnibus Reconciliation Act of 1986 as amended.

“Continuity of Care”: means the co-ordination of care received by a patient over time and across multiple health-care providers.

“Contracted hospital”: means a hospital under contract to provide in-patient services to HCG members.

“Contracted Provider”: means a doctor, hospital or other healthcare provider who has entered into an agreement with Healthcare Group HCG Plan to provide healthcare services to members for a negotiated rate of reimbursement

“Contractor”: means a person or entity that has a contract with the administration pursuant to section 36-2904 to provide healthcare to Members or through subcontracts with Providers.

“Co-payment”: also co-pay means a fixed-dollar amount that a Member is required to pay directly to a Provider at the time the services are rendered in order to receive the services.

“Coverage Month”: the month for which a premium is paid for covered services.

“Covered services”: means the health and medical services described in AAC R9-27-201, the GSA and the Member Handbook.

“Creditable Coverage”: means coverage solely for an individual, other than limited benefits coverage, under any of the following:

- (a) An employee welfare benefit plan that provides medical care to employees or the employees' Dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.
- (b) A church plan as defined in the employee retirement income security act of 1974.
- (c) A health benefits plan, as defined in section 20-2301, issued by a health plan.
- (d) Part A or part B of title XVIII of the social security act.
- (e) Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.
- (f) Title 10, chapter 55 of the United States Code.
- (g) A medical care program of the Indian health service or of a tribal organization.
- (h) A health benefits risk pool operated by any State of the United States.
- (i) A health plan offered pursuant to title 5, chapter 89 of the United States Code.
- (j) A public health plan as defined by federal law.
- (k) A health benefit plan pursuant to section 5(e) of the Peace Corps Act (22 United States Code section 2504(e)).
- (l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a healthcare services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).
- (m) A policy or contract issued by a healthcare insurer or the administration to a Member of a bona fide association

Calculation: A credit of one month given for each month of creditable coverage a person had under any qualified health plan if, after the period of coverage and before the effective date of coverage with HCG, there was not more than 63 consecutive days in which the person was uninsured.

“Custodial Care”: Provision of room and board nursing care, personal care designated to assist an individual in activities of daily living or other such care with respect to an individual who in the opinion of the health plan has reached the maximum level of recovery. Custodial care also includes respite care and home care, which is or can be performed by family Members.

“Custodial Parent”: means the parent with custody; the legal term referring to the right of the person to make decisions about the care and welfare of a child, such as education, healthcare and religious training.

“Day”: A calendar day unless otherwise specified.

“Decree”: means the declaration of the court announcing the legal consequences of the facts found. The term “judgment” has generally replaced the term “decree”.

“Deductible”: means the annual fixed-dollar amount of covered expenses that the Member must pay before the HCG Plan starts to pay for covered services, subject to the co-payment and coinsurance.

“Dependent”: Means the eligible child and spouse of a Subscriber.

“Dependent student verification notices”: means a HCGA form that is sent to the parent of a Dependent to verify the information that the Dependent is a full-time student in regular attendance at an accredited school, college or university in order to determine that the Dependent remains eligible to participate in the HCG program beyond the age of nineteen (19).

“Disability”: means permanently and continuously disabled and incapable of self-support by reason of mental incapacity or physical handicap.

“Disabled Dependent”: A Subscriber’s Dependent who has attained 19 years of age and is permanently and continuously incapable of self-sustaining support by reason of mental incapacity, retardation or physical handicap incurred prior to age 19.

“Durable Medical Equipment (DME)”: means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness or injury.

“Effective date of coverage”: means the date on which a subscriber or dependent can receive HCG coverage.

“Eligibility Application”: The forms and any other information or documentation requested by HCGA to verify an employer’s, employee’s, spouse’s or Dependent’s eligibility for enrollment.

“Eligibility Waiting Period”: The period determined by the Employer that an employee must wait before the employee is eligible to enroll in HCG.

“Eligible Employee”: A person who works for an Employer for a minimum of 20 hours per week or who is self-employed for at least 20 hours per week and who meets the eligibility requirements of the Group Service Agreement.

“Emergency Ambulance Services”: means transportation by a ground or an air ambulance company for a Member requiring emergency medical services in which the emergency medical services are provided by a person certified or licensed by a State to provide the services before, during or after the Member is transported by a ground or an air ambulance company.

“Emergency Medical Condition” has the same meaning prescribed in the Emergency Medical Treatment and Labor Act (P.L. 99-272; 100 Stat. 164; 42 United States Code Section 1395dd(e).

The term “emergency medical condition” means—

- (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
 - (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - (ii) serious impairment to bodily functions, or
 - (iii) serious dysfunction of any bodily organ or part; or
- (B) with respect to a pregnant woman who is having contractions—
 - (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

“Emergency Medical Services”: means covered medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, may reasonably expect the absence of immediate medical attention to result in:

- Placing the patient’s health in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ.

“Employee”: means a person employed by an employer, a person who is self-employed, or a person who is eligible for a federal health coverage tax credit under 26 U.S.C. 35. A self-employed person shall meet the criteria specified in R9-27-301. An Employee is an individual who works for wages and is paid wages two or more days in each month not more than 16 days apart as fixed paydays.

“Employer Group”: means all eligible enrolled subscribers and eligible enrolled dependents who receive HCG coverage through a contract with the Employer.

“Employer”: means a business within this State that employs at least one but not more than 50 eligible full-time employees on the effective date of the first GSA with an HCG Plan, or an eligible political subdivision of this State. An Employer includes a person who is self-employed.

“End Stage Renal Disease (ESRD)”: means severe kidney dysfunction reached when kidney function is reduced to 10 percent or less of normal function. End-stage renal disease (ESRD) is an administrative term in the United States, based on the conditions for payment for healthcare by the Medicare ESRD Program, specifically the level of GFR and the occurrence of signs and symptoms of kidney failure necessitating initiation of treatment by replacement therapy. ESRD includes patients treated by dialysis or transplantation, irrespective of the level of GFR.

“Enrollment”: means the process in which an eligible employee and any eligible Dependents, are qualified to receive HCG covered services by selecting HCG coverage by completing and submitting all necessary and required documentation specified by HCGA under R9-27-302, provided that HCGA receives the full required premium for the entire Employer Group no later than the due date specified in the Employer Group GSA.

“Evidence of Coverage or Member Handbook”: means the written description that HCGA provides to each Subscriber on enrollment, of the rights and responsibilities of Members, list of covered services, limitations, exclusions, coinsurance, co-payments and deductibles that apply to the Member's choice of coverage.

“Excess Benefit”: means a payment over the maximum amount that the insurance company will allow for the services provided under the medical plan.

“Exclusions”: means services which are not covered in the Member’s choice of Benefit options.

“Experimental Services”: means services that are associated with treatment or diagnostic evaluation that are not generally and widely accepted as a standard of care in the United States unless:
The weight of evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or In the absence of such articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of the opinions from specialists who provide the service attests to the safety and effectiveness of the service.

“Federal Employee Health Benefits Plan (FEHBP)”: means the federal program that provides health insurance to federal employees, retirees and their survivors.

“First Year Dollar Cap” on medical benefits which all new Members are subject to for the first twelve (12) months of continuous coverage

“Formulary”: means approved pharmaceutical drugs and glucose monitors to be prescribed to Members when medically necessary. A preferred list of drugs selected to meet patient needs, which is reviewed and updated on a regular basis by medical and pharmacy professionals.

“Fraud”: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

“Full-Time Employee”: An employee who works at least 20 hours per week for an enrolled employer.

“Full-time student”: means a Member’s Dependent who attends an accredited school, college or university twelve (12) semester hours or more on a regular and continuous basis.

“Gap in coverage” means a period for which all coverage is terminated and no covered benefits are available to Members; usually used when describing an uninsured period between two insured periods.

“Gender Rule”: means a rule that coordinates benefits and provides that the male’s plan pays primary benefits on the eligible Dependent before a female’s plan.

“Genetic Test”: Any test that analyzes human DNA, RNA, chromosomes, proteins, or certain metabolites in order to detect alterations related to a heritable disorder.

“Genetic information”: means information about genes, gene products and inherited characteristics that may derive from the individual or a family Member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

“Grievance”: An expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the enrollee’s rights.

“Group Enrollment/Change Form”: means the form required by HCGA to be completed and submitted to enroll a new Employee, change an address or contact person, change a business name, county or tax identification number, terminate or re-apply for group coverage.

“Group Service Agreement (GSA)”: means a contract between an Employer Group and HCGA or between HCGA and a person eligible for the federal health coverage tax credit.

“HCG” means Healthcare Group of Arizona, the program within the Administration authorized by ARS § 36-29-12 that allows HCG Plans to provide prepaid healthcare coverage to Subscribers of small businesses and political subdivisions within the State of Arizona through contracts with HCGA.

“HCGA”: means Healthcare Group of Arizona Administration which directs, determines eligibility and regulates the continuous development and operation of the HCG program.

“HCG Benefit Plan”: means the scope of healthcare and prescription benefit coverage that an Employer or Subscriber selects on enrollment or renewal.

“HCG Benefit Plan Summary”: grid containing information about the Plan that you selected. The Benefit Plan Summary provides the Deductible Options, Out-of-Pocket Maximums after the Deductibles, Out-of – Network Benefits, Lifetime Maximum, Co-payments and Coinsurance for Primary and Preventive Care, Hospitalization, Outpatient Care, Reproductive Care, Support and Ancillary Care, Mental Health and Substance Abuse Care and Prescription Drugs.

“HCG Plan”: means a health plan offered by HCGA or by an entity under contract with HCGA that establishes networks, manages the provision of covered services, arranges for and pays for HCG covered services through subcontracts with providers.

“Healthcare Group Administration (HCGA)”: means the section within AHCCCS that directs, determines eligibility, and regulates the continuous development and operation of the HCG program.

“Healthcare Group Medical Director”: A physician who is designated by HCG to have overall administrative authority to determine medical necessity.

“Healthcare Group of Arizona (HCG)”: The registered name of the Healthcare Group Program, a medical coverage product marketed by HCGA to small uninsured businesses and political subdivisions within the State.

“Health Coverage Tax Credit Program (HCTC)”: means the federal tax credit that pays sixty-five percent (65%) of qualified health plan premiums for eligible trade-impacted workers and certain Pension Benefit Guaranty Corporation (PBG) benefit recipients.

“Home Health Agency”: An organization duly licensed and certified or otherwise authorized pursuant to the laws of the State of Arizona and is Medicare certified as a home healthcare agency and is approved for the delivery of intermittent skilled nursing care in the home of a Member.

“Hospice Services”: Palliative and support services provided to terminally ill Members and their families and/or caregivers through a facility or organization, or a subdivision of that facility/organization licensed by the State of Arizona and Medicare certified as a hospice.

“Hospital”: means a healthcare institution licensed as a hospital by the ADHS under A.R.S. Title 36, Chapter 4, Article 2, and certified as a Provider under Title XVIII of the Social Security Act, as amended, or is determined by AHCCCS to meet the requirements for certification under Title XVIII of the Social Security Act, as amended.

“Implantable Device”: Any object that is partially or totally introduced into the human body and is intended to remain after insertion.

“Incapacitated”: Incapable of communication, physically or intellectually. Arizona Revised Statute 14-5101(1) defines an incapacitated person as any person who is impaired by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, chronic use of drugs, chronic intoxication or other cause, except minority, to the extent that he lacks the sufficient understanding or capacity to communicate responsibility decisions concerning his person.

“Individually identifiable health information”: means all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper or

oral. The Privacy Rule of HIPAA calls this information “protected health information”. This information includes demographic data that relates to: the individual’s past, present or future physical or mental health or condition, the provision of healthcare to the individual or the past, present or future payment for the provision of healthcare to the individual—and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g. name, address, birth date, Social Security number)

“Infusion”: The intravenous administration of prescribed medication. Infusion therapy involves medicines and fluids given through a catheter into your bloodstream. Therapies commonly used include antibiotics, chemotherapy drugs, pain medicines, and nutrients.

“Injectible”: A physician prescribed medication that is administered by injection into a vessel, tissue or cavity of the human body. This includes but is not limited to intramuscular, intradermal, subcutaneous, epidural, intrathecal and intravascular routes of administration.

“Injectible Drug”: A method of putting medication into the body with a syringe and a hollow needle, which is pierced through the skin long enough for the medication to be placed into a blood vessel, tissue, or cavity of the body.

“Inpatient Admission”: means an admission into a hospital upon written orders of a licensed physician that results in a claim containing billing codes for an inpatient admission.

“Intermittent”: Periodic, but not more than four hours per day in duration.

“Judgment”: means the final decision of the court resolving the dispute and determining the rights and obligations of the parties.

“Lapse of Coverage” means the termination of an insurance policy due to non payment of premium.

“Late Enrollee”: A Member who enrolls 31 days after the effective date of the Employer's initial GSA or 31 days after a qualifying event or outside of the open enrollment period.

“Lifetime Dollar Maximum”: means the maximum amount of benefits your policy will pay for covered expenses over the course of your lifetime while covered by the Plan.

“Limitations”: means specific circumstances or services listed in the contract for which benefits will be limited.

“Limited data set”: means protected health information that excludes the following direct identifiers of the individual or of relatives, employers, or household Members of the individual:

- (i) Names,
- (ii) Postal address information, other than town or city, State, and zip code,
- (iii) Telephone numbers,
- (iv) Fax numbers,
- (v) Electronic mail addresses,
- (vi) Social security numbers,
- (vii) Medical record numbers,
- (viii) Health plan beneficiary numbers,
- (ix) Account numbers,
- (x) Certificate/license numbers,
- (xi) Vehicle identifiers and serial numbers, including license plate numbers,
- (xii) Device identifiers and serial numbers,
- (xiii) Web Universal Resource Locators (URLs),
- (xiv) Internet Protocol (IP) address numbers,
- (xv) Biometric identifiers, including finger and voice prints, and
- (xvi) Full face photographic images and any comparable images.

“Maternity”: Any condition that is pregnancy related. Maternity care includes but is not limited to prenatal and postnatal care, labor and delivery, postpartum care, treatment for the complications of pregnancy, such as ectopic pregnancy or spontaneous abortion (miscarriage).

“Medically Necessary or Medical Necessity”: Services determined by a physician or other licensed medical practitioner necessary to prevent death, treat/cure disease, and ameliorate disabilities or other adverse health conditions; and/or prolong life.

“Medicare”: Title XVIII of the Social Security Act, as amended.

“Member”: means a Subscriber, and the Subscriber’s Dependents who are enrolled with an HCG Plan for healthcare coverage.

“Member Handbook and Evidence of Coverage or ‘Member Handbook’ ”: means the written description that HCGA provides to each Subscriber on enrollment, of the rights and responsibilities of Members, list of covered services, limitations, exclusions, coinsurance, co-payments and deductibles that apply to the Member's choice of coverage.

“Member Health History Form”: means the form required by HCGA from each Subscriber on his/her behalf and each of his/her Dependents when applying to become a Member of HCGA. The statement of health shall contain all medical procedures and treatments received by each person within the six months prior to HCG enrollment.

“Misrepresentation”: means an untrue statement of fact; a statement made to deceive or mislead.

“Network” means the affiliation of physicians, hospitals and other providers that provide healthcare services to members through contracts with HCGA or HCG Plans.

“Network Providers”: means the Providers who have subcontracts with HCG Plans in which Members are enrolled.

“Newborn”: means the period from birth to thirty (30) days of age.

“New Employer Group” means an Employer Group business which has never previously been enrolled in Healthcare Group of Arizona.

“Non-Contracted Provider”: means a Provider who is not contracted or sub-contracted with a HCG Plan, an HCGA Contractor or HCGA.

“Non-Duplication Provision”: means when a plan of insurance is secondary and provides benefits in accordance with all of its provisions to the extent that benefits are not provided by any other valid and collectible insurance. This is meant to avoid paying more than the full amount of the claim.

“Notice”: means a written notification that is mailed through the United States Postal Service, postage prepaid, addressed to the last known address furnished to HCGA by the Employer or Subscriber, or as otherwise set forth in the GSA.

“Notice of Termination of Coverage”: means a written notice from HCGA to an Employer or Member that confirms and notifies the individual that HCG coverage has been terminated.

“Nutritional Supplement”: means a product that is taken by mouth as a pill, capsule, tablet or liquid intended to supplement the diet and contains one or more vitamins, minerals, herbs or other botanicals, amino acids, substances supplementing the diet by increasing the daily dietary intake, or a concentrate, constituent, metabolite, extract, or combination of these, that is not represented as a food or as constituting a meal or the sole item of the diet.

“Nutritional Support”: means a medically prescribed item administered enterally as the sole source of nutrition.

“Open Enrollment”: The period each year when eligible employees, their spouses and Dependents may enroll in HCG, make changes to existing coverage, enroll in a different benefit plan, or change HCG Plans or Provider networks.

“Order of Benefit Determination Rules”: see “Coordination of Benefits”.

“Order”: means direction of the court or judge made or entered in writing.

“Orthotics”: A custom fabricated brace or support that is designed based on medical necessity for the support, correction, or alleviation of neuromuscular or musculoskeletal dysfunction, disease, injury or deformity. Mechanical appliances for orthopedic use concerning preventing or correcting musculoskeletal disorders involving joints, muscles, ligaments, and cartilage. Orthotics refer to braces, splints and ankle foot supports utilized to prevent a significant anatomical deformity or a surgical intervention related to structural development in a child for immediate postoperative management.

“Out-of-Network Provider”: A Provider that is not contracted with the HCG Plan, HCGA contractor or HCGA to provide covered services to HCG Members.

“Outpatient Services”: Medically necessary covered services that may be provided in a clinic, emergency room, hospital or non-hospital surgical facility without admission to the hospital or facility.

“Partial Hospitalization”: means a treatment program that is freestanding or hospital-based that provides services for at least 20 hours a week.

“Participating Provider”: Any Provider or entity, including but not limited to, hospitals, urgent care facilities, physicians, pharmacies, and other health professionals or suppliers of healthcare that have entered into a contract to provide services that are covered benefits under the GSA.

“Pended Coverage” means coverage is suspended awaiting receipt of the required premium in order to allow coverage to be reinstated without a gap in coverage.

“Pension Benefit Guaranty Corporation (PBGC)”: means a federal agency created by the Employee Retirement Income Security Act of 1974 to encourage the continuation and maintenance of private-sector defined benefit pension plans, provide timely and uninterrupted payment of pension benefits, and keep pension insurance premiums at a minimum. Defined benefit pension plans promise to pay a specified monthly benefit at retirement, commonly based on salary and years on the job.

“Personal Comfort Items”: Items, services or supplies not for the specific treatment of a Member’s illness or injury.

“Pharmacy Benefit Manager” (PBM): A company under contract with HCG Plans, self-insured companies, and government programs to manage pharmacy network management, drug utilization review, outcomes management, and disease management. A pharmacy benefit manager may, for example, fill drug prescriptions by mail order as part of a corporate health insurance plan.

“Physician”: means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

“Place of Residence”: means the place a Member resides other than a facility that is licensed to provide skilled nursing care. Place of residence includes a private home, apartment or group home.

“Political Subdivision”: means the state of Arizona or a county, city, town, or school district within the state, or an entity whose employees are eligible for hospitalization and medical care under A.R.S. Title 38, Chapter 4, Article 4.

“Post Stabilization Services” means covered services related to an emergency medical condition provided after the condition is stabilized.

“Pre-Existing Condition”: A condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefit plan issued by a contractor. Pre-existing condition does not include a genetic condition in the absence of a diagnosis of the condition related to the genetic information. A refill of maintenance prescriptions without a face to face encounter with a licensed healthcare Provider during the six (6) month period prior to HCG coverage is not considered a pre-existing condition.

“Pre-Existing Condition Waiting Period”: The length of time a Member must wait for services to be covered under the GSA for conditions for which the Member sought medical advice or treatment, face to face from a licensed healthcare Provider, in the six months prior to HCG coverage, and did not have creditable coverage sufficient to eliminate the waiting period.

“Premium”: means the entire monthly pre-payment amount due to HCGA by the employer for coverage of medical benefits for all Subscribers and Dependents.

“Pre-payment” means the monthly submission by the employer or any eligible employee of the full premium payment in advance of coverage under the GSA.

“Prescription Drugs”: Those pharmaceutical substances approved by the Food and Drug Administration (FDA) and required under federal or State law to be dispensed by a prescription order, and prescribed by a professional licensed to prescribe drugs by the State.

“Preventive and Wellness Care”: means routine physical examinations, diagnostics and immunizations performed for prevention and early detection. Primary diagnostic screening and immunization services in the absence of a diagnosed disease or illness. Services to prevent complications of a diagnosed illness or disease, or to prevent an illness or disease from progressing is not considered preventive and wellness care.

“Primary Care Provider (PCP)”: A physician who specializes in family practice, general medicine, pediatrics, internal medicine or obstetrics/gynecology (if plan allows this) and is responsible for managing and coordinating our Members healthcare.

“Primary Plan”: means when the patient is insured by two plans, the plan that is billed first is the primary plan.

“Primary legal residence”: means the home or address where the Member actually lives the majority of the time. A residence will no longer be considered a primary residence if the Member moves without intent to return.

“Prior authorization”: The process by which authorization is made in advance of the delivery of a covered service. **Prior authorization is not a guarantee of payment.**

“Prosthetic”: The replacement of a missing body part by an artificial substitute, such as an artificial limb, or an artificial part such as a hip joint or device to augment performance of a natural function. Prosthetics refer to artificial limbs – including the initial purchase and replacements due to physical growth for a continuously covered Member, obtained from a participating Provider when the artificial limbs are a result of injury or sickness occurring while the Member was enrolled with HCG.

“Protected Health Information (PHI)”: means any information, whether oral or recorded in any form or medium, that--(A) is created or received by a healthcare Provider, HCG Plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and "(B) relates to the past, present, or

future physical or mental health or condition of an individual, the provision of healthcare to an individual, or the past, present, or future payment for the provision of healthcare to an individual.

The term 'individually identifiable health information' means any information, including demographic information collected from an individual, that—

- (A) is created or received by a healthcare Provider, health plan, employer, or healthcare clearinghouse, and
- (B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of healthcare to an individual, or the past, present, or future payment for the provision of healthcare to an individual, and--
 - (i) identifies the individual, or
 - (ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

“Provider Directory”: a listing of all Contracted Providers contracted with HCG Health Plan as of the date of the Directory.

“Prudent Layperson”: A person who, although not a medical professional, possesses an average knowledge of health and medicine and can reasonably determine that an individual may be suffering from an emergency medical condition.

“Qualified Medical Child Support Order or Administrative Order”: Any order that creates or recognizes an alternative payment right to receive covered services for which a person is eligible under the GSA. This order can be issued by a court or administrative agency that has jurisdiction for such matters.

“Qualifying Event”: means a situation as described in the GSA that enables a person to enroll outside a designated open enrollment period without being considered a late enrollee or to obtain continuation coverage if applicable.

“Re-enrollment” means any enrollment by an Employer Group after the initial enrollment.

“Request for Hearing”: Request for a formal hearing by a Member with the Office of Administrative Hearings.

“Secondary Plan”: means the group plan that pays benefits only after the primary plan has paid.

“Service Area”: The geographic area where covered services are available to Members.

“Skilled Nursing Facility”: An extended care facility which is licensed as a Skilled Nursing Facility and operated in accordance with the laws of the State of Arizona and is certified by Medicare.

“Sole Proprietor”: means a form of business organization in which an individual is fully and personally liable for all the obligations (including debts) of the business, is entitled to all of its profits and exercises complete managerial control. A sole proprietor can have employees.

“Specialist”: A provider who has been specially trained in practices in a specific type of care other than family practice, general practice or internal medicine.

“Specialty Drug”: Specialty medications are high-cost injectible, infused, oral, or inhaled medications that generally require close supervision and monitoring of the patient’s medication therapy.

Specialty medications have the following key characteristics:

- Need frequent dosage adjustments
- Cause more severe side effects than traditional medications

- Need special storage, handling and/or administration
- Have a narrow therapeutic range
- Require periodic laboratory or diagnostic testing

“Spouse”: means the husband or wife of an HCG Subscriber who has entered into a marriage recognized as valid by the State of Arizona.

“State Fair Hearing”: An administrative hearing under Arizona Revised Statutes Title 41, Chapter 6, Article 10.

“State”: The State of Arizona.

“Subscriber”: means an enrolled HCG employee including a person who meets the eligibility requirements for the federal health coverage tax credit under 26 U.S.C. 35 (Sections 35 of the Internal Revenue Code of 1986).

“Trade Adjustment Assistance (TAA)”: means aid to workers and firms that have been harmed by import competition.

“Transition of Care”: means a process by which a Member request that a non-contracted provider continue the Member’s treatment for a period of time until the Member can be transferred to the care of a contracted provider.

“United States”: The 50 States, the District of Colombia and includes the territorial waters adjoining these entities. A ship or aircraft, even of American registry, is not considered to constitute American territory when it is not within or above the land area or territorial waters of the United States.

“Urgent Condition”: means a medical condition requiring prompt medically necessary covered services to prevent serious health deterioration resulting from an unforeseen illness or injury.

“Urgently Needed Care”: means care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening. Your primary care doctor generally provides urgently needed care or you may go to an Urgent Care Center.

“Valid Payment”: means the timely delivery of money or its equivalent by the Employer Group in such a manner that it is immediately negotiable and unconditional upon receipt.

“Waiver of Coverage”: means the relinquishment of the right to enroll in HCG when the Employee is covered by another health plan.