AMENDMENT NO. 2
to the ARIZONA PUBLIC EMPLOYERS HEALTH POOL (APEHP)
Medical Benefits Plan Document/Summary Plan Description
Effective July 1, 2015

Effective July 1, 2016, the Plan Document is amended as follows:

In the Quick Reference Chart, the Prescription Drug Program row, the text is amended to add the text in italics and delete the text in strike-through:

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Prescription Drug Program • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy Service • Formulary of Preferred Drugs • Precertification of Certain Drugs • Direct Member Reimbursement (for Non-Network retail pharmacy use) • Specialty Drug Program: Precertification and Ordering • Prescription Drug Information	~~CatamaranRx~~ ~~24/7 Catamaran Customer Care Center: 1-855-395-2022~~ ~~For Prior Authorization: 1-855-395-2022~~ ~~Website: www.mycatamaranrx.com~~ ~~Mail Order Customer Service: 1-800-881-1966~~ ~~Mail Order Address:~~ ~~Catamaran Home Delivery~~ ~~P.O. Box 407096~~ ~~Ft. Lauderdale, FL 33340 – 7096~~ ~~BriovaRx Specialty Drug Service:~~ ~~855-4BRIOVA (855-427-4682)~~ ~~Address for Direct Member Reimbursement:~~ ~~Catamaran~~ ~~P.O. Box 968022~~ ~~Schaumberg, IL 60196-8022~~ ***CVS/Caremark*** *Customer Care: (800) 552-8159* *www.caremark.com*

In the Schedule of Medical Benefits of each of the five medical plan options (Core Plan, Copay Plan, $1,500 HDHP, $2,500 HDHP and $5,000 HDHP), in the Acupuncture row, the following statement under the Explanations and Limitations column is amended to add the text in italics:

- Acupuncture services and the visit to a naturopathic or homeopathic provider are payable to a maximum of **8 visits** per person per plan year, ***after the deductible has been met.***

In the Medical Expense Coverage chapter, under the section titled Coverage of Certain Over the Counter (OTC) Drugs, the text is amended as noted by the addition of the text in italics:

COVERAGE OF CERTAIN OVER THE COUNTER (OTC) DRUGS

For an over-the-counter drug to be covered by the Plan, the drug must be:

1. obtained through the outpatient Prescription Drug Program at a participating network retail pharmacy and
2. presented to the pharmacist with a prescription for the OTC drug from your Physician or Health Care Practitioner.

(Note that while these OTC drugs require a prescription, certain types of insulin are payable by the Plan without a prescription).

The following chart outlines the OTC drugs that are payable by the non-grandfathered medical plans discussed in this document, at no cost, in accordance with Health Reform and the US Preventive Service Task Force (USPSTF) A and B recommendations. To be covered, OTC drugs must be purchased at a participating network retail or mail order pharmacy, and be presented along with a prescription for the OTC drug. (Note that while these OTC drugs require a prescription, insulin is payable by the Plan without a prescription).

Drug Name	Who Is Covered for this Drug?	Cost-Sharing?	Payment Parameters, in addition to a prescription:
Aspirin	• For men 45-79 years to reduce chance of a heart attack • For women 55-79 years to reduce the chance of a stroke. • *For pregnant women who are at high risk for preeclampsia (a pregnancy complication).*	None, if payment parameters met	Since dosage not established by USPSTF, plan covers (one bottle of generic 100 tablets every 3 months). *For pregnant women at high risk for preeclampsia: plan covers daily low dose aspirin (81mg) as preventive medication after 12 weeks gestation.*

In the Schedule of Medical Benefits of each of the five medical plan options (Core Plan, Copay Plan, $1,500 HDHP, $2,500 HDHP and $5,000 HDHP), in the row titled "Wellness (Preventive) Program: Well Child Examinations and Immunizations," the following statement is added under the Explanations and Limitations column:

- *Coverage is provided in primary care clinician visits for fluoride varnish applied to the primary teeth of children through age 5 years.*

In the Medical Plan Exclusions chapter, the following exclusion is amended to add the text in italics:

U. Weight Management and Physical Fitness Exclusions

1. Expenses for medical or surgical treatment of obesity, including, but not limited to, gastric restrictive procedures, intestinal bypass and reversal procedures, weight loss programs, dietary instructions, skin reduction procedures/treatment, and any complications thereof, even if those procedures are performed to treat a co-morbid or underlying health condition, *except weight management screening and services required to be covered in accordance with Health Reform law.*

In the Schedule of Medical Benefits of each of the five medical plan options (Core Plan, Copay Plan, $1,500 HDHP, $2,500 HDHP and $5,000 HDHP), in the row titled "Wellness (Preventive) Program: Adult Health Maintenance Examinations," the following is amended to add the text in italics and delete the text in strike-through:

- As a preventive counseling benefit in compliance with Health Reform, the Plan covers the following services: For adults (1) with a body mass index of 30 kg/m^2 or higher, OR (2) who are overweight (defined as a BMI of 25 to 29.9 kg/m^2) or obese (defined as a BMI of 30 kg/m^2 or higher) AND have additional cardiovascular disease (CVD) risk factors, the Plan covers Physician prescribed **intensive behavioral counseling** interventions. Intensive behavioral counseling interventions means the Plan will consider as medically necessary preventive services, up to a combined limit of **26** individual or group visits per 12-month period by an in-network provider. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician.

- **Screening Colonoscopy** is payable (at the frequency recommended by the American Cancer Society beginning at age 50 and repeated every 10 years). A screening colonoscopy may be payable at a younger age, or more frequently, with proof of a first-degree relative with a history of colorectal cancer or familial adenomatous polyposis or hereditary non-polyposis colorectal cancer. The Plan will pay 100% no deductible, for a *screening* colonoscopy that is performed in-network once every ten plan years, including *a specialist pre-procedure consultation, bowel prep medication used prior to a screening colonoscopy, anesthesia services or the lab charges for analysis of polyps removed during a screening colonoscopy* ~~the bowel prep and any polyp removal~~. If you have more than one colonoscopy performed because it is

medically necessary, or for a colonoscopy obtained at an out-of-network provider, benefits are payable with the applicable coinsurance and deductible.

- Certain additional preventive care expenses are payable for all covered females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits including but not limited to well woman office visits, screening for gestational diabetes, *genetic counseling for females at risk for breast cancer,* BRCA breast cancer gene test, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, ~~rental of~~ breastfeeding equipment and ~~necessary~~ supplies ~~after delivery~~ *needed to operate the equipment, and* lactation support ~~following delivery~~). These services are covered ~~under the Wellness/Preventive Services category~~ without cost sharing for a female when obtained from in-network providers. *See also the Durable Medical Equipment and Maternity Services rows in this Schedule.*

Throughout the document, any reference to coverage of a Breastfeeding/Lactation Educator is deleted, as the Plan will now cover lactation counseling, (in compliance with Health Reform), for any provider acting within the scope of their license, not just a Breastfeeding/Lactation Educator.

In the Schedule of Medical Benefits of each of the five medical plan options (Core Plan, Copay Plan, $1,500 HDHP, $2,500 HDHP and $5,000 HDHP), in the row titled "Durable Medical Equipment," the following text is amended to add the text in italics and delete the text in strike-through:

- ~~For the first 12 months following the birth of a child,~~ *For females who are breastfeeding,* coverage is provided for a standard manual or standard electric breast pump, plus necessary breast pump supplies. Rental, purchase and repair is payable. Coverage is available at no cost from in-network providers only. No coverage out-of-network. *A hospital grade breast pump is payable if the Plan determines it to be medically necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. See also the Maternity row for information on breastfeeding lactation counseling.*

In the Schedule of Medical Benefits of each of the five medical plan options (Core Plan, Copay Plan, $1,500 HDHP, $2,500 HDHP and $5,000 HDHP), in the row titled "Maternity," the following text is amended to add the text in italics and delete the text in strike-through:

- Certain prenatal care/maternity related preventive care expenses are payable for all females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to routine prenatal obstetrical office visits, screening for gestational diabetes, HPV testing starting at age 30, ~~rental of~~ breastfeeding equipment and ~~necessary~~ supplies *needed to operate the equipment* ~~after delivery, and in conjunction with birth,~~ *and for females who are breastfeeding the plan covers* ~~coverage for~~ comprehensive lactation support and counseling by a ~~trained~~ provider *acting within the scope of their license* ~~during pregnancy and/or in the postpartum period~~). These services are covered without cost sharing for a female when obtained from in-network providers. ~~See also the definition of Breastfeeding/Lactation Educator~~.
- ~~In conjunction with birth, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a trained provider during pregnancy and/or in the postpartum period, at 100%, no deductible, when provided by an in-network provider. Under this plan a trained provider is a Breastfeeding/Lactation Educator, as defined in the Definitions chapter~~. *For females who are breastfeeding, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) at 100%, no deductible, when provided by an in-network provider acting within the scope of his/her license. In-network providers are listed on the network directory described on the Quick Reference Chart.* See the Durable Medical Equipment row for information on coverage for breast pump and supplies.

In the Schedule of Medical Benefits of each of the five medical plan options (Core Plan, Copay Plan, $1,500 HDHP, $2,500 HDHP and $5,000 HDHP), in the row titled "Dietitian Services," the following text is added under the Explanation and Limitations column:

- *This visit limit does not apply to nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health or substance abuse condition, such as an eating disorder.*

- *Certain dietary counseling may be payable as a Wellness service in accordance with Health Reform requirements. See the Wellness row in the Schedule of Medical Benefits.*

In the Schedule of Medical Benefits of each of the five medical plan options (Core Plan, Copay Plan, $1,500 HDHP, $2,500 HDHP and $5,000 HDHP), in the row titled "Drugs," the following text is amended to add the text in italics:

- **FDA-approved contraceptives for females**: generic contraceptives paid at 100%, no copay or deductible applies. Normal cost-sharing applies to preferred brand and non-preferred brand contraceptives. No charge for brand contraceptive drug only if a generic contraceptive is unavailable, (or medically inappropriate *as determined by the prescribing provider).*

- *Certain CDC-recommended vaccinations are payable at 100%, no cost sharing when obtained at an in-network retail pharmacy. Contact the Prescription Drug Program for more information.*

In the Schedule of Medical Benefits of the $5,000 HDHP Plan, in the row titled "Out of Pocket Limit," the following text is added under the Benefit Description column:

- *The family out-of-pocket limit accumulates cost sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.*

In the Schedule of Medical Benefits of the $1,500 HDHP medical plan, in the row titled "Out of Pocket Limit," the following text is added under the In-network column:

$3,500 per person *with self-only coverage*
~~$7,000~~ *$6,550* per family *coverage*

In the Schedule of Medical Benefits of the $2,500 HDHP medical plan, in the row titled "Out of Pocket Limit," the following text is added under the In-network column:

$3,450 per person *with self-only coverage*
~~$6,900~~ *$6,550* per family *coverage*

In the Schedule of Medical Benefits of the $5,000 HDHP medical plan, in the row titled "Out of Pocket Limit," the following text is added under the In-network column:

$6,450 per person *with self-only coverage*
$6,450 per person with family coverage
$12,900 per family

In the Medical Plan Exclusion chapter, page 110, a new exclusion #35 is added:

35. **Specifically Identified Providers and/or Facilities:** Regarding implementing a reasonable medical management technique with respect to the frequency, method, treatment or setting for care, all non-emergency services, supplies or other expenses for consultation, care or treatment of any injury, sickness, illness, disease or preventive services at or by the following providers and/or facilities (notwithstanding any other provision or term or condition in the Plan) are not covered: Cancer Treatment Centers of America (CTCA) and related providers and affiliates. In-network providers are available by referring to the In-network PPO Provider row of the Quick Reference Chart in the front of this document.

In the Plan Options and Medical Networks chapter, the following section on Special Reimbursement is amended to delete the text in strike-through:

SPECIAL REIMBURSEMENT PROVISIONS

The following chart explains the Plan's special reimbursement for services when Out-of-Network providers are used. The Plan Administrator or its designee determines if and when the following special reimbursement circumstances apply to a claim.

SPECIAL REIMBURSEMENT PROVISIONS This chart explains the Plan's special reimbursement provisions if the services of an Out-of-Network Provider are used. The Plan Administrator or its designee determines if/when the following reimbursement applies to a claim.	WHAT THE PLAN PAYS
a. Child over 19 resides temporarily outside the service area while attending college. b. Child resides outside the service area under a QMCSO. c. **The individual had care for a medical emergency (as emergency is defined in this Plan) at a provider outside the In-Network service area.** d. The individual was treated/confined in an In-Network facility but an Out-of-Network provider performed certain medically necessary covered services such as emergency room visit, pathology, laboratory, radiology, anesthesia, or assistant surgery services. e. Ancillary services (such as lab or x-rays) received from an Out-of-Network provider in connection with a visit to an In-Network provider, if the choice of the Out-of-Network provider who performed ancillary services was outside the patient's control. For example, the in-network provider accidentally sends the patient's lab work to an out of network lab for processing. f. ~~If the individual resides more than 50 miles outside the In-Network service area.~~ g. There is no in-network provider qualified by area of professional specialty or practice available to provide medically necessary eligible health care services.	As if the care was provided In-Network including deductible, coinsurance, copays and out-of-pocket limits and bills will be reimbursed according to the Allowed Charges allowance for non-network providers. See the definition of Allowed Charges in this Plan.
h. Use of an Out-of-Network provider when an In-Network provider was available to be used.	As if the care was provided Out of Network including deductible, coinsurance, copays and out-of-pocket limits.

This Plan Document/Summary Plan Description is amended as stated above this 27th **day of** June, **20**16**:**

Tracy Foss

Signature Plan Sponsor/Plan Administrator

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