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BCBSAZ CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact BCBSAZ at one of the departments listed below or call the direct phone number on the back of your ID card.

BCBSAZ also makes information available at www.azblue.com and you may wish to look there before calling. BlueNet is the member area on www.azblue.com that allows you to manage your health insurance plan from anywhere you have Internet access. Go to www.azblue.com/member for more information and to register for a BlueNet account. Once you are registered for BlueNet, you have access to the following*:

Claims and benefits information	Search for providers
Track deductible, if applicable to your plan	Compare hospitals
Update account information	Research prescription benefits
Verify enrollment status	HealthyBlue [®] - tools for a healthier life
Order ID cards	Review Medical Coverage Guidelines

*Depending on your plan, access to links on BlueNet may vary.

BCBSAZ Customer Service (benefit questions or claim information)

BCBSAZ customer service hours are Monday through Friday, 8:00 a.m. to 4:30 p.m. MST (except holidays).

Maricopa County	(602) 864-4400
Pima County	(520) 745-1883
Flagstaff	(928) 526-0232
Statewide	(800) 423-6484
Outside of Arizona	(800) 232-2345

Send all correspondence to this address unless otherwise indicated below:

Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, Arizona 85002-3466

Claims

Mail new claims to:

Blue Cross Blue Shield of Arizona
P.O. Box 2924
Phoenix, Arizona 85062-2924

Claims for transplant travel and lodging:

Attn: Transplant Travel Claim Processor
Mail Stop: A116
Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ 85002-3466

Claims for services received on a cruise ship:

Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, Arizona 85002-3466

Claims for chiropractic services:

Claims Administration
American Specialty Health Networks, Inc
P.O. Box 509001
San Diego, CA 92150-9001

Customer Walk-In Office Locations

Phoenix (main office)	2444 W. Las Palmaritas Drive, 85021-4883 (2 blocks north of Northern Avenue between the Black Canyon Freeway (I-17) and 23rd Avenue)
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Tucson	5285 E. Williams Circle, Suite 1000, 85711- 7411 (East on Broadway Road, right on S. Williams Circle, left on E. Williams Circle)
Flagstaff	1500 E. Cedar Avenue, Suite 56, 86004 -1643 (Intersection of Cedar Avenue and West Street)
Chandler	2121 W. Chandler Blvd., Suite 115, 85224 (East of the 101 Freeway; West of Dobson Road)

Provider Network Status

Check the online provider directory at www.azblue.com or call BCBSAZ customer service at the numbers listed above.

BCBSAZ Other Information

Behavioral Services Administrator (BSA) (800) 224-2125

BlueCard® Program

Blue Cross Blue Shield (BCBS) Association (800) 810-2583
Web site: www.bcbs.com

Cancer Clinical Trials (for information on services directly associated with a cancer clinical trial or to obtain a copy of Arizona law requirements for cancer clinical trials)

Maricopa County (602) 864-5841
Statewide (800) 232-2345, ext. 5841

Care Management and Disease Management Support Line

Information on care management services, how to contact a care manager or how to make a referral and information on health management programs that support members with complex, catastrophic and/or chronic conditions. (877) My-HBlue or (877) 694-2583

Chiropractic Benefits Administrator (800) 678-9133

Continuity of Care Requests (877) My-HBlue or (877) 694-2583

Hearing Impaired (TDD) (Claim information)

Maricopa County (602) 864-4823
Statewide (800) 232-2345, ext. 4823

Medical Appeals and Grievances

Attn: Medical Appeals and Grievances	Maricopa County: (602) 544-4938
Mail Stop A116	Statewide: (866) 595-5998
BCBSAZ	Fax: (602) 544-5601
P.O. Box 13466	
Phoenix, AZ 85002-3466	

Medical Coverage Guidelines (request a copy of the Medical Coverage Guidelines)

Maricopa County (602) 864-4614
Statewide (800) 232-2345, ext. 4614

BlueNet members' area of www.azblue.com under Claims & Benefits/Health Benefits/Medical Coverage Guidelines

Membership Services (change mail address, add or remove dependents, termination of coverage)

Maricopa County (602) 864-4115
Statewide (800) 232-2345, ext. 4115
Fax (602) 864-4041

Attn: Membership Services
Mail Stop: A102
Blue Cross Blue Shield of Arizona
PO Box 13466
Phoenix, AZ 85002-3466

Precertification (your doctor must contact BCBSAZ)

Maricopa County (602) 864-4320
Statewide (800) 232-2345, ext. 4320

Precertification Denial Appeals

Maricopa County (602) 544-4938
Statewide (866) 595-5998
Fax (602) 544-5601

Attn: Appeals
Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ 85002-3466

Prescription Benefit Unit

Maricopa County (602) 864-4273
Statewide (800) 232-2345, ext. 4273

Requests for Transplant Travel and Lodging Claim Forms

Maricopa County (602) 864-4051
Statewide (800) 232-2345, ext. 4051

Spanish-Language Telephone Service (en Español – preguntas sobre su solicitud, beneficios, reclamos, o pagos)

Maricopa County (602) 864-4884
Statewide (800) 232-2345, ext. 4884

Supply Line (provider directories, claim forms, health coverage appeal information packet, ID cards, Rx mail order packet)

Maricopa County (602) 995-6960
Statewide (800) 232-2345 ext. 6960

DEFINITIONS

“Allowed amount” means the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost-share payment.

BCBSAZ calculates deductible and coinsurance based on the allowed amount, less any access fees or precertification charges. BCBSAZ uses the allowed amount to accumulate toward any out-of-pocket maximum or out-of-pocket maximum that applies to the member’s benefit plan. The allowed amount does not include any balance bills from noncontracted providers. The allowed amount is neither tied to, nor necessarily reflective of, the amounts providers in any given area usually charge for their services.

If the allowed amount is calculated based upon a fee schedule, a change to the fee schedule may result in higher member cost-share.

The allowed amount is calculated as follows:

Type of Provider	Type of Claim	Basis for Allowed Amount	Payee for Reimbursement
Providers contracted with BCBSAZ	Emergency and Non-emergency	Lesser of the provider’s billed charges* or the applicable BCBSAZ fee schedule, with adjustments for any negotiated contractual arrangements and certain claim editing procedures	BCBSAZ reimburses the provider the allowed amount, less any member cost share
Providers contracted with the BSA	Emergency and non-emergency	The BSA fee schedule	The BSA reimburses the provider the allowed amount, less any member cost share
Providers contracted with the CBA	Emergency and non-emergency	The lesser of the provider’s billed charges or the CBA fee schedule, with adjustments for any negotiated contractual arrangements	The CBA reimburses the provider the allowed amount, less any member cost share
Providers contracted with another Blue Cross or Blue Shield Plan (“Host Blue”)	Emergency and non-emergency	Lesser of the provider’s billed charges* or the price the Host Blue plan has negotiated with the provider	The Host Blue, on behalf of BCBSAZ, reimburses the provider the allowed amount less any member cost share
Noncontracted providers (in Arizona and out-of-state)	Non-emergency	Lesser of the provider’s billed charges* or the applicable BCBSAZ fee schedule, with adjustments for certain claim editing procedures	BCBSAZ reimburses the member the allowed amount, less any member cost share
Noncontracted providers (in Arizona and out-of-state)	Emergency	The highest of the three following amounts, not to exceed billed charges*: <ul style="list-style-type: none"> • The median in-network provider negotiated rate for the emergency service furnished, • The amount for the emergency service calculated using the same method BCBSAZ generally uses to determine reimbursement for out-of-network services, or • The amount that would be paid by Medicare Part A or B. 	BCBSAZ reimburses the member the allowed amount, less any member cost share

*A provider’s billed charges are defined as the lowest price the provider is willing to accept as payment in full for a covered service when the provider has no contract with BCBSAZ, a Host Blue, or the BlueCard Worldwide program that governs the amount of reimbursement.

"BCBSAZ" or "We" means Blue Cross Blue Shield of Arizona when acting as the issuer of insurance coverage or as the administrator of a group benefit plan. Within this benefit book, “BCBSAZ” or “We” may also include the BSA or the CBA, when the BSA or CBA is performing functions delegated to it by BCBSAZ.

Blue Cross® Blue Shield® of Arizona is an independent licensee of the Blue Cross and Blue Shield Association.

BCBSAZ is a non-profit corporation organized under the laws of the State of Arizona as a hospital, medical, dental and optometric services corporation and is authorized to operate a health care services organization as a line of business.

“Bariatric surgery” means a surgical procedure to promote weight loss for the treatment of morbid obesity. Bariatric surgery also includes any revisions to an eligible bariatric surgical procedure.

“Behavioral Services Administrator (BSA)” means the independent company that contracts with BCBSAZ to administer and deliver some of the behavioral and mental health benefits, along with certain other education and training benefits, available through some plans.

“Benefit book” means this document, which may also be referred to as benefit booklet or benefit plan booklet.

“Benefit plan” or “plan” means the document describing the benefits and terms of coverage that the sponsor of a group health plan provides to its group members and their dependents.

Your BCBSAZ plan includes this book and schedule page, your application for coverage, your ID card, any plan that is issued to replace this plan and any rider, amendment or modification to this plan, including but not limited to, any changes in deductible, coinsurance or copay amounts. **Changing deductible options within a product does not constitute a new plan.**

Many group health insurance plans (other than government plans, church plans, and certain other types of plans) must comply with the federal Employee Retirement Income Security Act of 1974 (ERISA). If your group health insurance plan is subject to ERISA, your plan sponsor must maintain a summary plan description and provide the summary plan description to you upon written request. While your plan sponsor may include this benefit book as part of its summary plan description, this benefit book is not a summary plan description.

“Chiropractic Benefits Administrator (CBA)” means the independent company that administers chiropractic benefits for BCBSAZ. The CBA develops and manages the BCBSAZ network of chiropractic providers, processes chiropractic claims, determines medical necessity and handles utilization management, grievances and appeals related to chiropractic services.

“Contract holder” means the person to whom the benefit plan is issued. Any other person approved for coverage with the contract holder under this plan is a dependent. Under group coverage, the contract holder is the member who is eligible for coverage because of his or her affiliation with a group.

“Cosmetic” means surgery, procedures or treatment and other services performed primarily to enhance or improve appearance, including but not limited to, those surgeries, procedures, treatments and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological or mental condition or function.

“Custodial care” means health services and other related services that meet any of the following criteria:

1. are for comfort or convenience;
2. do not seek to cure;
3. are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition (except as stated in “Home Infusion/Medication Administration Therapy”) or other self care; **or**
4. are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as an L.P.N., R.N. or licensed therapist.

“Diagnosis Related Grouping” or “DRG” means a method for reimbursing hospitals for inpatient services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

“Emergency” means an illness or condition which requires relief of severe pain or if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize life, health or the ability to completely recover, resulting in serious impairment or permanent disability.

“Fee Schedules” mean proprietary schedules of provider fees compiled by BCBSAZ or BCBSAZ’s contracted vendors. BCBSAZ or BCBSAZ’s contracted vendors develop proprietary schedules of fees based on annual reviews of information from numerous sources, including, but not limited to: Medicare fee schedules from the Centers for Medicare and Medicaid Services (CMS), BCBSAZ’s or the contracted vendor’s historical claims experience, pricing information that may be available to BCBSAZ or the vendor, information and comments from providers and negotiated contractual arrangements with providers. **BCBSAZ and/or BCBSAZ’s contracted vendors may change their fee schedules at any time without prior notice to members. If the allowed amount is calculated based upon a fee schedule, a change to the fee schedule may result in higher member cost-share.**

"Group" means the employer, trust or other entity that sponsors the group benefit plan on behalf of its employees or participants.

"Group Master Contract" (sometimes referred to as "Agreement") means the legal agreement between the group and BCBSAZ.

"Inpatient residential care" means medical or mental-behavioral care provided in a 24-hour facility licensed by the state in which it is located, and not licensed as a hospital, that offers integrated therapeutic services, educational services and activities of daily living. These services are part of a well-defined, individually tailored, medical or mental-behavioral treatment plan that is clinically appropriate based upon the individual's medical or mental-behavioral needs and is performed in a clinically appropriate facility.

"Medical Coverage Guidelines" means BCBSAZ medical, pharmaceutical, dental and administrative criteria that are developed from review of published, peer-reviewed medical, pharmaceutical and dental literature and other relevant information and used to help BCBSAZ determine whether a service, procedure, medical device or drug is eligible for benefits under a member's benefit plan. The Medical Coverage Guidelines also include prescription medication limitations. BCBSAZ periodically reviews and amends the Medical Coverage

Guidelines in response to changes and advancements in medical knowledge and scientific study. Benefit determinations are based on the Medical Coverage Guidelines in effect at the time of service. You or your provider can review a specific guideline by going to the "Claims & Benefits" section on www.azblue.com and choosing "Health Benefits and Medical Coverage Guidelines." Specific Guidelines are also available by calling the number for requesting Medical Coverage Guidelines listed in the front of this book.

The CBA establishes medical coverage guidelines for chiropractic services. To obtain a copy of the guidelines applicable to chiropractic services, contact the CBA at the number listed in the front of this book or go to www.ashcompanies.com. Also, if the BSA provides or administers benefits under your plan, the BSA may establish medical coverage guidelines for services covered through the benefits it administers. Contact the BSA at the number listed at the front of this book for a copy of coverage guidelines maintained by the BSA.

"Member" or "You" means an individual, employee, participant or dependent covered under a benefit plan.

"Per diem" means a method of reimbursement based on a negotiated rate per day for payment of covered services provided to a patient in a facility.

"Pharmacy Coverage Guidelines" means BCBSAZ pharmaceutical and administrative criteria that are developed from review of published peer-reviewed medical and pharmaceutical literature and other relevant information and are used to help BCBSAZ determine whether a medication or other products such as medical devices or supplies are eligible for benefits under a member's retail or mail order benefit. Pharmacy Coverage Guidelines are available by going to www.azblue.com, under Prescription Medications and then Pharmacy Coverage Guidelines. Guidelines are also available by calling the number listed for the Prescription Benefit Unit listed in the front of this book.

"Physician," for purposes of classifying benefits and member cost-shares in this benefit plan, means a properly licensed M.D., D.O., D.P.M., or D.C.

"Primary Care Provider (PCP)" means a health care professional who is contracted with BCBSAZ as a PCP and generally specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, pediatrics or any other classification of provider approved as a PCP by BCBSAZ. Your benefit plan does not require you to have a PCP or to have a PCP authorize specialist referrals.

"Provider" means any properly licensed, certified or registered person or facility furnishing medical care to you, such as a doctor, hospital, laboratory or other health professional.

"Service" means a generic term referencing some type of health care treatment, test, procedure, supply, medication, technology, device or equipment.

"Specialist" means either a physician or other health care professional who practices in a specific area other than those practiced by primary care providers, or a properly licensed, certified or registered individual health care provider whose practice is limited to rendering mental health services. This definition of "specialist" does not apply to dentists. BCBSAZ does not require you to obtain an authorization or referral to see a specialist.

UNDERSTANDING THE BASICS

Your Responsibilities

Read your benefit materials. Before you receive any services you need to understand what is covered and excluded under your benefit plan, your cost-sharing obligations and the steps you can take to minimize your out-of-pocket costs. You need to carefully review this book, your schedule page and other materials that BCBSAZ has provided to you.

Review your explanation of benefits (EOB) forms, other claim-related information and available claims history. Notify BCBSAZ of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

Tell us about changes. We need current information to correctly process your claims, update you on changes to your benefits and explain how we are administering your benefit plan. Check the BCBSAZ customer service section at the front of this book for information on contacting Membership Services. Tell us right away about any changes in the following:

- Individuals being added to the benefit plan: Spouse, newborns, adopted children, children placed for adoption, stepchildren
- Eligibility of you or your dependents for Medicare during the term of this contract
- Your mailing address or phone number
- Other medical coverage that you or your dependents add or lose, including any changes in benefits
- Eligibility of you or your dependents for Arizona Health Care Cost Containment System (AHCCCS) coverage during the term of this contract
- Individuals removed from the benefit plan due to divorce or death
- A disabled dependent age 26 or older who is no longer disabled

If you do not tell us about changes, correspondence from BCBSAZ may not reach you in a timely manner. Also, you may have to reimburse BCBSAZ for claims payments we make on behalf of you or your dependents, if you or your dependents became ineligible but incurred claims before you gave us notice. You may also have to pay costs incurred by BCBSAZ for collection of claims payments made after you or your dependents became ineligible.

BCBSAZ ID Card

Your ID card has basic eligibility and cost-sharing information: Contract holder and dependent names, group number, ID number, card issue date and certain cost-sharing amounts.

- Bring your ID card with you each time you seek health care services.
- Have your ID card available for reference when you contact BCBSAZ for information.

Benefit Maximums

Some benefits may have a specific benefit maximum or limit based on dollar amount, number of days or visits, type, timeframe (calendar year or benefit plan), age, gender or other factors. If you reach a benefit maximum, any further services are not covered under that benefit and you may have to pay the provider's billed charges for those services. However, if you reach the benefit maximum on a particular line of a claim, you will be responsible for paying only up to the allowed amount for the remaining charges on that line of the claim.

All benefit maximums are included in the applicable benefit description.

Coverage Changes

Your benefits and coverage can change while this benefit plan is in effect. You will be notified of any changes as required by law.

Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available.

Covered Services

To be covered a service must be all of the following:

- a benefit of this plan;
- medically necessary as determined by BCBSAZ;
- not excluded;
- not experimental or investigational as determined by BCBSAZ;
- precertified where precertification is required;
- provided while this benefit plan is in effect and while the person claiming benefits is eligible for benefits;
and
- rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ.

Experimental or Investigational Services

BCBSAZ, in its sole and absolute discretion, decides whether a service is experimental or investigational. A service is considered experimental or investigational unless it meets all of the following criteria:

- The service must have final approval from the appropriate governmental regulatory bodies if applicable;
- The scientific evidence must permit conclusions concerning the effect of the service on health outcomes;
- The service must improve the net health outcome;
- The service must be as beneficial as any established alternative; **and**
- The improvement resulting from the service must be attainable outside the investigational setting.

In addition to classifying a service as experimental or investigational using the above criteria, BCBSAZ may also classify the service as experimental or investigational if any one or more of the following apply:

- The service cannot be lawfully marketed or used without full (unrestricted) approval of appropriate governmental regulatory bodies and approval for marketing or use has not been given at the time the service is submitted for precertification or rendered;
- The provider rendering the service documents that the service is experimental or investigational; **or**
- Published reports and articles in authoritative (peer-reviewed) medical and scientific literature show that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, appropriate selection, efficacy or efficacy as compared with the standard treatment for the diagnosis.

Medically Necessary

BCBSAZ, in its sole and absolute discretion, decides whether a service is medically necessary based on the following definition:

A medically necessary service is a service that meets all of the following requirements:

- Is consistent with the diagnosis or treatment of a symptom, illness, disease or injury;
- Is not primarily for the convenience of a member or a provider;
- Is the most appropriate site, supply or service level that can safely be provided; **and**
- Meets BCBSAZ's medical necessity guidelines and criteria in effect when the service is precertified or rendered. If no such guidelines or criteria are available, BCBSAZ will base its decision on the judgment and expertise of a BCBSAZ medical professional or medical consultant retained by BCBSAZ.

Medical Necessity Guidelines and Criteria

Listed below are some sources and criteria that BCBSAZ uses to make medical necessity decisions. BCBSAZ does not rely on each of these sources for every decision. Information on how to obtain a copy of the Medical Coverage Guidelines is in the BCBSAZ customer service section at the front of this book.

- Medical Coverage Guidelines (local medical policy)
- InterQual ® Clinical Decision Support Criteria
- Medical Policy Reference Manual (MPRM) of the Blue Cross Blue Shield Association
- Medicare Guidelines
- Pharmacy Coverage Guidelines
- Technology Evaluation Center (TEC) of the Blue Cross Blue Shield Association

BCBSAZ contracts with a behavioral services administrator (BSA) and a chiropractic benefits administrator (CBA) to administer some or all of these types of benefits for some plans. The BSA and CBA also make medical necessity determinations based on their own medical necessity criteria, which are also available to you on request.

BCBSAZ's decision about medical necessity may differ from your provider's opinion. A provider may prescribe, order, recommend or approve a service that BCBSAZ decides is not medically necessary and therefore is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered.

In addition, not all medically necessary services will be covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A service may be medically necessary and still excluded from coverage.

Provider Eligibility and Network Status

Check your provider's eligibility and network status before you receive services. Not all medical professionals are eligible providers, and not all eligible providers are contracted with BCBSAZ. If you don't know your provider's status with BCBSAZ, check our online provider directory at www.azblue.com or call BCBSAZ customer service.

Schedule Page

BCBSAZ gives you a schedule page that lists the persons covered; applicable copays, access fees, coinsurance percentages, deductible amounts, other cost-sharing amounts; your effective date of coverage; and other important information. Please keep your current schedule page with your benefit book.

MEMBER COST-SHARING

Members pay part of the costs for benefits received under this plan. Depending on your particular benefit plan, the service you receive and the provider you choose, you may have an access fee, balance bill, coinsurance, copay, deductible or some combination of these payments. Each cost-share type is explained below. This section, the benefit descriptions in this book and your schedule page will explain which cost-share types apply to each benefit.

If the allowed amount is calculated based upon a fee schedule, a change to the fee schedule may result in higher member cost-share.

BCBSAZ uses your claims to track whether you have met some cost-share obligations. We apply claims based on the order in which we process the claims and not based on date of service.

Access Fee

An access fee is a fixed fee you pay to a provider for certain covered services, usually at the time of service. If an access fee applies to a particular service, you must pay the access fee in addition to any other applicable cost-share for the service. Access fees do not count toward meeting your calendar-year deductible or toward satisfaction of the out-of-pocket maximum.

Balance Bill

The balance bill refers to the amount you may be charged for the difference between a noncontracted provider's billed charges and the allowed amount.

In-network providers will accept the allowed amount for covered services. They will not charge you for the difference between their billed charges and the allowed amount.

Noncontracted providers have no obligation to accept the allowed amount. You are responsible to pay a noncontracted provider's billed charges, even though BCBSAZ will reimburse your claims based on the allowed amount. Depending on what billing arrangements you make with a noncontracted provider, the provider may charge you for full billed charges at the time of service or seek to balance bill you for the difference between billed charges and the amount that BCBSAZ reimburses you on a claim.

Any amounts paid for balance bills do not count toward deductible, coinsurance or the out-of-pocket maximum.

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for covered services each calendar year (January through December) before the benefit plan begins to pay for covered services. The deductible applies to every covered service unless the specific benefit section says it does not apply.

Each individual member has a calendar-year deductible. If you have family coverage, there is also a calendar-year deductible for the family. Amounts counting toward an individual's calendar-year deductible will also count toward any family deductible. An individual member cannot contribute more than his or her individual calendar-year deductible toward a family calendar-year deductible. When the family satisfies its calendar-year deductible, it also satisfies the deductible for all the individual members.

The deductible is calculated based on the allowed amount.

Amounts you pay for copays and access fees do not count toward the deductible.

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for many covered out-of-network services and some in-network services after meeting any applicable deductible. BCBSAZ subtracts any applicable access fees or precertification charges from the allowed amount before calculating coinsurance. BCBSAZ normally calculates coinsurance based on the allowed amount. **There is one exception.** If a hospital provider's billed charges are less than the hospital's DRG reimbursement, BCBSAZ will calculate your coinsurance based on the lesser billed charge.

Carry Over Deductible

Any amounts applied to the deductible for services provided in October, November or December will be carried over and applied to the next year calendar year deductible if you satisfy the requirements of this section:

- You remain enrolled in this plan for the entire calendar year;
- If you change coverage during this calendar year, or at the next open enrollment, you switch to coverage that also allows for carryover of deductible.

Your group or employer may already offer a plan without carryover deductible credit, or could decide to change your group's coverage only to plans without carryover credit. If you switch to a plan without carryover, or your employer limits coverage to plans without carryover, you will not be able to transfer deductible amounts that were satisfied in October, November or December, to the next calendar year.

Copay

A copay is a specific dollar amount you must pay to the provider for some covered services. If a copay applies to a covered service you must pay it when you receive services. You may have different copays for various covered services. See your schedule page for specific amounts. If a copay does not apply to a service, you pay the applicable deductible and coinsurance, unless otherwise specified within the benefit provision.

Out-of-Pocket Maximum (Individual & Family)

An out-of-pocket maximum is the amount each member must pay each year before BCBSAZ begins paying 100 percent of the allowed amount on covered services, for the remainder of the calendar year. The payments listed below do not count toward the out-of-pocket maximum. You must keep paying them even after you reach your out-of-pocket maximum:

- Amounts above a benefit maximum
- Any amounts for balance billing
- Any amounts for noncovered services
- Any charges for lack of precertification
- Cost-sharing for contacts following cataract surgery received from out-of-network providers
- Cost-sharing for hearing exams
- Cost-sharing for hearing aids received from out-of-network providers
- Cost-sharing for services provided by medicine men

If you have family coverage, there is an out-of-pocket maximum for your family. Amounts applied to each member's out-of-pocket maximum also apply to the family out-of-pocket maximum. The family maximum is applied in the same way as the individual maximum described above and is subject to the same rules. When the family has met its family out-of-pocket maximum, it also satisfies the out-of-pocket maximum requirements for all the individual members.

Precertification Charges

You must make sure that your provider obtains precertification from BCBSAZ for any service that requires it. Otherwise, you are subject to a precertification charge or complete loss of your benefit, depending on the plan. Applicable precertification charges are shown on your schedule page.

BCBSAZ will send your provider a letter, with a copy to you, to confirm that BCBSAZ has precertified a service. If you are not sure whether your service needs precertification or if your provider has precertified your service, you can call BCBSAZ customer service at the number listed on your ID card or the front of this book.

Amounts applied as precertification charges do **not** count toward the calendar-year deductible or out-of-pocket maximum.

PROVIDERS

Eligible Providers

Eligible providers include the properly licensed, certified or registered providers listed below, when acting within the scope of their practice. Benefits may also be available from other health care professionals whose services are mandated by Arizona state law or federal law or who are accepted as eligible by BCBSAZ. The fact that a service is rendered by an eligible provider does not mean that the service will be covered. Eligible providers are not necessarily contracted with BCBSAZ. For information on a provider's status as an eligible or network provider, check our online provider directory at www.azblue.com, or call BCBSAZ customer service, before you receive services.

Eligible providers include the following:

Professional	Facility Ancillary
<ul style="list-style-type: none"> • Board Certified Applied Behavioral Analyst (BCABA) • Certified Nurse First Assist (CRNFA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Doctor of chiropractic (D.C.) • Doctor of dental surgery (D.D.S.) • Doctor of medical dentistry (D.M.D.) • Doctor of medicine (M.D.) • Doctor of optometry (O.D.) • Doctor of osteopathy (D.O.) • Doctor of podiatry (D.P.M.) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner • Licensed professional counselor • Medicine Men • Physician Assistant (PA) • Psychologist (Ph.D., Ed.D. and Psy.D.) • Perfusionist • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational or physical therapist • Surgical Assist (SA) • Surgical Technician (ST) 	<ul style="list-style-type: none"> • Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Fronske Health Center (not available to Retirees) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long Term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Rehabilitation Treatment Centers (substance abuse centers) • Retail, mail order and specialty pharmacies • Skilled Nursing Facility • Specialty Laboratory • Sleep Lab • Urgent Care

Choosing a Provider

Please call BCBSAZ customer service before you receive services if you have any questions about a provider's eligibility or network participation with BCBSAZ.

Your costs will be lower when you use an in-network provider. Before receiving scheduled services, verify the network status of all providers who will be involved in your care, such as assistant surgeons, anesthesiologists and radiologists, as well as the facility where the services will be performed.

In-Network Providers (Contracted)

In-network providers are the following: (1) health care providers who have a contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ members); and (2) out-of-state providers licensed in the United States who have a PPO contract with a Host Blue plan. In-network providers will file your claims with BCBSAZ or the Host Blue plan with which they are contracted. The provider's contract generally prohibits the provider from charging more than the allowed amount for covered services. However, when there is another source of payment, such as liability insurance, all providers may be entitled to collect their balance bill from the other source, or from proceeds received from the other source. The provider's contract does allow the provider to charge you up to the provider's billed charges for non-covered services. We recommend that you discuss costs with the provider before you obtain non-covered services.

BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan directly reimburse in-network providers for your benefit plan's portion of the allowed amount for covered services. **You are responsible to pay your member cost-share directly to the provider.**

In-network providers must be licensed in the United States. Except for emergencies, in-network providers must render covered services in the United States in order for covered services to be considered in-network and subject to in-network member cost-share. If an in-network provider renders covered services outside the United States, the covered services will be considered out-of-network and subject to out-of-network member cost-share, including balance bills (except for emergencies).

Out-of-Network Providers (Contracted and Noncontracted)

Out of network providers are: (1) Providers who are contracted with a Host Blue plan as “Participating” only providers; (2) Eligible providers who have no contract with BCBSAZ or a Host Blue plan (Noncontracted providers); and (3) Providers who are contracted with the BlueCard Worldwide program.

- **Participating-Only Providers**

Participating-only providers are contracted with a Host Blue plan as “Participating” and are not contracted as PPO or Preferred providers. Participating-only providers are out-of-network providers. Participating-only providers will submit your claims to the Host Blue plan with which they are contracted. If you receive covered services from a Participating-only provider, you will pay out-of-network deductible and coinsurance and access fees. However, you will not have to pay the balance bill because the provider is contracted.

- **Noncontracted Providers**

Eligible providers who have no provider participation agreement with BCBSAZ or any Host Blue plan are noncontracted providers. Noncontracted providers are out-of-network providers.

If you receive covered services from an eligible noncontracted provider, you will pay out-of-network deductible and coinsurance, access fees and the balance bill. Noncontracted providers may bill you up to their full billed charges. The difference between the noncontracted provider’s billed charges and payment under this benefit plan may be substantial. Please check with the noncontracted provider regarding the amount of your financial responsibility before you receive services.

BCBSAZ does not send claim payments to noncontracted providers. BCBSAZ will send payment to you for whatever benefits are covered under your benefit plan. You are responsible for paying the noncontracted provider. A noncontracted provider will not receive a copy of your explanation of benefits (EOB) and will not know the amount this benefit plan paid you for the claim.

- **Providers Contracted with the BlueCard Worldwide Program**

Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. For covered services from these providers, you will pay out-of-network deductible and coinsurance and access fees (except for emergency services), plus the balance bill.

Provider Status and Payment – Summary Table

Provider contract status	Network status and applicable cost share	Provider required to file claim on member’s behalf	Accept BCBSAZ Allowed Amount¹ and do not Balance Bill	Payee for Reimbursement
Providers contracted with BCBSAZ	In-network ²	Yes	Yes	BCBSAZ reimburses the provider the allowed amount, less any member cost-share
Providers contracted with another Blue Cross or Blue Shield Plan (“Host Blue”) as PPO providers	In-network ²	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the provider the allowed amount less any member cost-share

Providers contracted with Host Blue as Participating only providers	Out-of-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the provider the allowed amount less any member cost-share
Providers contracted with Blue Card World Wide Program	Out-of-network	Yes	No	Blue Card Worldwide reimburses the provider the allowed amount less any member cost share
Noncontracted providers (in Arizona and out-of-state) (must be eligible providers)	Out-of-network	No (provider may elect to do so as courtesy to member)	No. May charge up to full billed charges. Difference between billed charges and BCBSAZ member reimbursement may be substantial ³	BCBSAZ reimburses the member the allowed amount, less any member cost-share. Provider does not get copy of member's EOB or know reimbursement amount.

¹ See "Definitions" section for basis of allowed amount computation.

² In-network providers must be licensed in the United States. Except for emergencies, in-network providers must render covered services in the United States in order for covered services to be considered in-network and subject to in-network member cost-share. If an in-network provider renders covered services outside the United States, the covered services will be considered out-of-network and subject to out-of-network member cost-share, plus balance bills.

³ **Please check with the noncontracted provider regarding the amount of your financial responsibility before you receive services.** All providers may charge you up to full billed charges for non-covered services. We recommend that you discuss costs with the provider before you obtain non-covered services.

Differences in Financial Responsibility

The following **example** shows how out-of-pocket expenses can differ depending on the provider you choose. This example is provided for demonstration purposes only. Your savings may vary depending on your benefit plan and your chosen provider.

In this example, the member has already satisfied the calendar-year deductible and has a 20 percent coinsurance for an in-network provider and 40 percent coinsurance for an out-of-network provider.

Billed Charges	Allowed Amount	Financial Responsibility	In-Network Providers 20% coinsurance	Out-of-Network (noncontracted) Providers 40% coinsurance
\$1,000	\$400	BCBSAZ pays:	\$320	\$240
		You pay:	\$ 80 coinsurance amount	\$160 coinsurance +600 balance bill \$760

Locating an In-Network Provider

Check the BCBSAZ provider directory to locate an in-network provider who offers the services you are seeking and contact the provider for an appointment.

If you cannot get an appointment with the in-network provider, you may either call BCBSAZ or ask an in-network provider with whom you have an existing treatment relationship for help in getting an appointment or locating another provider.

Precertifications for Out-of-Network Providers

BCBSAZ does not guarantee that every specialist or facility will be in our network. Not all providers will contract with health insurance plans. If you believe or have been told there is no in-network provider available to render covered services that you need, you may ask your treating provider to request precertification of in-network cost-share for services from an out-of-network provider. BCBSAZ will not issue this precertification if we find that an in-network provider is available to treat you. The section on precertification explains how to make this request.

Continuing Physician Care from an Out-of-Network Physician (M.D., D.O.)

You may be able to receive benefits at the in-network level for services from an out-of-network Arizona physician, under the circumstances described below. Continuity of care benefits are subject to all other applicable provisions of your benefit plan.

Continuity of care only applies to otherwise covered services rendered by doctors of medicine and osteopathy who are located in Arizona. Continuity of care is not available for facility services. If the hospital or other facility at which your physician practices is not an in-network facility, the out-of-network provisions of coverage will apply to covered facility services.

New Members	Current Members
<p>A new member may continue an active course of treatment with an out-of-network Arizona physician during the transitional period after the member's effective date if:</p> <p>The member has:</p> <ol style="list-style-type: none">1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of coverage; or2. Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; and	<p>A current member may continue an active course of treatment with an out-of-network Arizona physician if BCBSAZ terminates the physician from the network for reasons other than medical incompetence or unprofessional conduct if:</p> <p>The member has:</p> <ol style="list-style-type: none">1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of the physician's termination; or2. Entered the third trimester of pregnancy on the effective date of the physician's termination, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; and
<p>The member's physician agrees in writing to do all of the following:</p> <ol style="list-style-type: none">1. Accept the BCBSAZ allowed amount applicable to covered services as if provided by an in-network physician, subject to the deductible, coinsurance and copay requirements of this benefit plan;2. Provide BCBSAZ with any necessary medical information related to your care; and3. Comply with BCBSAZ's policies and procedures, as applicable, including precertification, network referral, claims processing, quality assurance and utilization review.	

Information on requesting continuity of care is listed in the BCBSAZ customer service section at the front of this book.

Out-of-Area Services

BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Plans referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Arizona but inside the United States (not BlueCard Worldwide), the claims for those services may be processed through one of these Inter-Plan Programs, which include the BlueCard[®] Program.

Typically, when accessing care outside Arizona but inside the United States (not BlueCard Worldwide), you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Plan in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-contracted healthcare providers. BCBSAZ's payment practices in both instances are described in this benefit plan book.

BlueCard Program

Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for fulfilling BCBSAZ's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Arizona but inside the United States (not BlueCard Worldwide) and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed charges for your covered services; **or**
- The negotiated price that the Host Blue makes available to BCBSAZ.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSAZ uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Precertification requirements and other benefit plan limitations apply to services received outside Arizona. You must make sure the provider obtains any required precertification. Otherwise, BCBSAZ may deny your benefits or require you to pay a precertification charge.

For assistance in locating a local BCBS network provider in another state, call (800) 810-BLUE (2583) or check the “BlueCard Doctor & Hospital Finder” online at www.bcbs.com.

See the “Provider” section and the definition of “Allowed Amount” in this benefit book for information regarding payment for services provided by non-contracted providers outside Arizona.

BlueCard Outside the United States (BlueCard Worldwide)

Always go directly to the nearest hospital in the event of an emergency. Emergency services are covered outside the United States. In-network member cost-sharing will apply to covered Emergency Services. See the Emergency Services section of this benefit book.

The BlueCard Worldwide program helps Blue Cross and/or Blue Shield members arrange medical services when they are outside the United States. BlueCard Worldwide works differently than BlueCard inside the United States.

If you need to locate a doctor or hospital or need medical assistance services outside the United States, call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Except for emergencies, you cannot obtain services at the in-network cost-share from providers located outside the United States. Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. If you receive covered services from a provider who is contracted with the BlueCard Worldwide program, you will pay out-of-network deductible and coinsurance and BCBSAZ access fees, plus the balance bill (except for emergency services).

- **Inpatient Services**

In most cases, hospitals contracted with the BlueCard Worldwide program will not require you to pay for covered inpatient hospital services, except for your member cost-share (out-of-network deductible and coinsurance and BCBSAZ access fees). In such cases, the BlueCard Worldwide hospital will submit your claim for processing. **You must still contact BCBSAZ to obtain precertification for non-emergent inpatient services.**

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the United States are generally not contracted with the BlueCard Worldwide program and will require you to pay for services in full at the time of service. Complete a BlueCard Worldwide claim form and send the claim form with the provider's bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claim processing. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide.

Services Received on Cruise Ships

If you receive health care services while on a cruise ship, you will pay in-network cost-share, and the allowed amount will be based on billed charges. A cruise ship claim is not considered an out-of-country claim. Claims should be submitted and processed through BCBSAZ, not through the BlueCard Worldwide program. Please call the BCBSAZ Customer Service department at the phone number listed in the front of this book for more information, or mail copies of your receipts to the BCBSAZ general correspondence address listed at the front of this book.

PRECERTIFICATION AND CARE COORDINATION

Precertification

Precertification is the process BCBSAZ uses to determine eligibility for benefits. Before receiving a covered service, check the benefit description for the service in this book to see if precertification is required. If precertification is required, you must obtain precertification regardless of the provider's network status.

Notwithstanding any other language in this benefit book, BCBSAZ may change the services that require precertification at any time. You will receive a notice of any changes to the services that require precertification.

If Required Precertification is Not Obtained

- Your benefits may be denied
- You may have to pay a precertification charge
- Your cost-sharing payments may be substantially higher

The benefit description will tell you whether you will be subject to a precertification charge or denial of benefits if you fail to obtain required precertification.

Prescription Medication Exception

If a covered medication requires precertification, but you must obtain the medication outside of BCBSAZ's precertification hours, you may have to pay the entire cost of the medication when it is dispensed. In such cases, you can file a reimbursement claim with BCBSAZ and have your provider request precertification on the next business day. Your claim for the medication will not be denied for lack of precertification, but all other exclusions and limitations of your plan will apply.

Factors BCBSAZ Considers in Evaluating a Precertification Request for Services or Medications

- Applicability of other benefit plan provisions (waiting periods, limitations, exclusions and benefit maximums);
- If the treating provider or location of service is in-network;
- Whether the service is medically necessary or investigational; **and**
- Whether your coverage is active.

Some of these factors may not be readily identifiable at the time of precertification, but will still apply if discovered later in the claim process and could result in denial of your claim.

How to Obtain Precertification

Ask your provider to contact BCBSAZ for precertification before you receive services. Your provider must contact BCBSAZ because he or she has the information and medical records we need to make a benefit determination. BCBSAZ will rely on information supplied by your provider. If that information is inaccurate or incomplete it may affect the ultimate disposition of your claim.

Precertification of In-Network Cost-Share for Services from an Out-of-Network Provider

If there is no in-network provider available to deliver covered services, your treating provider may contact BCBSAZ and ask BCBSAZ to precertify the in-network cost-share for services from an out-of-network provider. BCBSAZ will evaluate whether there is an in-network alternative. If BCBSAZ determines that an in-network provider is available to treat you, BCBSAZ will not precertify in-network cost-share for services from your out-of-network provider of choice.

Precertification of in-network cost-share for services from an out-of-network provider is a process separate from precertification of services. If you want an out-of-network provider to render services that require precertification and you also want to be eligible for the in-network cost-share, you must ensure that your provider makes two separate precertification requests: one for the service itself and one for use of the out-of-network provider. The benefit descriptions in this book refer only to your obligation to obtain precertification for the service.

If BCBSAZ precertifies you for the in-network cost-share, your services will be subject to the in-network cost-share. **You will still be responsible for any balance bill.**

Remember you are responsible for making sure your provider obtains precertification as required.

If BCBSAZ Precertifies Your Service

- If BCBSAZ precertifies you for services from an out-of-network provider at the in-network cost-share, you are responsible for the provider's balance bill in addition to any applicable deductible, coinsurance, copays and access fees.
- Precertification is not a pre-approval or a guarantee of payment. Precertification made in error by BCBSAZ is not a waiver of BCBSAZ's right to deny payment for noncovered services.
- You and your provider will receive a letter explaining the scope of the precertification.

If BCBSAZ Denies Your Precertification Request

If BCBSAZ denies your precertification request, you or your provider may appeal. Information on where to file an appeal is in the BCBSAZ customer service section at the front of this book.

If your request for precertification of a service is denied because BCBSAZ decides that the service is not medically necessary, remember that BCBSAZ's interpretation of medical necessity is a benefits determination made in accordance with the provisions of this plan. Your provider may recommend services or treatment not covered under this plan. You and your provider should decide whether to proceed with the service or procedure if BCBSAZ denies precertification.

Care Coordination

If you seek outpatient services (other than behavioral therapy for treatment of autism spectrum disorders) through the BSA, you will need to call the BSA before you make an appointment with a provider. The BSA will help you determine the type of provider best suited to your needs and provide you with provider names. After you have chosen a provider and scheduled your first appointment, you will need to contact the BSA so they can send necessary paperwork to the provider.

DESCRIPTION OF BENEFITS

Please review this section for an explanation of covered services and benefit-specific limitations and exclusions. Also be sure to review “What is Not Covered” for general exclusions and limitations that apply to all benefits.

To be covered and eligible for benefits, a service must be:

- a benefit of this plan;
- medically necessary as determined by BCBSAZ;
- not excluded;
- not experimental or investigational as determined by BCBSAZ;
- precertified if precertification is required;
- provided while this benefit plan is in effect and while the person claiming benefits is an eligible member;
- **and**
- rendered by an eligible provider acting within the provider’s scope of practice, as determined by BCBSAZ.

BCBSAZ does not determine whether a service is covered under this benefit plan until after services are provided and BCBSAZ receives a complete claim describing the services actually rendered.

Most diagnosis, management and treatment of behavioral health conditions that are eligible for benefits, including medication management, are covered under your behavioral and mental health benefit. Depending on how your provider submits a claim and the scope of services provided, certain services involving both behavioral health and medical diagnoses may be covered under the behavioral and mental health benefit, and cost-shares for behavioral and mental health services will apply.

Benefits are listed in alphabetical order:

A. **AMBULANCE SERVICES**

Precertification: Not required.

Your Cost-Share: Deductible is waived. You pay 20 percent of the allowed amount.

Benefit Description: Ground ambulance transportation from the site of an emergency, accident or acute illness to the nearest facility capable of providing appropriate treatment; **or**

Interfacility ground or air ambulance transfer for admission to an acute care facility, extended active rehabilitation facility or skilled nursing facility when the transferring facility is unable to provide the level of service required; **or**

Air ambulance transportation to the nearest facility capable of providing appropriate treatment when the emergency, accident or acute illness occurs in an area inaccessible by ground vehicles or transport by ground ambulance would be harmful to the member’s medical condition.

Benefit-Specific Exclusion: All other expenses for travel and transportation are not covered, except for the limited travel benefits described in “Transplant Travel and Lodging.”

B. **BEHAVIORAL AND MENTAL HEALTH SERVICES** (including chemical dependency or substance abuse treatment)

Behavioral and Mental Health Services (Outpatient Facility and Professional Services):

Precertification: Not required for services from the BSA; however, you must contact the BSA for care coordination before receiving services.

Your Cost-Share:

BSA: You pay one copay per member, per office visit.

Non-BSA (in-network): You pay one copay per member, per office or home visit. The amount of your copay will vary depending on the type of provider you see during the visit. See your schedule

page for the applicable copay. BCBSAZ pays 100 percent of the allowed amount for outpatient services delivered in locations other than the provider's office or the member's home.

Non-BSA (out-of-network): You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Non-emergency outpatient behavioral and mental health services are available either through office visits to BSA providers or from non-BSA providers. Those services include psychotherapy, outpatient therapy services for chemical dependency or substance abuse, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, electroconvulsive therapy (ECT), and counseling for personal and family problems. **Outpatient mental health services are not available from the BSA outside the provider's office. BSA services are available only in Arizona.**

Behavioral and Mental Health Services (Inpatient):

Precertification: Required for non-emergency inpatient behavioral and mental health admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share:

In-Network Facility and Professional Services: You pay one inpatient admission copay per member, per admission, then BCBSAZ pays 100 percent of the allowed amount.

Out-of-Network Facility and Professional Services: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Inpatient facility and professional behavioral and mental health services are covered. Benefits are available for inpatient behavioral and mental health services that meet all the following criteria:

- The inpatient program is provided in a facility licensed to provide an inpatient level of care;
- The facility designated medical director is a psychiatrist or physician with behavioral or mental health work experience, and is in charge of the medical services at the facility;
- A behavioral or mental health medical practitioner is present at the facility or on-call at all times to admit to the inpatient program and respond to the needs of patients;
- The facility's license requires 24/7 nursing coverage;
- The facility has sufficient behavioral or mental health professional staff to provide appropriate treatment; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.

Behavioral and Mental Health Emergency Services (Professional and Facility Charges):

Precertification: Not required.

Your Cost Share: For emergency services, you will pay your in-network cost share, even for services from out-of-network providers. If you receive services from a noncontracted provider, you will also be responsible for the balance bill, which may be substantial.

Emergency Room: You pay one access fee per member, per facility, per day then BCBSAZ pays 100 percent of the allowed amount for emergency room professional, ancillary and facility charges.

Admission to the Hospital from the Emergency Room: The emergency room access fee is waived if you are admitted to the hospital. Following admission, BCBSAZ pays 100 percent of the allowed amount for all other hospital and professional services related to the emergency.

If you receive emergency services from a noncontracted facility or professional provider, BCBSAZ will base the allowed amount used to calculate your cost-share on the highest of the three following amounts, not to exceed the applicable provider's billed charges:

- The median in-network provider negotiated rate for the emergency service furnished,
- The amount for the emergency service calculated using the same method BCBSAZ generally uses to determine reimbursement for non-emergency out-of-network services, or
- The amount that would be paid by Medicare Part A or B.

The provider's billed charges often exceed the above amounts, which leaves a balance bill. **You will be responsible for the balance bill, which may be substantial.**

For all non-emergency services following the emergency treatment and stabilization, you pay applicable deductible, coinsurance, copays and access fees. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which may be substantial.

Benefit Description: Benefits are available for emergency behavioral and mental health services.

Behavioral Therapy Services For The Treatment Of Autism Spectrum Disorder

Precertification: Required. If you fail to obtain precertification, behavioral therapy services for the treatment of autism spectrum disorder will not be covered.

Your Cost-Share:

BSA: You pay one copay per member, per office or home visit. Your cost-share is waived for services delivered in locations other than the provider's office or the member's home.

Non-BSA (in-network): You pay one copay for behavioral therapy services provided during an office or home visit. The amount of your copay will vary depending on the type of provider you see during the visit. See your schedule page for the applicable copay. BCBSAZ pays 100 percent of the allowed amount for behavioral therapy services delivered in locations other than the provider's office or the member's home.

Non-BSA (out-of-network): You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definitions:

"Autism Spectrum Disorder" means Autistic Disorder, Asperger's Syndrome, or Pervasive Developmental Disorder (not otherwise specified), as defined in the BCBSAZ Medical Coverage Guidelines and referenced in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral Therapy" means interactive therapies derived from evidence-based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

Benefit Description: Behavioral therapy services for the treatment of Autism Spectrum Disorder are available for members who have been diagnosed with Autism Spectrum Disorder. Services are available either through the BSA or from non-BSA providers. Covered behavioral therapy services must be delivered by a provider who is licensed or certified as required by law. **BSA services are available only in Arizona.**

Benefit- Specific Exclusions (applicable to all Behavioral and Mental Health Services):

- Activity therapy, milieu therapy and any care primarily intended to assist an individual in the activities of daily living
- Biofeedback and hypnotherapy
- Development of a learning plan and treatment and education for learning disabilities (such as reading and arithmetic disorders)
- IQ testing
- Lifestyle education and management services

- Neurofeedback
- Neuropsychological and cognitive testing
- Partial hospitalization
- Inpatient and outpatient facility charges for services provided by the following facilities are not covered: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes. Inpatient and outpatient facility charges for services provided by residential treatment facilities are not covered except for very limited situations based upon BCBSAZ medical necessity criteria. All other inpatient and outpatient services provided by residential treatment facilities are not covered.

C. **CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES**

Precertification: Not required.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for outpatient Phase I and II cardiac rehabilitation programs and pulmonary rehabilitation services.

D. **CATARACT SURGERY**

Precertification: Required for inpatient cataract surgery. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable inpatient admission copays, deductible, coinsurance and copays for the cataract surgery and any associated services. The cost-share amount will depend on the provider's network status and the place you receive services. BCBSAZ pays 100 percent of the allowed amount, up to \$250, then you pay 25 percent coinsurance for contacts following cataract surgery received from in-network providers. You pay out-of-network deductible and coinsurance for contacts following cataract surgery received from out-of-network providers, which does not count toward any out-of-pocket maximums. In addition, you pay any amounts above the \$250 maximum per member, per six (6) month period for eyeglasses. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for the removal of cataracts, including placement of a single intraocular lens at the time of the cataract removal. Benefits are also available for the first pair of external contact lenses or eyeglasses post-cataract surgery or for treatment of keratoconus. The eyeglasses or external contact lenses must be prescribed and purchased within six (6) months of the surgery.

Benefit-Specific Exclusion: Any procedures associated with cataract surgery that are not included in the benefit description, including replacement, piggyback or secondary intraocular lenses or any other treatments or devices for refractive correction.

E. **CHIROPRACTIC SERVICES**

Precertification: Not required.

Your Cost-Share:

In-Network: You pay one copay for each office, home or walk-in clinic visit. BCBSAZ pays 100 percent of the allowed amount for services provided in locations other than an office, home or walk-in clinic, including but not limited to, inpatient and outpatient facilities. The copay does not apply if you receive only physical therapy (PT) services and no other covered service during your office, home or walk-in clinic visit. BCBSAZ pays 100 percent of the allowed amount for the first 160 modalities or therapeutic services of PT provided and billed by an in-network chiropractor, regardless of the location where services are provided. After 160 modalities/therapeutic services of PT, you pay 50 percent coinsurance.

In-Network: You pay one copay, per member, per provider, per day for office, home, or walk-in clinic visits. The copay does not apply if you receive only physical therapy (PT) services and no other covered service during your visit. For physical therapy services, you pay deductible. You pay deductible for services provided in locations other than an office, home or walk-in clinic, including but not limited to, inpatient and outpatient facilities.

Out-of-Network: You pay out-of-network deductible and coinsurance for services rendered by an out-of-network provider. You pay out-of-network deductible and coinsurance for the first 160 modalities or therapeutic services of PT provided and billed by an out-of-network chiropractor. After 160 modalities/therapeutic services of PT provided and billed by an out-of-network chiropractor, you pay 50 percent coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for chiropractic services.

Benefit-Specific Exclusions:

- Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Spinal decompression or vertebral axial decompression therapy

F. CLINICAL TRIALS FOR TREATMENT OF CANCER AND OTHER LIFE-THREATENING DISEASES

Precertification: Required for services directly associated with a clinical trial for treatment of cancer or other life-threatening diseases or conditions. Precertification will be issued in accordance with the requirements of applicable law, regardless of whether the clinical trial would otherwise be considered investigational. See specific benefit provisions for precertification charges.

Precertification of covered services directly associated with an eligible clinical trial is not a guarantee of coverage, assurance that the clinical trial satisfies the requirements of applicable law or evidence of any determination that the service provided through the clinical trial is safe, effective or appropriate for any member.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: A "life-threatening disease or condition" is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefit Description: Benefits are available for covered services directly associated with a member's participation in a clinical trial meeting all requirements specified by applicable Arizona and/or federal law. Benefits are limited to those services eligible for coverage under this plan that would be required if you received standard, non-investigational treatment. If you have any questions about whether a particular service will be covered, please contact BCBSAZ customer service. You or your provider must inform BCBSAZ that you are enrolled in a clinical trial, that the trial meets the requirements of applicable law, and that the services to be rendered are directly associated with the trial. Otherwise, BCBSAZ will administer your benefits according to the other terms of your benefit plan, which may result in a denial of benefits.

Benefit-Specific Exclusions:

- Investigational medications (except as stated in "*Prescription Medications for the Treatment of Cancer*") and devices
- Any item, device or service that is the subject of the clinical study, or which is provided solely to meet the need for data collection and analysis
- Costs and services customarily paid for by government, biotechnical, pharmaceutical and medical device industry sources

- Costs to manage the clinical trial research
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services not otherwise covered under this plan

G. DENTAL SERVICES BENEFIT

Not all dentists who are contracted with BCBSAZ are contracted to provide medical-related dental services. Call BCBSAZ customer service with questions.

1. Dental Accident Services

Precertification: Not required.

Your Cost-Share: You pay applicable inpatient admission copays, deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definitions:

"Accidental dental injury" is an injury to the structures of the teeth that is caused by an external force or element such as a blow or fall. An injury to a tooth while chewing is not considered an accidental dental injury, even if the injury is due to chewing on a foreign object.

A "sound tooth" is a tooth that is:

- Whole or virgin; **or**
- Restored with amalgam (silver filling) or composite resin (tooth-colored filling) or restored by cast metal, ceramic/resin-to-metal or laboratory processed resin/porcelain restorations (crowns); **and**
- Without current periodontal (tissue supporting the tooth) disease or current endodontal (tooth pulp or root) disease; **and**
- Not in need of the treatment provided for any reason other than as the result of an accidental dental injury.

Benefit Description: Benefits are only available for the following services to repair or replace sound teeth damaged or lost by an accidental dental injury:

Covered Services:

- Extraction of teeth damaged as a result of accidental dental injury
- Original placement of fixed or removable complete or partial dentures
- Original placement, repair or replacement of crowns
- Original placement, repair or replacement of veneers
- Orthodontic services directly related to a covered accidental injury

Benefit-Specific Exclusions:

- Gold foil restorations or inlays
- Occlusal rehabilitation and reconstruction
- Original placement, repair or replacement of dental implants and any related services
- Repair and replacement of fixed or removable complete or partial dentures
- Routine dental care
- Routine extractions

2. Dental Services Required for Medical Procedures

Precertification: Required for non-emergency inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable inpatient admission copays, deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for dental services which are required in order to perform the medical services listed in this benefit. These dental services may either be part of the medical procedure or may be performed in conjunction with and made medically necessary solely because of the medical procedure.

Benefits are available for the following:

- Diagnostic services prior to planned organ or stem cell transplantation procedures
- Removal of teeth required for covered treatment of head and neck cancer or osteomyelitis of the jaw
- Restoration of teeth made medically necessary because of the covered treatment of head and neck cancer or osteomyelitis of the jaw

Benefit-Specific Exclusions:

- Dental implants and any related services
- Gold foil restorations and inlays
- Occlusal rehabilitation and reconstruction
- Orthodontic services
- Routine dental care
- Routine extractions
- Repair and replacement of fixed or removable complete or partial dentures

3. Medical Services Required for Dental Procedures (Facility and Professional Anesthesia Charges)

Precertification: Required for non-emergency inpatient admissions. If you fail to obtain precertification, these services will not be covered.

Your Cost-Share: You pay applicable inpatient admission copays, deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for facility and professional anesthesiologist charges to perform dental services under anesthesia in an inpatient or outpatient facility due to one or more of the following concurrent or co-morbid conditions:

- Children 5 years or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office
- Malignant hypertension
- Mental retardation
- Senility or dementia
- Unstable cardiovascular condition
- Uncontrolled seizure disorder

H. DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS

Precertification: Not required.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. For services from an in-network provider, your cost-share is waived for one FDA-approved manual or electric breast pump and breast pump supplies per female member, per calendar year. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

1. Durable Medical Equipment (DME)

Benefit Description: To be eligible for coverage, DME must meet all of the following criteria:

- Be designed for repeated medical use in the home setting;
- Be specifically designed to improve or support the function of a body part;
- Cannot be primarily useful to a person in the absence of an illness or injury; **and**

- Intended to prevent further deterioration of the medical condition for which the equipment has been prescribed.

Benefits are available for DME rental up to the purchase price of the item, as determined by BCBSAZ, and for DME repair or replacement due to normal wear and tear caused by use of the item in accordance with the manufacturer's instructions or due to growth of a child. Benefits are limited to the allowed amount for the DME item base model. BCBSAZ will determine what is covered as the base model. Deluxe or upgraded DME items may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusions: The following services or charges are not covered:

- Charges for continued rental of a DME item after the purchase price is reached
- Repair costs that exceed the replacement cost of the DME item
- Repair or replacement of DME items lost or damaged due to neglect or use that is not in accordance with the manufacturer's instructions or specifications

2. Medical Supplies

Benefit Description: Benefits are available for the following medical supplies:

- Any device or supply required by applicable law or as otherwise permitted under the Medical Coverage Guidelines
- Blood glucose monitors
- Blood glucose monitors for the legally blind and visually impaired
- Diabetic injection aids and drawing-up devices
- Diabetic syringes and lancets
- Ostomy and urinary catheter supplies
- Peak flow meters
- Supplies associated with oxygen or respiratory equipment
- Test strips for glucose monitors and urine test strips
- Volume nebulizers

Benefits are limited to the allowed amount for the medical supply base model. BCBSAZ will determine what is covered as the base model. Deluxe or upgraded medical supplies may be eligible for coverage based upon BCBSAZ medical necessity criteria.

3. Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- Prosthetic appliances to replace all or part of the function of an inoperative or malfunctioning body organ or to replace an eye or limb lost as a result of trauma or disease
- Orthotics (such as foot orthotics, collars, braces, molds) to protect, restore or improve impaired bodily function
- Wig(s) for individuals diagnosed with alopecia (absence of hair) resulting from illness or injury (up to a maximum benefit of \$300 per member, per calendar year)
- Orthopedic shoes that are:
 - ◆ attached to a brace;
 - ◆ therapeutic shoes (depth inlay or custom-molded) along with inserts, for individuals with diabetes; or
 - ◆ covered in accordance with BCBSAZ medical necessity criteria.

Benefits are limited to the allowed amount for the prosthetic appliance or orthotic base model. BCBSAZ will determine what is covered as the base model. Deluxe or upgraded prosthetic appliances or orthotics may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusion: Prosthetic appliances and orthotics exceeding one unit or one pair, as applicable, per member, per calendar year

Benefit-Specific Exclusions (apply to Durable Medical Equipment, Medical Supplies and Prosthetic Appliances and Orthotics):

- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, cushions, disposable hygienic items, dressing aids and devices, elastic/support stockings (except TED hose), elevators, exercise equipment, foot stools, grab bars, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs and vehicle or home modifications.
- Hospital grade breast pumps and hospital grade breast pump supplies
- Manual and electric breast pumps and supplies for male members
- Items used primarily for assistance in daily living, socialization, personal comfort, convenience or other non-medical reasons
- Strollers of any kind
- Tilt or inversion tables or suspension devices
- Supplies used by a provider during office treatments
- Wig(s), when hair loss results from male or female-pattern baldness or natural or premature aging

I. EDUCATION AND TRAINING

Precertification: Not required for services from the BSA; however, you must contact the BSA for care coordination before receiving lifestyle education and management services, biofeedback or hypnotherapy. Not required for other education and training services.

Your Cost-Share: See descriptions under subheadings.

1. Diabetes and Asthma Education and Training

Your Cost-Share: Waived.

Benefit Description: Benefits are available for diabetes and asthma education and training that meet the following criteria:

- An in-network provider delivers the education and training;
- Education and training are provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Training is conducted in person; **and**
- Your health care provider prescribes the training as part of a comprehensive plan of care related to your condition to enhance therapy compliance and improve self-management skills and knowledge.

Benefit-Specific Exclusion: Diabetes and asthma education and training provided by an out-of-network provider.

2. Nutritional Counseling and Training

Your Cost-Share: Copays are waived for services from an in-network provider. You pay out-of-network deductible and coinsurance for services from an out-of-network provider. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: Benefits are available for a maximum of three (3) nutritional counseling and training visits per member, per calendar year.

Benefit Description: Nutritional counseling and training is available only for members diagnosed with the following conditions:

- Coronary Artery Disease
- Heart Failure
- High Cholesterol

- Hypertension
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

3. Lifestyle Education and Management Services, Biofeedback and Hypnotherapy

Your Cost-Share: You may pay one copay per member, per visit for services provided through the BSA. If you are referred to a BCBSAZ or community resource, you may be responsible for additional fees. Check with the provider regarding fees before obtaining services.

Benefit Description:

- Lifestyle education and management services, which are designed to provide members with information, skills and social support to maximize health
- Biofeedback
- Hypnotherapy

Lifestyle education and management services, biofeedback and hypnotherapy services are available only through the BSA. **BSA services are available only in Arizona.**

J. EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)

Precertification: Not required.

Your Cost Share: For emergency services, you will pay your in-network cost share, even for services from out-of-network providers. If you receive services from a noncontracted provider, you will also be responsible for the balance bill, which may be substantial.

Emergency Room: You pay one access fee per member, per facility, per day then BCBSAZ pays 100 percent of the allowed amount for emergency room professional, ancillary and facility charges.

Admission to the Hospital from the Emergency Room: The emergency room access fee is waived if you are admitted to the hospital. Following admission, BCBSAZ pays 100 percent of the allowed amount for all other hospital and professional services related to the emergency.

If you receive emergency services from a noncontracted facility or professional provider, BCBSAZ will base the allowed amount used to calculate your cost-share on the highest of the three following amounts, not to exceed the applicable provider's billed charges:

- The median in-network provider negotiated rate for the emergency service furnished,
- The amount for the emergency service calculated using the same method BCBSAZ generally uses to determine reimbursement for non-emergency out-of-network services, or
- The amount that would be paid by Medicare Part A or B.

The provider's billed charges often exceed the above amounts, which leaves a balance bill. **You will be responsible for the balance bill, which may be substantial.**

For all non-emergency services following the emergency treatment and stabilization, you pay applicable deductible, coinsurance, copays and access fees. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which may be substantial.

Benefit Description: Benefits are available for services needed to treat an emergency.

Teletrauma Services:

If a member is receiving covered emergency services, benefits may be available for teletrauma consultations between providers at the facility where the member is being treated and providers at certain Level 1 trauma centers. In order for teletrauma services to be covered, the member must be receiving emergency treatment in a facility that is not equipped to handle that member's medical condition and the treating providers must need the consultation to appropriately treat or stabilize the member. A teletrauma consultation may include telephonic or electronic communications between

providers and video presentation of the member's condition. Both facilities must have certain equipment to facilitate the teletrauma communications.

For purposes of this benefit, "trauma" is defined as a physical wound or injury that results from a sudden accident or violent cause and which, if not immediately treated, is likely to result in death, permanent disability or severe pain.

K. EOSINOPHILIC GASTROINTESTINAL DISORDER

Precertification: Not required.

Your Cost-Share: Deductible is waived. You pay 25 percent of the Cost for amino-acid based formula ("Formula").

Benefit-Specific Definitions: "Cost" is defined as either billed charges, if the Formula is purchased from an out-of-network provider, or the allowed amount, if purchased from an in-network provider.

Benefit Description: Benefits are available for Formula for members who meet all of the following criteria:

- At risk of mental or physical impairment if deprived of the Formula;
- Diagnosed with eosinophilic gastrointestinal disorder; **and**
- Under the continuous supervision of a physician or a registered nurse practitioner.

L. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Precertification: Required for inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share:

Implanted Devices: Your cost-share is waived for professional charges for implantation and/or removal of FDA-approved implanted contraceptive devices for female members when the purpose of the procedure is contraception, as documented by your provider on the claim, and the device is inserted and/or removed in an in-network physician office. You pay applicable deductible, coinsurance and copays when the location of service is outside an in-network physician office. If you receive services from a noncontracted provider, you also pay the balance bill.

Sterilization Procedures: Your cost-share is waived for professional and facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim. You pay out-of-network deductible and coinsurance for professional and facility charges from out-of-network providers for FDA-approved sterilization procedures provided to female members. You pay applicable deductible, coinsurance and copays for professional and facility charges from in- and out-of-network providers for FDA-approved sterilization procedures provided to male members. If you receive services from a noncontracted provider, you also pay the balance bill.

Hormonal Contraceptive Methods (includes oral contraceptives, patches, rings and contraceptive injections). See the "Physician Services" section and the "Prescription Medications Obtained From a Retail or Mail Order Pharmacy" section for benefits and cost-share.

Emergency Contraception: FDA-approved over-the-counter emergency contraception is covered when prescribed by a physician or other provider. See the "Prescription Medications Obtained From a Retail or Mail Order Pharmacy" section for benefits and cost-share.

Barrier Contraceptive Methods (includes diaphragms, cervical caps and cervical shields). See the "Physician Services" section and the "Prescription Medications Obtained From a Retail or Mail Order Pharmacy" section for benefits and cost-share.

Benefit Description: Benefits are available for FDA-approved contraceptive methods and sterilization procedures that require a physician or other provider prescription.

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices for male members, even if the contraceptive method or device is FDA-approved and prescribed by a physician or other provider, including but not limited to, male condoms.

M. HEARING SERVICES

Precertification: Not required.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays for hearing exams. You pay 50 percent of the cost of hearing aids or appliances. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill. Your payments for hearing exams and your 50 percent coinsurance for hearing aids received from out-of-network providers does not count toward any out-of-pocket maximums.

Benefit Maximum: There is a maximum benefit of one (1) hearing aid or appliance per ear, per member, per every three (3) years. In addition, benefits are available for one (1) hearing exam per member, per calendar year.

N. HOME HEALTH AND HOME INFUSION - MEDICATION ADMINISTRATION THERAPY

Precertification: Required for certain medications covered under this benefit. Go to www.azblue.com for a listing of medications that require precertification or call the customer service number listed in the front of this book. If you fail to obtain precertification for these medications, they will not be covered.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: Any combination of skilled nursing services necessary to provide home infusion medication administration, enteral nutrition and/or other services requiring skilled nursing care, up to a maximum of six (6) hours per member, per day.

Benefit Description: Benefits are available for the following services:

- Home infusion medication administration therapy, including:
 - ◆ Blood and blood components
 - ◆ Hydration therapy
 - ◆ Intravenous catheter care
 - ◆ Intravenous, intramuscular or subcutaneous administration of medication
 - ◆ Specialty injectable medications, as defined by BCBSAZ
 - ◆ Total parenteral nutrition
- Enteral nutrition (tube feeding) when it is the sole source of nutrition. Sole source of nutrition is defined as the inability to orally receive more than 30 percent of daily caloric needs.
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition and other services that require skilled nursing care

The services covered under this section must meet the following criteria:

- A licensed home health agency must provide the services;
- A health care provider must order the services pursuant to a specific plan of home treatment;
- Services must be provided in the member's residence;
- The health care provider must regularly review the appropriateness of the services ("regularly" means at least every thirty (30) days or more frequently if appropriate under the treatment plan); and
- The services must be provided by a licensed practical nurse (L.P.N.) or a registered nurse (R.N.) or another eligible provider.

Benefit-Specific Exclusions:

- Any combination of skilled nursing services necessary to provide home infusion medication administration, enteral nutrition and/or other services requiring skilled nursing care in excess of six (6) hours per member, per day
- Custodial care
- Respite care

O. HOSPICE SERVICES

Precertification: Required for inpatient admissions not related to hospice services. Not required for inpatient hospice admissions. If you fail to obtain required precertification, you will be responsible for a precertification charge, or inpatient services will not be covered, depending on the type of admission.

Your Cost-Share: Deductible and coinsurance are waived for in- and out-of-network hospice services. If you receive services from a noncontracted provider, you may pay the balance bill.

Benefit-Specific Definition: “Hospice services” are an alternative multi-disciplinary approach to medical care for the terminally ill. No curative or aggressive treatments are used.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.

Benefit Description: When a member elects to use the hospice benefit, it is in lieu of other medical benefits available under this plan, except for care unrelated to the terminal illness or related complications.

The hospice agency determines the required level of care, which is subject to the medical necessity provision of the benefit plan. Once the member selects the hospice benefit, the hospice agency coordinates all of the member’s health care needs related to the terminal illness.

The member’s physician must certify that the member is in the later stages of a terminal illness and prescribe hospice care, which must be provided by a state-licensed hospice agency. The member must meet the requirements of the hospice.

Benefits are available for the following:

- ***Continuous Home Care:*** 24-hour skilled care provided by an RN or LPN during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- ***Inpatient Acute Care:*** Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- ***Respite Care:*** Admission of the member to an approved facility for up to five (5) days to provide rest to the member’s family or primary caregiver; respite care is available once every twenty-one (21) days
- ***Routine Care:*** Intermittent visits provided by a member of the hospice team

P. INPATIENT DETOXIFICATION

Precertification: Required for non-emergency admissions. If you fail to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable inpatient admission copays, deductible and coinsurance. The cost-share amount will depend on the provider’s network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: “Detoxification services” means the initial medical treatment and support provided to a chemically dependent or addicted individual during acute withdrawal from a drug or substance.

Benefit Description: Benefits are available for medical observation and intervention to stabilize a member who has developed substance intoxication due to the ingestion, inhalation or exposure to one or more substances.

Q. INPATIENT HOSPITAL

Precertification: Required prior to all elective or scheduled inpatient admissions. If you fail to obtain precertification for elective or scheduled inpatient admissions, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable inpatient admission copays, deductible and coinsurance for inpatient admissions. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share is waived for facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.

Benefit Description:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including radiology and laboratory services
- General, spinal and caudal anesthetic provided in connection with a covered service
- Intensive care units and other special care units
- Medications, biologicals and solutions
- Operating, recovery and treatment rooms and equipment for covered services
- Radiation therapy or chemotherapy, except in conjunction with a noncovered transplant
- Room and board in a semi-private room, unless the hospital only has private rooms. If the hospital only has private rooms, only standard private rooms are covered (not deluxe).

Benefit-Specific Exclusion: Medications dispensed at the time of discharge from a hospital

R. INPATIENT REHABILITATION SERVICES – EXTENDED ACTIVE REHABILITATION (EAR)

Precertification: Required. If you fail to obtain precertification for an EAR admission, the services will not be covered.

Your Cost-Share:

In-Network: BCBSAZ pays 100 percent of the allowed amount.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive EAR services at a noncontracted provider, you also pay the balance bill, in addition to out-of-network deductible and coinsurance.

After 150 days of care, you pay all charges for EAR services for the remainder of the calendar year.

Benefit Maximum: 150 days of EAR services per member, per calendar year.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.

Benefit Description: An intense therapy program provided in a facility licensed to provide extended active rehabilitation. This care is for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience, except for limited hospice benefits
- Custodial Care
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

S. LONG-TERM ACUTE CARE (INPATIENT)

Precertification: Required. If you fail to obtain precertification for a long-term acute care admission, those services will not be covered.

Your Cost-Share:

In-Network: BCBSAZ pays 100 percent of the allowed amounts.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: Plan coverage is limited to three hundred sixty-five (365) days of long-term acute care per member. If you have questions about the benefit maximum, contact BCBSAZ customer service at the number listed at the front of this book.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.

Benefit Description: Specialized acute, medically complex care for patients provided in a facility licensed to provide long-term acute care. This care is for patients who require hospitalization on an extended basis in a facility offering specialized treatment programs and aggressive clinical and therapeutic interventions.

Benefit-Specific Exclusions:

- Custodial Care
- Respite Care

T. MATERNITY

Precertification: Not required

Your Cost-Share:

Inpatient Services: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Outpatient Services:

In-Network: You pay one physician visit copay, which covers all prenatal visits, the physician's global charge and other physician office and home visits submitted with a primary diagnosis of maternity. If the amount of your physician visit copay changes during the course of your pregnancy, you will also pay the difference between the two copay amounts in addition to the original copay amount (even though you already paid the original copay amount). If maternity is not the primary diagnosis on a claim submitted by your provider for a physician visit, you will pay an additional physician visit copay per member, per provider, per day. You pay copays for other covered maternity services from any other in-network providers.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided in the member's home must be rendered by an eligible provider. Your cost-share will vary depending on the type of provider and the provider's network status.

Applicable deductible and copays are waived for maternity services covered under the "Preventive Services" benefit and delivered by an in-network provider. If you receive these services from an out-of-network provider, the services will be covered through your maternity benefit and you will pay the out-of-network cost-share. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share obligations may be affected by the automatic addition of a newborn or adopted child, as described in the **Plan Administration** section of this book. If you have coverage only for yourself and no dependents, automatic addition of a child will result in a change from individual coverage to family coverage. If you currently have a per person deductible and out-of-pocket maximum, when a child is added to your plan, you will also be required to meet a family deductible and out-of-pocket maximum, and you may be required to pay additional premium.

Benefit-Specific Definition:

Global Charge: A fee charged by the delivering provider that may include certain prenatal, delivery and postnatal services.

Benefit Description:

Maternity benefits are available for covered services related to pregnancy. This includes certain screening tests such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases and others as determined by BCBSAZ. Certain tests, including some genetic screening, may not be covered. For a complete listing of covered prenatal screening, please call BCBSAZ customer service at the numbers listed in the front of this benefit book.

Maternity benefits are available for the expense incurred by a birth mother (who is not a member) for the birth of any child legally adopted by a member, if all of the following requirements are met:

- The member adopts the child within one year of birth;
- The member is legally obligated to pay the costs of birth; **and**
- The member has provided notice to BCBSAZ within sixty (60) days of the member's acceptability to adopt children.

This adopted child maternity benefit is secondary to any other coverage available to the birth mother. Contact Membership Services at the number listed in the front of this book to receive a BCBSAZ adoption packet.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

U. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Precertification: Not required.

Your Cost-Share: Deductible is waived. You pay 50 percent of the allowed amount for Medical Foods.

Benefit-Specific Definitions:

“Inherited Metabolic Disorder” means a disease caused by an inherited abnormality of body chemistry that meets all of the following requirements:

- The disorder is one of the diseases tested under the newborn screening program required under Arizona law (A.R.S. § 36-694);
- The disorder is such that an afflicted individual will need to consume Medical Foods throughout life in order to avoid serious mental or physical impairment; **and**
- The disorder must involve amino acid, carbohydrate or fat metabolism and have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues as determined by BCBSAZ.

“Medical Foods” means modified low protein foods and metabolic formulas that are all of the following:

- Administered for the medical and nutritional management of a member who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation;
- Essential to the member’s optimal growth, health and metabolic homeostasis;
- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an M.D. or D.O. physician or a registered nurse practitioner;
- Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs (metabolic formula only); **and**
- Processed or formulated to contain less than one gram of protein per unit of serving (modified low protein foods only).

Benefit Description: Benefits are available for Medical Foods to treat Inherited Metabolic Disorders.

Benefit-Specific Exclusions:

- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available for purchase without a prescription or order from an M.D. or D.O. physician or registered nurse practitioner
- Foods and formulas that do not require supervision by an M.D. or D.O. physician or a registered nurse practitioner
- Medical food benefits are not available for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
- Spices and flavorings

Claim submission for Medical Foods

You may buy Medical Foods from any source. If you buy Medical Foods from an out-of-network provider, you must submit a claim form with the following information:

- Member’s diagnosis for which the Medical Foods were prescribed or ordered;
- Member’s name, identification number, group number and birth date;
- Prescribing or ordering physician or registered nurse practitioner;
- The amount paid for the Medical Foods;
- The dated receipt or other proof of purchase; **and**
- The name, telephone number and address of the Medical Food supplier.

Please contact BCBSAZ at the Supply Line number listed at the front of this book to request copies of the Medical Foods Claim Form. To obtain reimbursement for Medical Foods you purchased directly, please submit the Medical Foods Claim Form and the dated receipt to the address for claims submission at the front of this book.

Medical Foods also may be covered under the “*Home Health and Home Infusion—Medication Administration Therapy*” benefit. Medical Foods are not covered under the “*Prescription Medications Obtained from a Retail or Mail Order Pharmacy*” or the “*Specialty Self-Injectable Medications*” benefits.

V. MEDICINE MEN

Precertification: Not required.

Your Cost-Share: You pay 50 percent of the provider’s billed charges. Your payments for services received from medicine men do not count toward any out-of-pocket maximums.

Benefit Maximum: There is a benefit maximum of \$500 per member, per calendar year.

Benefit Description: Benefits are available for services provided by Medicine Men.

W. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Precertification: Not required.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider’s network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Services are available for the evaluation of decreased mental function or developmental delay.

X. OUTPATIENT SERVICES

Precertification: Not required.

Your Cost-Share: Outpatient services are often available in multiple settings, and generally result in separate charges for professional and facility services. Your cost-share will vary depending on the type of outpatient service, the location of the service, and the provider’s network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share is waived for facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception as documented by your provider on the claim.

Outpatient Surgery:

In-Network: You pay one copay per surgery, per member, then BCBSAZ pays 100 percent of the allowed amount.

Out-of-Network: You pay out-of-network deductible and coinsurance.

Diagnostic Laboratory services

- ***In-Network Physician’s Office:*** You pay the physician visit copay (copay is waived if you receive only covered laboratory services during your visit).
- ***In-Network Clinical Laboratory:*** Your cost-share is waived.
- ***In-Network Hospital Outpatient Laboratory Department:*** BCBSAZ pays 100 percent of the allowed amount.
- ***Out-of-Network Physician’s Office, Clinical Laboratory or Hospital Outpatient Laboratory Department:*** You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Radiology services

- ***In-Network Physician’s Office:*** You pay the physician visit copay.
- ***In-Network Hospital Radiology Department and Free-Standing Radiology Facility:*** BCBSAZ pays 100 percent of the allowed amount.

- **Out-of-Network Physician's Office, Free-Standing Radiology Facility or Hospital Radiology Department:** You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided by a radiologist or pathologist, including a dermapathologist, are always subject to applicable deductible and coinsurance, even when the services are provided in a physician's office.

Benefit Description: Benefits are available for the following outpatient services:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including laboratory and radiology services
- Outpatient surgery, which is defined as operative procedures and other invasive procedures such as epidural injections for pain management and various scope procedures, such as arthroscopies and colonoscopies.
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant

Y. PHYSICAL THERAPY (PT) - OCCUPATIONAL THERAPY (OT) - SPEECH THERAPY (ST)

Precertification: Not required.

Your Cost-Share:

In-Network: BCBSAZ pays 100 percent of the allowed amount for the first 160 modalities or therapeutic services for PT and OT and the first 20 visits for ST. After 160 modalities /therapeutic services and 20 visits, you pay 50 percent coinsurance.

Out-of-Network: Deductible is waived. You pay out-of-network coinsurance for the first 160 modalities or therapeutic services for PT and OT and the first 20 visits for ST. After 160 modalities/therapeutic services and 20 visits, you pay 50 percent coinsurance.

If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for physical therapy, occupational therapy and speech therapy services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience, except for limited hospice benefits
- Cognitive therapy
- Computer speech training and therapy programs and devices
- Custodial Care
- Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines
- Physical or occupational therapeutic services performed in a group setting of 2 or more individuals
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Strength training, cardiovascular endurance training, fitness programs, strengthening programs and other services designed primarily to improve or increase strength

Z. PHYSICIAN SERVICES

Precertification: Not required.

Your Cost-Share: The physician visit copay shown on your SBC applies to each in-network physician office and home visit, except as specified within this benefit. Some services in a physician office or the member's home and all services rendered by a physician outside a physician office or member's home (e.g., surgery) are subject to applicable deductible and coinsurance.

You are required to pay the applicable physician visit copay for all covered services received in an in-network physician's office.

Only one copay per person, per provider, per day will be collected even if you receive multiple services from the same provider on the same date. The following are the only exceptions to the above copay requirement for services received in a physician's office:

- ◆ **Physical, Occupational and Speech Therapy (PT, OT and ST)** - If the only service you receive in a physician's office is PT, OT or ST the office visit copay does not apply, but such services are subject to applicable deductible and coinsurance. If other covered services are received during the same visit as the PT, OT or ST, a physician visit copay will apply, in addition to the applicable deductible and coinsurance.
- ◆ **Immunizations** - If the only service you receive in a physician's office is an immunization, covered immunizations will be paid at 100 percent of the allowed amount. If other covered services are received during the same visit as the immunization, a physician visit copay will apply.
- ◆ **Allergy Injections** - If the only service you receive in a physician's office is an allergy injection, covered allergy injections will be paid at 100 percent of the allowed amount. If other covered services are received during the same visit as the allergy injection, a physician visit copay will apply.
- ◆ **Maternity Services (Physician Services)** - You will pay one office visit copay per pregnancy for all prenatal visits, the physician's Global Charge and other physician office and home visits submitted with a primary diagnosis of maternity.

Please note: There is a different copay for PCPs and specialists, as shown on your SBC.

Covered physician services provided by an out-of-network provider are subject to out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share will be waived for the following services, when the purpose of the procedure is contraception as documented by your provider on the claim:

- Professional physician services for FDA-approved sterilization procedures provided to female members, regardless of the location of service.
- Professional physician services for fitting, implantation and/or removal of FDA-approved contraceptive devices in female members provided during a physician office or home visit.
- FDA-approved implanted contraceptive devices in female members
- The following FDA-approved prescription hormonal and barrier contraceptive methods and devices for female members: patches, rings, contraceptive injections, diaphragms, cervical caps and cervical shields

If you receive preventive physician services from an in-network physician, your cost-share may be waived, as described in this benefit section and in the "*Preventive Services*" section of this benefit book. You pay applicable copays for physician services for sterilization procedures provided to male members.

Benefit Description: Benefits are available for the following:

- FDA-approved patches, rings and contraceptive injections for female members
- FDA-approved diaphragms, cervical caps and cervical shields
- FDA-approved emergency contraception
- Professional physician services for FDA-approved sterilization procedures
- Professional physician services for fitting, implantation and/or removal of FDA-approved contraceptive devices in female members
- FDA-approved implanted contraceptive devices for female members

- Abortifacient medications, including oral medications as described in the BCBSAZ Medical Coverage Guidelines.
- Home or office visits and consultations
- Preferred walk-in clinics. PCP office visit copay applies (urgent care facilities are not walk-in clinics).
- General surgical procedures (including assistance at surgery)

Surgical assistants (physicians or other eligible providers) are reimbursed at a reduced percentage of the BCBSAZ fee schedule for the surgeon's covered services. Only certain providers are eligible for reimbursement for assisting at surgery. Your out-of-pocket costs will be higher if services are provided by an out-of-network provider.

Please contact BCBSAZ to determine the assistant's eligibility and network status.

Benefits for these services provided by a non-eligible provider may be denied, in which case you will be responsible for the full charges from that provider.

Also, multiple surgical procedures performed during a single operative session are reviewed to determine appropriate benefits. In general, eligible secondary procedures are reimbursed at reduced levels; incidental procedures are non-reimbursable.

- Inpatient medical visits, including care provided during those visits
- Second surgical opinions
- Fronske Health Center (**Not Available to Retirees**)
 - ♦ General health care and prescription services for employees and covered dependents received from Fronske Health Center are subject to the copay shown on your SBC.

You may receive services in a physician's office that incorporate services or supplies from a provider other than your physician. If those services or supplies are rendered and billed by a provider other than your physician, you will pay the cost-share applicable to the billing provider, in addition to the cost-share for your office visit. Examples of services or supplies from another provider include durable medical equipment from a medical supply company, specialty injectable medications provided by a pharmacy, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices for male members, even if the contraceptive method or device is FDA-approved and prescribed by a physician or other provider, including but not limited to, male condoms.

AA. POST-MASTECTOMY SERVICES

Precertification: Required for inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable inpatient admission copays, deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available, to the extent required by applicable state and federal law, for breast reconstruction following a medically necessary mastectomy. Benefits include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance, including postoperative implanted or external prostheses; and treatment of physical complications for all stages of the mastectomy, including lymphedema.

Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage, as described above under "Benefit Description," will be provided in a manner determined in consultation between the attending physician and the member being treated. These benefits are provided subject to the same deductibles and coinsurance generally applicable to other medical and surgical benefits provided under this plan, as described above in "Your Cost Share" and in the schedule page for this benefit plan. If you would like more information on WHCRA benefits, call BCBSAZ customer service at the number listed in the front of this benefit book.

BB. PREGNANCY, TERMINATION

Precertification: Required for inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable inpatient admission copays, deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for abortions that meet the following requirements:

The treating provider certifies in writing the abortion is medically necessary in order to save the life of the mother or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.

Benefits are also available for abortifacient medications, including some oral medications as described in the BCBSAZ Medical Coverage Guidelines.

Benefit-Specific Exclusion: Non-spontaneous, medically-induced abortions (by surgical or non-surgical means), except as stated in this benefit.

CC. PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER

Precertification: May be required depending on the medication received. A list of medications that require precertification is available online at www.azblue.com or you or your provider may contact BCBSAZ at the numbers listed in the front of this book. This list is subject to change at any time without prior notice. If you fail to obtain precertification for medications that require precertification, the medications will not be covered.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: "Off-label prescription medication" means a medication prescribed by your provider for the treatment of cancer that has not been approved by the FDA for that specific medical condition, but otherwise meets all of the requirements of Arizona law. These requirements include but are not limited to scientific evidence obtained by your provider that the drug has been recognized as safe and effective for the specific type of cancer for which it is being prescribed.

Benefit Description: Benefits are available, to the extent required by applicable state law, for off-label use of prescription medications and services directly associated with the administration of prescription medications for the treatment of cancer. All other applicable benefit limitations and exclusions will apply to this benefit.

In administering claims for an off-label prescription medication, BCBSAZ does not represent or warrant that the prescribed medication is safe or effective for the purpose for which your treating provider has prescribed the medication.

Decisions regarding whether the medication is safe and effective for the type of cancer for which it has been prescribed and whether it is appropriate for you, are decisions to be made by your provider using his or her independent medical judgment. If the medication is subject to precertification, your provider must specifically notify BCBSAZ that your provider is requesting approval for this off-label use. After receiving your provider's request, BCBSAZ will review the criteria and eligibility for benefits.

DD. PRESCRIPTION MEDICATIONS OBTAINED FROM A RETAIL OR MAIL ORDER PHARMACY

Precertification: Required for certain medications. A list of medications that require precertification is available online at www.azblue.com or you or your provider may contact BCBSAZ at the numbers listed in the front of this book. The list of specific medications that require precertification is subject to change at any time without prior notice. If you fail to obtain precertification for medications that require precertification, the medications will not be covered.

Benefit-Specific Definition: "Compounded medications" are medications that contain at least one FDA-approved component and are custom-mixed by a pharmacist.

Your Cost-Share: You pay a Level 1, 2, 3 or 4 prescription copay for most medications. You pay the greater of the Level 3 copay or 50 percent coinsurance for compounded medications. Your copay is waived for preventive medications received from in-network pharmacies. BCBSAZ will determine which medications are considered preventive and for which your copay is waived. For more information on preventive medications, go to www.azblue.com or contact the Prescription Benefit Unit at the number listed in the customer service section of this book. If you obtain medications from a noncontracted pharmacy, you also pay the balance bill. Balance bill payments do not apply toward deductibles or out-of-pocket maximums.

Your cost-share is waived for the following contraceptive methods when obtained from in-network pharmacies:

- FDA-approved diaphragms, cervical caps and cervical shields
- FDA-approved emergency contraception for female members of any age, when prescribed by a physician or other provider
- FDA-approved generic oral, patch, vaginal ring and injectable contraceptives
- FDA-approved brand oral, patch, vaginal ring and injectable contraceptives with no generic equivalent components

Oral contraceptives must be prescribed for or including the purpose of contraception and not solely for some other medical reason to be covered with no member cost-share.

When the prescription medication price is less than the copay at a contracted pharmacy, you will never have to pay more than your copay. However, some pharmacies may charge you a lower price if the pharmacy's regular price for the medication is less than your copay.

If your prescription exceeds BCBSAZ quantity limits, your total cost-share may be higher than the amount of your copay.

Additional Information About Medication Levels

Copays are based on the Level to which BCBSAZ has assigned the medication at the time the prescription is filled. BCBSAZ may change the Level of a medication at any time without notice. Many medications and the Level to which BCBSAZ has assigned the medication are listed in the Retail and Mail Order Pharmacy Guide available at www.azblue.com or by calling BCBSAZ at the numbers listed in the front of this book. You or your provider may contact BCBSAZ to check on the status of a medication.

No exceptions will be made concerning the assigned Level of a medication or the copay or coinsurance that will apply, regardless of the medical reasons requiring use of a particular medication. This means if you are taking a Level 2, 3, 4, or compound medication, you pay the applicable cost-share for the Level even when there is no equivalent medication on a lower Level or if you are unable to take a medication on the lower Level for any reason.

The assignment of a medication to any particular Level is not a recommendation on the use of a medication.

Benefit Description: Benefits are available for prescription medications that meet the following criteria:

- The medication is not excluded by a different provision in this plan;
- The medication must be approved by the U.S. Food and Drug Administration (FDA) for the diagnosis for which the medication has been prescribed; **and**
- The medication must be dispensed by a pharmacy located in the U.S. and by a pharmacist licensed in the U.S., unless the medication is needed for an urgent or emergency medical situation while the member is traveling outside the U.S. Claims for medications dispensed outside the U.S will be subject to the U.S. dollar exchange rate on the date the claim is paid.

You may obtain prescription medications from retail pharmacies or the in-network mail order pharmacy. Compounded medications are only available through retail pharmacies. Certain vaccines are covered when obtained from in-network retail pharmacies and administered by a certified, licensed pharmacist.

Prescription medications are subject to BCBSAZ limitations, including but not limited to, quantity, age, gender and refill limits. **BCBSAZ prescription medication limitations are subject to change at any time without prior notice.** You can check the list of prescription medications subject to BCBSAZ prescription medication limitations at www.azblue.com or by calling the BCBSAZ Prescription Benefits Unit at the number listed in the front of this book.

Members or providers can ask BCBSAZ to review coverage of a medication when the use of the medication exceeds or differs from BCBSAZ prescription medication limitations by contacting the number listed in the front of this book. There is no guarantee that a review will result in coverage of a medication or an increase in quantity.

Benefit-Specific Exclusions:

- Administration of a covered medication
- Biologic serums
- Certain categories of injectable medications
- Compounded medications obtained from a mail order pharmacy
- Medications, devices, equipment and supplies lawfully obtainable without a prescription, except as stated in the “Preventive Services” benefit
- Medication delivery implants
- Medications designated as clinic packs
- Medications designed for weight gain or loss, including but not limited to, Xenical® and Meridia®, regardless of the condition for which it is prescribed
- Medications dispensed to a member who is an inpatient in any facility
- Medications for athletic performance
- Medications for lifestyle enhancement
- Medications labeled “Caution - Limited by Federal Law to Investigational Use” or words to that effect and any experimental medications as determined by BCBSAZ, except as stated in this plan
- Medications obtained from an out-of-network mail order pharmacy
- Medications packaged with one other or multiple other prescription products
- Medications packaged with over-the-counter medications, supplies, medical foods, vitamins or other excluded products, except as stated in the “Preventive Services” benefit
- Medications to improve or achieve fertility or treat infertility
- Medications used for any cosmetic purpose
- Medications used to treat a condition not covered under this plan
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging or name, except as stated in the “Preventive Services” benefit
- Prescription medications dispensed in unit-dose packaging, unless that is the only form in which the medication is available
- Prescription refills for medications that are lost, stolen, spilled, spoiled or damaged
- Specialty self-injectable medications, as defined by BCBSAZ
- Abortifacient medications
- All over-the-counter contraceptive methods and devices for male members, even if the contraceptive method or device is FDA-approved and prescribed by a physician or other provider, including but not limited to, male condoms.

EE. PREVENTIVE SERVICES

Precertification: Not required.

Your Cost-Share:

In-Network:

Your cost-share is waived, regardless of the location where services are provided, if:

- You receive services from an in-network provider;
- You receive one of the services listed in the Benefit Description subsection of this Preventive Services section; and
- The procedure code, the diagnosis code or the combination of procedure codes and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

See the cost-share for “Nutritional Counseling and Training” under “*Education and Training*” for the cost-shares applicable to these preventive services.

For more information on the foreign travel immunizations covered under this benefit, go to the Medical Coverage Guidelines available at www.azblue.com/member, or call BCBSAZ Customer Service at the number listed in the front of this book.

Any otherwise covered tests, procedures, or services not listed in this section are subject to deductible and applicable coinsurance, including but not limited to, radiology and pathology, even if performed in the provider’s office or provided in connection with a covered preventive service.

Benefit-Specific Definition: “Preventive services” are those services performed for screening purposes when you do not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition, which is determined by the combination of procedure and diagnosis codes your provider submits on the claim.

Benefit Description: Benefits are available for the following services, as appropriate for the member’s age and gender and as recommended by your provider:

- Preventive physical examination, i.e. routine physical examination, including the following services when done for screening purposes only:
 - ◆ resting electrocardiogram (EKG)
 - ◆ lung function test (spirometry)
 - ◆ vision and hearing screening (this may include newborn audiological evaluation in the hospital)
 - ◆ fecal occult blood test
 - ◆ general health laboratory panel (bilirubin, calcium, carbon dioxide, chloride, creatinine, alkaline phosphatase, potassium, total protein, sodium, ALT, SGPT, AST, SGOT, BUN, TSH)
 - ◆ thyroid function testing (TSH)
 - ◆ complete blood count (CBC)
 - ◆ lipid panel (cholesterol panel and triglycerides)
 - ◆ fasting glucose (blood sugar)
 - ◆ urinalysis
 - ◆ blood lead
 - ◆ sexually transmitted disease (STD) testing
 - ◆ prostate specific antigen (PSA)
 - ◆ TB testing
- Screening for abdominal aortic aneurysm for men ages 65 to 75 who have ever smoked
- Routine gynecologic exam including Pap test and other cervical cancer screening test
- Mammogram
- Bone density testing for osteoporosis
- Screening sigmoidoscopy or colonoscopy
- Routine immunizations and immunizations for foreign travel, as determined by BCBSAZ
- Folic acid supplementation prescribed for females
- Aspirin prescribed for prevention of cardiovascular disease for men ages 45 to 79 and women ages 55 to 79
- Behavioral intervention to promote breast-feeding for women
- Oral fluoride supplementation prescribed for children ages 6 months through 5 years who live in areas where the water service is deficient in fluoride
- Depression screening for members age 18 and older
- Screening for major depressive disorders for members ages 12 through 18
- Routine iron supplementation prescribed for asymptomatic children ages 6 months through 12 months who are at increased risk for iron deficiency anemia
- Routine screening for iron deficiency anemia for asymptomatic pregnant women
- Counseling and behavioral interventions to promote sustained weight loss for obese adults
- Tobacco cessation counseling and augmented pregnancy counseling for members who use tobacco
- Newborn screenings as required by Arizona and federal law
- Vision screenings for children under age 5
- Alcohol misuse screening and behavioral counseling interventions for pregnant women

- Screening for asymptomatic bacteriuria for pregnant women at 12-16 weeks gestation or at first prenatal visit, if later
- Screening for Hepatitis B virus infection for pregnant women at their first prenatal visit
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Repeated antibody testing for unsensitized Rh(D)-negative pregnant women at 24-28 weeks gestation, unless the biological father is known to be Rh(D) negative
- Smoking cessation medications and devices, as prescribed
- Counseling (annually) on sexually transmitted infections for all sexually active women
- Counseling (annually) for HIV infection for all sexually active women
- Counseling on contraceptive methods for all women with reproductive capacity
- FDA-approved contraceptive methods for female members, as prescribed. See the *“Family Planning”*, *“Physician Services”* and *“Prescription Medications Obtained From a Retail or Mail Order Pharmacy”* benefit sections.
- FDA-approved sterilization procedures for female members, as prescribed. See the *“Family Planning”* and *“Physician Services”* benefit sections.
- Lactation support counseling during pregnancy and/or in the post-partum period
- Rental of manual or electric breast-feeding pumps and supplies; limited to one (1) manual or electric (not hospital grade) pump per female member, per calendar year, but only when obtained from in-network durable medical equipment (DME) providers. See the *“Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics”* benefit section.
- Screening for gestational diabetes in pregnant women between 24 and 28 weeks gestation and at first prenatal visit
- Screening and counseling (annually) for interpersonal and domestic violence

Benefit-Specific Exclusions:

- Any service or test not specifically listed in this benefit description or in another section of this benefit book, such as chest X-rays, will not be covered when performed for preventive or screening purposes
- Abortifacient medications
- All over-the-counter contraceptive methods and devices for male members, even if the contraceptive method or device is FDA-approved and prescribed by a physician or other provider, including but not limited to, male condoms.

Services or tests listed under this benefit and provided to a member with a specific diagnosis, signs or symptoms of a condition or disease for which the test is being performed may be covered through another benefit section of this plan. Certain maternity services covered under this benefit are also available through the “Maternity” benefit.

FF. RECONSTRUCTIVE SURGERY AND SERVICES

Precertification: Required for inpatient admissions. If you fail to obtain precertification for covered inpatient reconstructive surgery and services, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable inpatient admission copays, deductible, coinsurance, and copays. The cost-share amount will depend on the provider’s network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for reconstructive surgery, which is surgery performed to improve or restore the impaired function of a body part or organ resulting from one of the following:

- Congenital defects;
- Illness and disease;
- Injury and trauma;
- Surgery; **or**
- Therapeutic intervention

Benefit-Specific Exclusion: Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy in accordance with state and federal law.

GG. SKILLED NURSING FACILITY (SNF)

Precertification: Required. If you fail to obtain precertification for a SNF admission, the services will not be covered.

Your Cost-Share:

In-Network: BCBSAZ pays 100 percent of the allowed amount.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive SNF services at a noncontracted provider, you also pay the balance bill, in addition to out-of-network deductible and coinsurance.

After 180 days of care, you pay all charges for skilled nursing facility services for the remainder of the calendar year.

Benefit Maximum: 180 days of SNF services per member, per calendar year.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.

Benefit Description: Benefits are available for inpatient skilled nursing facility services provided in a facility licensed to offer skilled nursing services and meeting BCBSAZ's definition of skilled nursing care. Skilled nursing services are provided by and under the supervision of qualified and licensed professionals, such as a licensed practical nurse (L.P.N.) or registered nurse (R.N.) and provided at a level of complexity and sophistication requiring assessment, observation, monitoring and/or teaching or training to achieve the medically desired outcome.

Benefit-Specific Exclusion: Custodial care

HH. SPECIALTY SELF-INJECTABLE MEDICATIONS

Precertification: Required for all specialty self-injectable medications. If you fail to obtain precertification, these medications will not be covered.

Your Cost-Share: You pay a Level A, B, C or D copay. Copays do not apply to deductibles.

If a member obtains a specialty self-injectable medication from an eligible provider other than a pharmacy contracted with BCBSAZ for the specialty self-injectable medications benefit ("specialty pharmacy"), the medication is excluded from coverage under this benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

Additional Information About Medication Levels

Copays are based on the Level to which BCBSAZ has assigned the medication at the time the prescription is filled. BCBSAZ may change the Level of a medication at any time without notice. Go to www.azblue.com to view a list of contracted specialty pharmacies and the specialty self-injectable medication list. To confirm the status and Level of a particular specialty self-injectable medication, you may also call the BCBSAZ Prescription Benefits Unit at the number listed in the front of this book.

No exceptions will be made concerning the assigned Level of a medication or the copay that will apply, regardless of the medical reasons requiring use of the medication. This means if you are taking a Level B, C or D medication, you pay the applicable copay for that Level even if there is no equivalent medication on a lower Level or you are unable to take a medication on the lower Level for any reason.

The assignment of a medication to any particular Level is not a recommendation on the use of a medication.

Benefit Description: Benefits are available for specialty self- injectable medications obtained from a specialty pharmacy contracted with BCBSAZ. Go to www.azblue.com to view a list of contracted specialty pharmacies and the specialty self-injectable medication list. To confirm the status and level of a particular specialty self-injectable medication, you may also call the BCBSAZ Prescription Benefits Unit at the number listed in the front of this book. Coverage of specialty self-injectable medications is determined by the Medical Coverage Guidelines and Pharmacy Coverage Guidelines and subject to change without notice.

Specialty self-injectable medications are subject to limitations contained in the Medical Coverage Guidelines and Pharmacy Coverage Guidelines and may change at any time without prior notice.

Benefit-Specific Exclusions:

- All benefit-specific exclusions listed under “*Prescription Medications Obtained from a Retail or Mail Order Pharmacy,*” except for the exclusion for specialty self-injectable medications
- Medications obtained from a pharmacy not specifically contracted with BCBSAZ as a specialty pharmacy

II. TRANSPLANTS - ORGAN - TISSUE - BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES

Precertification: Required prior to any organ, tissue or bone marrow transplant or stem cell procedure. If you fail to obtain precertification, the services will not be covered.

Your Cost-Share: You pay applicable inpatient admission copays, deductible, coinsurance, and copays. The cost-share amount will depend on the provider’s network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

If both a donor and a transplant recipient are covered by a BCBSAZ plan or a plan administered by BCBSAZ, the transplant recipient pays the cost-share related to the transplant.

BCBSAZ is contracted with certain facilities to provide covered transplants to BCBSAZ members. Not all such facilities are contracted to provide services related to a covered transplant, such as pre-transplant testing, certain types of chemotherapy and radiation therapy and other services covered under this plan. If you receive pre-transplant testing or other services associated with the transplant from a facility that is not contracted with BCBSAZ or a Host Blue to provide those services, you will pay your out-of-network cost-share, plus the balance bill.

Benefit-Specific Definition: “Bone Marrow Transplant” is a medical or surgical procedure comprised of several stages, including:

- Administration of high dose chemotherapy and high dose radiotherapy as prescribed by the treating physician;
- Harvesting of stem cells from the bone marrow or the blood of a third-party donor (allogeneic transplant) or the member (autologous transplant) and all component parts of the procedure;
- Hospitalization and management of reasonably anticipated complications;
- Infusion of the harvested stem cells; **and**
- Processing and storage of the stem cells after harvesting.

Benefit Description: The following transplants are eligible for coverage if they meet the Medical Coverage Guidelines:

- Allogeneic and autologous bone marrow or stem cell
- Autologous islet cell transplantation (AICT)
- Cornea
- Heart; heart-lung; lung (lobar, single and double lung); kidney; pancreas; kidney-pancreas; liver; small bowel; small bowel-multivisceral

Benefits are available for the following services in connection with or in preparation for a covered transplant:

- Inpatient and outpatient facility and professional services
- Air and ground transportation of a medical team to and from the site in the contiguous states of the United States to obtain tissue that is subsequently transplanted into a member

- Bone marrow search and procurement of a suitable bone marrow donor when a member is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
- Chemotherapy or radiation therapy associated with transplant procedures
- Harvest and reinfusion of stem cells or bone marrow
- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ. Covered donor expenses include complications and medically necessary follow-up care related to the donation for up to six (6) months post transplant, as long as the recipient's BCBSAZ coverage remains in effect.
- Pre-transplant testing and services

Benefit-Specific Exclusions:

- Expenses related to a noncovered transplant
- Expenses related to donation of an organ to a recipient who is not covered by BCBSAZ
- Transplants that do not meet the Medical Coverage Guidelines

JJ. TRANSPLANT TRAVEL AND LODGING

Precertification: Not required.

Your Cost-Share: Not applicable.

Benefit Maximum: Maximum of \$10,000 per member, per transplant. Covered expenses incurred by a caregiver accumulate toward the member's \$10,000 per transplant maximum.

Benefit-Specific Definition: "Caregiver" is the individual primarily responsible for providing daily care, basic assistance and support to a member or donor who is eligible for transport lodging and reimbursement. Caregivers may perform a wide variety of tasks to assist the member or donor in his or her daily life, such as preparing meals, assisting with doctors' appointments, giving medications or assisting with personal care and emotional needs.

Benefit Description: Coverage is available for reimbursement of travel and lodging expenses, as listed below, that are incurred by a member receiving a covered transplant, a donor donating for a covered transplant and a caregiver for the donor or recipient member. Total reimbursement will not exceed actual expenses, up to a maximum of \$200 per day. The daily maximum is an aggregate amount, not a per person amount, for the member receiving a covered transplant, donor and caregiver.

To qualify for reimbursement, all the following criteria must be met:

- BCBSAZ has precertified the transplant procedure;
- The distance from the member's, donor's or caregiver's residence must be more than seventy-five (75) miles from the transplant facility;
- The member is receiving a covered solid organ, bone marrow or stem cell transplant;
- The member must receive the transplant from a provider contracted with BCBSAZ, a provider contracted with the local Blue Cross and/or Blue Shield plan where services are rendered or a Blue Distinction Centers for Transplants (BDCT) facility;
- The member or donor must be receiving medically necessary pre and post-operative treatments, including without limitation, treatment of complications related to the covered transplant or routine follow-up care for a covered transplant or a transplant that occurred while the member was covered by another insurance plan; **and**
- The expenses are for any of the following:
 - ◆ Meal expenses;
 - ◆ Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; bus; train or air fare; **and**
 - ◆ Room charges from hotels, motels and hostels or apartment rental.

Benefit-Specific Exclusions:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or internet service charges; spa services; gym facilities; or other hotel or motel amenities

- All travel and lodging expenses in excess of the \$10,000 per member, per transplant maximum
- Ambulance transportation (ground or air)
- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with noncovered transplant services or any follow-up care, including treatment of complications
- Expenses for travel or lodging related to evaluation, consultation or medical testing to determine if a member is a candidate for transplantation
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Travel and lodging expenses for transplants other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service
- Travel and lodging expenses for members, donors or caregivers when the member, donor or caregiver does not travel more than seventy-five (75) miles for an authorized transplant or transplant related services, including follow-up care and treatment of complications
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement

To request reimbursement of eligible transplant travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to BCBSAZ. The address for claims submission and phone number for requesting claim forms are listed in the BCBSAZ customer service section at the front of this book.

KK. URGENT CARE

Precertification: Not required.

Your Cost-Share: You pay one urgent care copay per member, per provider, per day for services from a provider who is contracted with BCBSAZ to render urgent care services. You pay applicable cost-share if you receive urgent care services from an in-network provider who is not specifically contracted for urgent care services. You pay out-of-network deductible and coinsurance if you receive services from an out-of-network urgent care provider. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: “Urgent care” means treatment for conditions that require prompt medical attention, but are not emergencies.

Benefit Description: BCBSAZ has contracted with certain free-standing urgent care providers to render these services to its members. These providers are listed in your provider directory and on the BCBSAZ Web site at www.azblue.com under “Urgent Care Centers.”

Please be aware that the BCBSAZ network includes some providers, such as hospitals, that offer urgent care services, but are not specifically contracted with BCBSAZ as urgent care providers. No matter what the circumstances, if you obtain urgent care services at a hospital or a hospital’s on-site urgent care department, you will be responsible for the applicable emergency room access fee.

LL. VISION EXAMS (ROUTINE)

This benefit plan does not provide a routine vision exam benefit. Contact your group benefit administrator for information.

WHAT IS NOT COVERED

NOTWITHSTANDING ANY OTHER PROVISION IN THIS PLAN, NO BENEFITS WILL BE PAID FOR EXPENSES ASSOCIATED WITH THE FOLLOWING:

Abortions – Non-spontaneous, medically-induced abortions (by surgical or non-surgical means), except as stated in this plan

Activity Therapy – Activity therapy and milieu therapy, including community immersion, integration, home independence and work re-entry therapy; and any care intended to assist an individual in the activities of daily living; and any care for comfort and convenience, except for limited hospice benefits

Acupuncture

Alternative Medicine – Non-traditional and alternative medical therapies; interventions; services and procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; aromatherapy

Benefit-specific exclusions and limitations listed in this book under particular benefits

Biofeedback and hypnotherapy, except as may be available through the BSA

Body Art, Piercing and Tattooing – Services related to body piercing, cosmetic implants, body art, tattooing and any related complications

Certain Types of Facility Charges – Inpatient and outpatient facility charges for treatment provided by the following facilities are not covered: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes. Inpatient and outpatient facility charges for services provided by residential treatment facilities are not covered except for certain very limited situations based upon BCBSAZ medical necessity criteria. All other inpatient and outpatient services provided by residential treatment facilities are not covered.

Charges associated with the preparation, copying or production of health records

Cognitive and Vocational Therapy – Services related to improving cognitive functioning (i.e., higher brain functions), reinforcing or re-establishing previously learned thought processes, compensatory training, sensory integrative activities and services related to employability

Complications of Noncovered Services – Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under this plan

Computer Speech Training, Therapy Programs and Devices

Cosmetic Services and any Related Complications – Surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy.

Counseling – Counseling and behavioral modification services, except as stated in this plan

Court-Ordered Services – Court-ordered testing, treatment and therapy, unless such services are otherwise covered under this plan as determined by BCBSAZ

Custodial Care

Dental – Except as stated in this plan, dental and orthodontic services; placement or replacement of crowns, bridges or implants; any fixed dental reconstruction of the teeth; orthodontics; extractions of teeth; dentures; vestibuloplasty and surgical orthodontics; and any procedures associated with the services listed in this exclusion, including but not limited to procedures associated with dental implants and fitting of dentures

Dietary and Nutritional Supplements – All dietary, caloric and nutritional supplements, such as specialized formulas for infants, children or adults or other special foods or diets, even if prescribed, except as stated in this plan

Expenses for services that exceed benefit limitations

Experimental or Investigational Services

Fees – Fees other than for medically appropriate, in-person, direct member services, except as stated in this plan

Fees – Fees for concierge medicine services

Fertility and Infertility Services – Services to improve or achieve fertility (ability to conceive) or to diagnose and treat infertility (inability to conceive)

Flat Feet – Services for treatment of flat feet, weak feet and fallen arches, except arch supports may be covered when medically necessary for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

Foot Care – Services for foot care, including trimming of nails or treatment of corns and calluses, except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

Free Services – Services you receive at no charge or for which you have no legal obligation to pay

Genetic and Chromosomal Testing and Screening – Genetic and chromosomal testing of an individual who is asymptomatic, unaffected or not displaying signs or symptoms of a disorder for which the test or screening is performed

Government Services – Services provided at no charge to the member through a governmental program or facility

Growth Hormone – Growth hormone, except as specified in the Medical Coverage Guidelines. Growth hormone to treat Idiopathic Short Stature (ISS) is expressly excluded.

Lifestyle education and management services, except as stated in this plan

Lodging and Meals – Lodging and meals, except as stated in this plan

Maintenance Services – Services rendered after a member has met functional goals; services rendered when no objectively measurable improvement is reasonably anticipated, services to prevent regression to a lower level of function, services to prevent future injury and services to improve or maintain posture

Manipulation of the Spine Under Anesthesia

Marijuana-Medical marijuana, marijuana and any costs or fees associated with obtaining medical marijuana, such as obtaining an initial or renewal registry identification card, even when prescribed and obtained in compliance with state law(s).

Massage Therapy – Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines

Medical equipment, supplies, and medications sold on or through unregulated distribution channels as determined by BCBSAZ, including online sources such as eBay, Craig's List or Amazon.com; or at garage sales, swap meets, and flea markets

Medications – Medications which are:

- Not FDA approved
- Not required by the FDA to be obtained with a prescription, except as stated in this plan
- Not used in accordance with the Medical Coverage Guidelines or Pharmacy Coverage Guidelines
- Used to treat a condition not covered by BCBSAZ
- Off-label, unlabeled and orphan medications, except as stated in this plan

Medications Dispensed in Certain Settings – Prescription medications given to the member, for the member's future use, by any person or entity that is not a licensed pharmacy, home health agency, specialty pharmacy or hospital emergency room

Neurofeedback

Non-Medically Necessary Services – Services that are not medically necessary as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered

Over-the-Counter Items – Medications, devices, equipment and supplies that are lawfully obtainable without a prescription, except as stated in this plan

Personal Comfort Services – Services intended primarily for assistance in daily living, socialization, personal comfort, convenience and other non-medical reasons

Reproductive Services---Procedures, treatment, office visits, consultations and other services related to the genetic selection and/or preparation of embryos and implantation services including, but not limited to, pre-implantation genetic diagnosis and in vitro fertilization and related services

Reversal of Sterilization

Screening Tests – Any testing performed on an individual who does not have a specific diagnosis or acute signs or symptoms of a condition or disease for which the test is being performed, regardless of whether the individual has a family history or other risk factors for the disease or condition, except as stated in this plan

Services for Idiopathic Environmental Intolerance – Services associated with environmental intolerance from unknown causes (idiopathic), multiple chemical sensitivity, the diagnosis or treatment of environmental illness (clinical ecology), such as chemical sensitivity or toxicity from exposure to atmospheric or environmental contaminants, pesticides or herbicides

Services for Weight Loss and Gain, except as stated in this plan

Services from a Family Member – Services delivered by an eligible provider who is a member of your immediate family. “Immediate family” members are: parents, siblings, children, stepparents, stepchildren, spouses, grandparents, grandchildren and any of the preceding individuals related to the member by marriage. When a provider is also the covered person, services rendered by that provider for himself or herself are also excluded from coverage.

Services from Ineligible Providers

Services Paid for By Other Organizations – Services customarily paid for by an employer, such as worksite or ergonomic evaluations; the government; a school; biotechnical, pharmaceutical or medical device industry sources; or other individuals and organizations

Services Prior to Effective Date

Services Provided After the Member’s Coverage Termination Date, except as stated in this plan

Services Related to or Associated with Noncovered Services

Services Without A Prescription – Services and supplies that are required by this plan to have a prescription and are not prescribed by a physician or other provider licensed to prescribe

Sexual Dysfunction – Services for sexual dysfunction not related to organic disease.

Smoking Cessation – Smoking cessation programs, medications, aids and devices, except as stated in this plan

Spinal Decompression or Vertebral Axial Decompression Therapy

Strength Training – Services primarily designed to improve or increase fitness, strength or athletic performance, including strength training, cardiovascular endurance training, fitness programs and strengthening programs, except as stated in this plan

Telephonic and Electronic Consultations – Telephonic and electronic consultations, except as stated in this plan

Therapy services, except as stated in this plan

Training and Education – Training and education, except as stated in this plan

Transplants and Related Services Not Precertified by BCBSAZ

Transportation – Transport services and travel expenses, except as stated in this plan

Transsexual Treatment, Surgery, Medications and Related Services

Vision – Routine vision exams, except for preventive vision screenings for members under age 5; vision therapy; all types of refractive keratoplasties; any other procedures, treatments and devices for refractive correction; eyeglasses, contact lenses and other eyewear; vision examinations for fitting of eyeglasses and contact lenses, except as stated in this plan

Vitamins – All vitamins, minerals and trace elements that are lawfully obtainable without a prescription, except as stated in this plan

Workers' Compensation – Illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election

CLAIMS INFORMATION

Filing Claims

In-network providers will file claims for you. Noncontracted providers may file your claims for you, but have no obligation to do so. Make sure you or your providers file all your claims so BCBSAZ can track your covered expenses and properly apply them toward applicable deductibles, coinsurance, out-of-pocket maximums and benefit maximums.

Time Limit for Claim Filing

A complete claim, as described below, must be filed within one year from the date of service. Any claim not filed within one year of the date of service may be denied.

Claim Forms

Claim forms are available from BCBSAZ. Go to the "Forms" section of the "Member" area of www.azblue.com or call the Supply Line telephone number listed at the front of this book.

Complete Claims

A complete claim includes, at a minimum, the following information:

- Billed charges
- Date of service(s)
- Diagnosis code
- Group number
- Member ID number
- Member name
- Name of provider
- Patient name
- Patient's birth date
- Procedure code
- Provider ID number
- Signature of provider who rendered services

BCBSAZ may reject claims that are filed without complete information needed for processing. If BCBSAZ rejects a submitted claim due to lack of information, BCBSAZ will notify you or the provider who submitted the claim. Lack of complete information may also delay processing.

Medical Records and Other Information Needed to Process a Claim

Even when the claim has all information listed above, BCBSAZ may need to request medical records or coordination of benefits information to make a coverage determination. If BCBSAZ has requested medical records or other information from a third party, claim processing will be suspended while the request is pending. BCBSAZ may deny a claim for lack of timely receipt of requested records.

Explanation of Benefits (EOB) Form

After your claim is processed, BCBSAZ will send you an EOB. The CBA or BSA will send you an EOB for any claim for chiropractic or behavioral health benefits, as applicable. Your BCBSAZ EOBs also will be available through the member portal on www.azblue.com. An EOB shows services billed, whether the services are covered or not covered, the allowed amount and the application of cost-sharing amounts. BCBSAZ, the CBA or the BSA will also send your in-network provider the information that appears on your EOB. BCBSAZ and the CBA do not send EOBs to out-of-network providers. Out-of-network providers do not receive any written information on how much BCBSAZ or the CBA paid on a claim or the reasons for how the claim processed. Save the EOB for your personal records. BCBSAZ, the CBA or the BSA may charge a fee for duplication of claims records. Carefully review your EOB for any discrepancies or inconsistencies with the amounts your provider actually collects from you or bills to you.

Monthly Statement

Some EOBs may be consolidated and sent to you in the form of a monthly statement rather than single EOBs.

Concurrent Care Decisions

BCBSAZ may require that your provider submit a plan of care. Based on that plan, BCBSAZ may precertify a certain number of visits or services over a certain period of time. You may request precertification for additional periods of care as long as your request is made at least seventy-two (72) hours prior to the expiration of an existing plan of care. BCBSAZ will make a determination as soon as possible in accordance with medical exigencies, but no later than seventy-two (72) hours after receipt of the request. If that precertification is denied, you may appeal that denial in the same way you appeal any other coverage denial.

Notice of Determination

If your claim is filed properly and your claim is then denied in whole or in part, you will receive notice of an adverse benefit determination that will:

- State the specific reason(s) for the adverse benefit decision (e.g., not covered because the provider is ineligible or because services are not covered under this benefit plan),
- Reference the specific plan provision on which the determination is based,
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary,
- Describe applicable grievance/appeal procedures,
- Disclose any internal rule, guideline or protocol relied on in making the adverse determination (or state that such information is available free of charge upon request),
- If the denial is based on medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state the information will be provided free of charge upon request).

Pharmacy Prescriptions; Submission of Claims by Members

When you submit a prescription to either a retail or mail order pharmacy, the prescription is not considered to be a claim. If you have any concerns about fulfillment of the prescription, you must submit a claim to BCBSAZ for the prescription. Send BCBSAZ a claim in the following circumstances:

- The pharmacy tells you that you are not eligible for coverage
- Coverage for the prescription was denied in whole or in part
- You feel that you paid the wrong copay or other cost-sharing amount for the prescription
- You were required to pay other amounts you feel you are not required to pay
- Other dispute or discrepancy regarding your prescription medication coverage

If the pharmacy tells you that you are not eligible for coverage and you are unable to purchase a temporary supply of medication that is needed immediately, please contact BCBSAZ member services immediately by calling the number on the back of your identification card.

Time Period for Claim Decisions:

Post-Service Claims

Within thirty (30) days of receiving your claim for a service that was already rendered, BCBSAZ will send you an Explanation of Benefits (EOB) adjudicating the claim, or a notice that BCBSAZ has requested records needed to make a decision on your claim.

If BCBSAZ cannot make a decision on your claim within thirty (30) days, BCBSAZ may extend the initial processing time by fifteen (15) days by notifying you, within the initial 30-day period, of the need for an extension and the date by which a determination can be expected. If the extension is necessary to obtain additional information, the extension notice will describe the information needed. You or your provider will have at least forty-five (45) days to submit the information.

Pre-Service Claims

When you request coverage for a service that has not yet been rendered (precertification), BCBSAZ will make a precertification decision within a reasonable time period considering the medical circumstances, but not later than ten (10) business days from receipt of the precertification request.

If BCBSAZ requires more time to make a precertification decision, BCBSAZ may extend the time by an additional fifteen (15) days by notifying you, within the initial 10-day period of need for an extension and the date by which a determination can be expected. If the extension is necessary to obtain additional information, the extension notice will describe the information needed. You and your provider will have at least forty-five (45) days to submit the information.

Urgent Claims

Federal law defines an “urgent” medical situation as the following: (a) one in which application of the “non-urgent” time periods could seriously jeopardize the member’s life, health or ability to regain maximum function or (b) one which, in the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

When you request coverage for an urgent care claim, a determination will be made as soon as possible in accordance with medical exigencies, but no later than twenty-four (24) hours after receipt of the request.

PLAN ADMINISTRATION

Coordination of Benefits

The Group Master Contract between the group and BCBSAZ contains a coordination of benefits provision that prevents duplication of payments. Under the provision, if you are eligible for benefits under any other group health insurance, the combined benefit payments from all coverages will not exceed 100 percent of the billed charges. In addition, BCBSAZ's payment will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If your other group health insurance does not include a coordination of benefits provision, that coverage pays first. If your other group health insurance provides for coordination of benefits, the following rules will be used to determine which coverage will pay first:

- If the person is an inpatient on the day this benefit plan becomes effective and benefits are payable under the person's prior health care coverage for the inpatient stay, the prior health care coverage pays first.
- If the person who received care is covered as an active employee under one benefit plan and as a dependent under another, the employee coverage pays first.
- If the person who receives care is covered as an active employee under one benefit plan and as an inactive employee under another, the coverage through active employment pays first.
- If the person who receives care is a dependent child, then the plan benefits of the parent whose birthday occurred earlier in a calendar year shall cover the child first.
- If both parents have the same birthday, the benefits of the plan that covered a parent longer shall cover a dependent child first.
- If one of the plans determines the order of benefits based upon the gender of a parent and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rule shall determine the order of benefits.
- If the dependent child's parents are legally separated or divorced, the following applies:
 - ◆ If a court decree specifies the parent who is financially responsible for the child's health care expenses, that parent's coverage pays first.
 - ◆ If there is no applicable court decree, the custodial parent's coverage pays first. If the custodial parent has remarried, the stepparent's coverage pays second. The non-custodial parent's coverage pays last.
 - ◆ If the parents have joint custody, the plan benefits of the parent whose birthday occurred earlier in a calendar year pays first.

When none of the above applies, the coverage you have had for the longest continuous period of time pays first (see "*Non-Duplication of Benefits*").

BCBSAZ does not coordinate benefits for services covered by the retail and mail order pharmacy benefit. For this benefit, BCBSAZ will pay primary, without regard to the member's other coverage.

Non-Duplication of Benefits

If services are covered under this benefit plan and one or more other group benefit plans that are issued or administered by BCBSAZ, the rules described above in "*Coordination of Benefits*" will be used to determine which coverage pays first. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If services are covered under this benefit plan and one or more BCBSAZ individual contracts, benefits will be paid first under the individual contract. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed 100 percent of the amount BCBSAZ would have paid if you had no other coverage. BCBSAZ does not coordinate benefits with non-group coverage provided by an insurance plan other than BCBSAZ.

BCBSAZ does not coordinate benefits for services covered by the retail and mail order pharmacy benefit. For this benefit, BCBSAZ will pay primary, without regard to the member's other coverage.

Definitions Related to Eligibility and Administration

- **“Dependents”** are the following individuals: (1) the contract holder's spouse under a legally valid existing marriage; (2) the contract holder's children or the children of the contract holder's spouse, including birth children, legally adopted children, step-children, children placed for adoption, children under legal guardianship substantiated by a court order and children who are entitled to coverage under a medical support order; (3) foster children; and (4) a domestic partner and the children of the domestic partner as defined below, if the domestic partnership satisfies the criteria outlined below. To qualify for coverage, a dependent must satisfy applicable eligibility rules, such as payment of any required premium.

Domestic Partner: An individual who is the same or opposite sex as the eligible employee and who has shared a long-term committed Domestic Partnership relationship with the eligible employee for a minimum of the last 12 months.

Children of a Domestic Partner: The children of the domestic partner, including natural children, legally adopted children, children placed for adoption, children under legal guardianship substantiated by a court order and children who are entitled to coverage under a medical support order.

Domestic Partnership: A relationship between an eligible employee and his/her domestic partner that meets all of the following criteria:

1. The partners currently reside together in an exclusive mutual commitment similar to marriage and have done so for at least the last 12 consecutive months and each intend to continue the relationship indefinitely;
 2. The partners are jointly responsible for basic living expenses;
 3. The partners are not married to each other or any other individual (statutory or common law) and neither is a member of another domestic partnership;
 4. Both partners are 18 years old or older;
 5. The partners are not related by blood or a degree of closeness which would prohibit marriage under A.R.S. 25-101(A);
 6. Both partners were mentally competent to consent to contract when the domestic partnership began and remain so for purposes of contracting for coverage for the domestic partner;
 7. Each partner is the other's sole domestic partner and is responsible for the other's common welfare;
 8. The partners are financially interdependent, jointly responsible for each other's basic living expenses and able to provide documents for at least three (3) of the following situations to demonstrate that interdependence has existed for a minimum of the last 12 consecutive months:
 - Joint mortgage, joint property tax identification or joint tenancy on a residential lease;
 - Joint bank, investment and/or credit account;
 - Joint liabilities (e.g., credit cards, automobile loans);
 - Joint ownership of real property or a common leasehold, interest in real property, such as a residence or business or common ownership of an automobile;
 - A will which designates the other as the primary beneficiary or a beneficiary designation form currently in effect for a retirement plan or life insurance policy setting forth that one partner is a beneficiary of the other;
 - Designation of one partner as holding power of attorney for health care or a general durable power of attorney for the other;
 - Written agreement(s) or contracts regarding the domestic partner relationship showing mutual support obligations.
- **“Disabled Dependent Child”** is a child who has reached age 26 and who meets criteria for coverage under this plan described in “Eligibility Requirements,” below.

- “**Employee/Retiree**” refers to the person eligible for this benefit plan because of his/her employment relationship or former employment relationship or affiliation to the group. An employee is also the contract holder under this plan.
- “**Group**” refers to the employer or other entity to which a Group Master Contract is issued and under which the contract holder and dependents become entitled to health coverage.
- “**Group Master Contract**” refers to the agreement between the group and BCBSAZ. The Group Master Contract controls the administration of the group coverage and is on file with the group. The coverage described in this book will terminate when the Group Master Contract terminates. The group is responsible to notify members if the group terminates the Group Master Contract or if the Group Master Contract is terminated for non-payment of premiums. BCBSAZ will notify members if the Group Master Contract is terminated for any other reason.
- “**Open Enrollment**” is an annual period during which the contract holder and dependents are eligible to enroll for coverage or change benefit plan options. The benefit plan administrator will notify the contract holder if the group has established such an open enrollment period. Contract holders and dependents can change benefit plans only during an open enrollment period, except as set forth in this benefit book.

Eligibility Requirements

- **Children** – Children are eligible for dependent coverage until their 26th birthday.
- **Contract Holder** – A contract holder becomes eligible to enroll for coverage after meeting the group’s eligibility requirements outlined in the Group Master Contract.
- **Disabled Dependent Children** – A child who has reached age 26 may continue coverage as a dependent under this plan if the child is otherwise eligible for the plan and meets all of the following criteria:
 - ◆ Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;
 - ◆ Is continuously incapable of self-sustaining employment because of mental or physical disability on the date the dependent reaches age 26; **and**
 - ◆ Is dependent on the contract holder for maintenance and support, as determined by BCBSAZ criteria.

Medical reports, acceptable to BCBSAZ, must substantiate the incapacity and must be submitted by the contract holder within thirty-one (31) days of the date such dependent child reaches age 26. The child’s eligibility to continue this coverage as a dependent under this plan is subject to periodic review by BCBSAZ.

BCBSAZ will determine whether your child meets disability criteria in its sole and absolute discretion and will provide a copy of the criteria used to make this decision upon request. A contract holder has an affirmative obligation to inform BCBSAZ if the child’s disability ceases. Cessation of the child’s disability or dependency will terminate the child’s coverage as a dependent under this plan.

- **Retiree** – Please see your benefit plan administrator to determine eligibility requirements for a retiree and his/her eligible dependents.

Effective Date of Coverage

- **Contract Holder** – A contract holder’s effective date of coverage will be either the date the contract holder becomes eligible to enroll or the first billing date after the contract holder becomes eligible to enroll as determined by the Group, as long as the contract holder completes the application process within thirty-one (31) days of becoming eligible. See your schedule page for contract holder effective date.
- **Dependent** – Dependent coverage is available only if an eligible contract holder has enrolled for coverage. Eligible dependents will have the same effective date as the contract holder if they are included on the application at the time the contract holder first enrolls. If the contract holder and/or dependents do not enroll when first eligible, the contract holder and/or dependents may only apply for coverage at the group’s annual open enrollment period, except as stated in “*Special Enrollment Provisions*” or if court-ordered. The effective date of coverage for an application made during an open enrollment period is the group’s anniversary date following that open enrollment period.

- **Spouse** – The effective date for a new spouse will be the date of marriage, as long as the contract holder completes an application within thirty-one (31) days of that date; otherwise, the spouse may not enroll until the next open enrollment period, unless he or she qualifies under *"Special Enrollment Provisions."*
- **Domestic Partner** – The effective date for a domestic partner will be the date the employee and partner have satisfied the eligibility criteria, if it is not satisfied at the time the employee is eligible to enroll. The domestic partner must enroll within thirty-one (31) days of the date eligibility criteria is met or the partner may not enroll until the next open enrollment period, unless he/she qualifies under *"Special Enrollment Provisions."*
- **Newborn/Adopted Child/Child Placed for Adoption** – A child is automatically eligible for coverage for the first thirty-one (31) days after the date of birth, adoption or placement for adoption, so long as the parent or guardian covered under this benefit plan remains eligible for coverage during that period and the newborn or child adopted or placed for adoption is otherwise an eligible dependent under this benefit plan. BCBSAZ will continue coverage for the child after the thirty-one (31) day period and the contract holder will be responsible for any additional premium, unless the contract holder notifies BCBSAZ in writing to remove the newborn or adopted child from this benefit plan. Even if no additional premium is required (e.g., you already have family coverage), the contract holder must notify BCBSAZ in writing to remove the child from the benefit plan.

Contact Membership Services at the number listed in the front of this benefit book to receive a BCBSAZ adoption packet.

- **Other Children** – The effective date for a dependent child who is not a newborn child, adopted child or a child placed for adoption (as described above) shall be the date the child becomes an eligible dependent, as long as the contract holder completes an application to add the child within thirty-one (31) days of that date. If an application is not completed within thirty-one (31) days, the child may not enroll until the next open enrollment period, unless the child qualifies under *"Special Enrollment Provisions."*
- **Retiree** – Please see your benefit plan administrator to determine effective dates of coverage for a retiree and his/her eligible dependents.

Loss of Eligibility

The date your eligibility ends is also the date coverage ends under the benefit plan.

Some groups have up to thirty-one (31) days to notify BCBSAZ that an employee has become ineligible. Until BCBSAZ receives notice and processes the termination of eligibility, benefits may be quoted, precertification given or claims paid that ultimately will be recouped from members or providers, if it is later determined the member(s) were ineligible on the date services were received. Such benefit quotations or precertifications become null and void, regardless of whether the employee has received notice of termination of eligibility from the group.

Contract holder eligibility ends on the following days:

- The last day for which the contract holder was entitled to receive compensation from the group, regardless of the date the contract holder receives such compensation, as defined in the Group Master Contract and for which BCBSAZ has received premium.
- The date on which an approved leave of absence expires, if the contract holder fails to return to active employment.
- The date of death.

Dependent eligibility ends on the following days:

- For a dependent spouse and any children of that spouse who are not the birth or adopted children of the contract holder the date a divorce decree becomes final.
- The birthday a child turns age 26, if the child is not a disabled dependent child.
- The date on which the disability or dependency ceases for a disabled dependent child over age 26.

- The date on which a child covered by a medical support order is no longer eligible under the court order or administrative order.
- The date of the contract holder's death or as might otherwise be provided in the Group Master Contract.
- The surviving dependent spouse, and any eligible dependent children of any law enforcement officer, firefighter, or correctional officer killed from injuries suffered in the line of duty are covered until the date on which the spouse remarries or attains Medicare eligibility or to the end of the month in which the eligible dependent child turns age 26.

Domestic partner eligibility ends:

In addition to the reasons stated above concerning dependent spouses and children, a domestic partner and/or the children of the domestic partner also lose eligibility for coverage as follows:

- The date on which the domestic partner who is the eligible employee loses coverage under this benefit plan.
- The date on which the domestic partnership is terminated or dissolved.
- The date on which the group discontinues eligibility for domestic partners and/or eligible children of the domestic partner.

The date coverage terminates for a domestic partner and/or the children of the domestic partner is as described in the benefit plan booklet for employees and dependents.

A domestic partner and/or their children who become ineligible for this coverage may be eligible for continuation coverage. Please contact the group's Benefit Administrator for information concerning eligibility for group continuation coverage. For information on other individual (non-group) coverage, such as individual portability or conversion coverage, please contact BCBSAZ.

Retiree eligibility:

Please see your benefit plan administrator for information regarding loss of retiree's eligibility and termination dates of coverage and the dates for a retiree's dependents.

Date of Termination of Coverage

A contract holder's and/or dependent's coverage will terminate on the **earlier** of the following:

- The date the Group Master Contract terminates; **or**
- The last day on which the contract holder or dependent is eligible for coverage (as described above) or the last day of the billing month when eligibility ends, as set forth in the Group Master Contract. The Group Master Contract controls whether coverage terminates on the date eligibility ends or the last day of the billing month when eligibility ends.

Contract holders' and/or dependents' coverage ends no later than the date the Group Master Contract terminates.

When a contract holder's coverage terminates, coverage for all dependents also terminates. Members may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Members may also be eligible for individual portability coverage or may apply to BCBSAZ for an individual conversion contract.

BCBSAZ will issue a certificate of creditable coverage upon receipt of notice of the contract holder's termination. Members may request a certificate of creditable coverage at anytime up to twenty-four (24) months after termination of coverage.

Special Enrollment Provisions

A special enrollment period is available for the following qualifying events, as applicable to the individual seeking coverage when such individual requests coverage under this benefit plan by completing an application within thirty-one (31) days of the loss of other coverage:

- A person loses minimum essential coverage, as that term is defined in applicable law
- A person gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption
- The death of the covered employee
- A person has coverage through his or her spouse and the spouse dies
- A person has coverage through his or her spouse and a divorce or legal separation occurs
- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of the covered employee's employment
- The divorce or legal separation of the covered employee from the covered employee's spouse
- The covered employee becomes entitled to Medicare
- A dependent child ceases to be a dependent child under the generally applicable requirement of the plan
- A proceeding in a case under title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time
- Exhaustion of a person's COBRA coverage;
- Termination of the employer's contribution toward coverage
- Termination of the covered employee's eligibility for coverage
- The covered employee's employer terminates coverage
- The covered employee is employed by an employer that offers multiple health benefit plans and the covered employee elects a different plan during open enrollment
- A person exhausts a lifetime maximum on all benefits under the other policy or plan (qualifying event is denial of claim due to operation of a lifetime maximum
- A person no longer lives, resides or works in the other plan's service area and no other benefit plan is available to that person; **and**

A special enrollment period is available for the following qualifying events, as applicable to the individual seeking coverage when such individual requests coverage under this benefit plan by completing an application within sixty (60) days of the loss of other coverage:

- A person loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- A person received notice that he or she is eligible for a Medicaid or CHIP premium assistance subsidy; **and**

Any other special enrollment rights available under applicable state or federal law

Leave of Absence

Please see your group benefits administrator for information regarding coverage during a leave of absence.

BCBSAZ will also continue coverage for members during any leave of absence the group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 and any amendments or successor provisions. If the contract holder returns to active employment by the end of the leave of absence period, coverage under this benefit plan will continue for the contract holder and covered dependents, so long as the group maintains coverage with BCBSAZ. If not, the contract holder will cease to be eligible and coverage for the contract holder and dependent(s) will terminate as described in "*Termination of Coverage.*"

Medical Support Orders

Coverage is available to a child of the contract holder in accordance with any court order or administrative order issued by a court of competent jurisdiction, that requires the contract holder to provide health benefits coverage for such child.

The order must clearly specify the name of the contract holder, the name and birth date of each child covered by the order and the time period to which the order applies.

Following receipt of the above information from the group, BCBSAZ will add the child to the contract holder's coverage, subject to BCBSAZ's guidelines for adding dependent children, as outlined above. If the contract holder does not have family coverage, the contract holder is required to enroll for family coverage and pay any additional required premium.

Termination of Coverage

Benefits After Termination

Except as described below, you have no coverage on and after the date coverage ends, regardless of the reason for termination. **There is one exception.** If a member is an inpatient in an acute care hospital on the day coverage ends, benefits for covered inpatient facility services delivered during that admission will be provided under this plan. **Any professional services rendered during the stay, but after the date of termination, are not covered.** This exception for continued coverage does not apply to inpatient stays in long-term acute care, skilled nursing, extended active rehabilitation or behavioral health facilities.

Certificates of Creditable Coverage

When your coverage ends, BCBSAZ will send you a certificate that shows the period you were covered under this plan. If you do not receive your certificate within thirty (30) days of your termination, you may request a certificate by contacting BCBSAZ Membership Services at any time up to twenty-four (24) months after your coverage ends.

Continuation of Coverage

Under federal law it is the group's responsibility, as plan administrator, to inform employees and dependents of the availability, terms and conditions of continuation of coverage available under COBRA.

COBRA requires most employers who have twenty or more employees and sponsor a group health plan to offer employees and their covered dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Continuation of coverage is available when an employee is absent from employment by reason of service in the uniformed services, as defined by applicable federal law. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Disability Extension of Benefits

BCBSAZ determines total disability in its sole and absolute discretion and will provide a copy of the criteria used to make this decision upon request. Eligibility to continue coverage for a disabling condition is subject to periodic review by BCBSAZ.

If you are totally disabled on the date that the group discontinues coverage through BCBSAZ, or on the date your coverage as an active employee (or as the dependent of an active employee) terminates, medical expense benefits will continue, **for the disabling condition only, for a period not to exceed twelve (12) months from the date of termination.** To ensure an orderly extension of benefits and timely processing of your claims, it is important to provide BCBSAZ with written notice of the disabling condition no later than thirty-one (31) days after such termination. You do not waive your right to extended benefits if you do not notify BCBSAZ; however, BCBSAZ cannot pay claims until notice is received.

When you provide notice, you will be required to also provide reports satisfactory to BCBSAZ that show the date of your termination, the condition that resulted in you becoming totally disabled and that you have been totally disabled from that condition from the time of such termination.

If your group discontinues coverage, you are eligible for this extension of benefits whether covered as an active employee, the dependent of an active employee or a qualified COBRA beneficiary on the date the group discontinues coverage through BCBSAZ.

If you are eligible for an extension of benefits because of an individual termination and you elect continuation coverage under COBRA, the extension of benefits shall run concurrently with your continuation coverage under COBRA, until the 12-month extension of benefits period is exhausted. Because these provisions run concurrently, please contact your employer before making any changes to or terminating your COBRA continuation coverage.

Individual Portability Coverage

You are eligible for certain individual coverage with no medical underwriting or pre-existing condition waiting periods if you meet **all** of the following criteria:

- You have eighteen (18) months of prior continuous creditable coverage; the most recent coverage must be with a group, government or church plan, **and**
- You are no longer eligible for a group plan, Medicare or Medicaid, **and**
- Coverage was not terminated for non-payment of premium or fraud, **and**
- You elected and exhausted COBRA continuation coverage (or other similar coverage) if this coverage was available to you, **and**
- You apply for individual portability coverage within sixty-three (63) days of the date your group (or COBRA) coverage ends.

Please contact BCBSAZ for information on individual portability coverage.

Conversion Coverage

If your coverage under this benefit plan ends for any reason other than the group changing insurance plans and you maintain your permanent residence in Arizona, you may apply for an individual conversion contract offered by BCBSAZ.

BCBSAZ must receive your written application for a conversion contract within thirty-one (31) days of your termination from this benefit plan. You may also apply for conversion coverage when your continuation coverage under COBRA expires, provided the Group Master Contract is still in force.

Transfer Coverage

Each Blue Cross and Blue Shield (BCBS) plan is required to offer a transfer policy to members of other BCBS plans who are under age 65.

If you cease to be a member under this benefit plan (for any reason other than the group changing insurance plans) and you move to an area served by another Blue Cross and/or Blue Shield plan, you may be eligible to enroll for transfer coverage with the BCBS plan serving your new address.

Transfer coverage available to you from the other BCBS plan may be very different from the coverage under this plan. You may have to apply and meet medical underwriting requirements just like any other new member. You may or may not receive credit for pre-existing condition waiting periods. Policies that do not require medical underwriting or that do not have pre-existing condition limitations may have significantly higher premiums and deductibles.

If you do not wish to enroll in the transfer coverage, you may be eligible for other policies issued by other BCBS plans.

Benefit-Specific Eligibility

Under the following limited circumstances, a non-member may be eligible to receive benefits under this plan:

- If a transplant recipient is covered under this plan and the donor is not a member, the donor may be eligible for limited benefits (see benefit descriptions for Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures and Transplant Travel and Lodging).
- If a non-member is pregnant with a baby that is to be adopted by a BCBSAZ member of this plan, the non-member may be eligible for maternity benefits under the following circumstances:
 - ◆ The child is adopted by a BCBSAZ member within one year of birth;
 - ◆ The member is legally obligated to pay the costs of birth; **and**
 - ◆ The member notified BCBSAZ that a court has certified the member as acceptable to adopt within 60 days of the court order or the effective date of this plan, whichever occurs later.

This benefit is considered secondary to any other coverage available to the birth mother.

GENERAL PROVISIONS

Appeal and Grievance Process

Members may participate in BCBSAZ's appeals and grievances processes, which are described in detail in the Health Coverage Appeal Information Packet, a separate document provided to you. You may ask BCBSAZ for another copy of the Health Coverage Appeal Information Packet at any time by submitting a request through www.azblue.com or by calling the BCBSAZ Supply Line telephone number listed in the front of this booklet.

You do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ. To appeal a denial of precertification for urgently needed services you have not yet received, please call the BCBSAZ Precertification Denial Appeals telephone number listed in the front of this booklet.

Billing Limitations and Exceptions

When there is another source of payment such as a liability insurer, in-network providers may be entitled to collect any difference between the allowed amount and the provider's billed charges from the other source or from proceeds received from the other source, pursuant to A.R.S. § 33-931.

A.R.S. § 33-931 may give providers medical lien rights independent of this benefit plan or any contract with BCBSAZ. BCBSAZ is not a party to any collection dispute that may arise under the provisions of A.R.S. § 33-931.

The provisions of this section do not constitute subrogation (reimbursement to the health plan from other payment sources). BCBSAZ does not subrogate. If you are represented by an attorney in a dispute concerning recovery for injuries or illness, please show this section of your book to your attorney.

Blue Cross and Blue Shield Association

You hereby expressly acknowledge and agree to the following:

- i. This benefit plan constitutes a contract between the group and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSAZ to use the Blue Cross and/or Blue Shield service marks in the State of Arizona;
- ii. BCBSAZ is not contracting as the agent of the Association;
- iii. In accepting the benefits of this plan, you are not relying on any representations by the Association or any other Blue Cross or Blue Shield plan, other than BCBSAZ; **and**
- iv. You will not seek to hold the Association or any Blue Cross and Blue Shield plan other than BCBSAZ, accountable or liable for BCBSAZ's obligations herein.

Broker Commissions

BCBSAZ sells health and dental coverage products either directly or through independent licensed insurance brokers. Commission payments to brokers are one of the costs factored into premiums, but BCBSAZ's premium calculation is not based on whether a product is sold directly or by a broker. BCBSAZ generally pays a commission to the broker of record or legal assignee designated by the broker until the insurance contract is terminated, the group terminates its relationship with the broker and notifies BCBSAZ or the broker becomes ineligible for receipt of commissions. Brokers are required under their agreement with BCBSAZ to provide information on commission rates with BCBSAZ.

Claim Editing Procedures

In order to process claims accurately, BCBSAZ uses a computer system to verify benefits, eligibility, claims accuracy and compliance with BCBSAZ coding guidelines and the Medical Coverage Guidelines. BCBSAZ uses claims coding and editing logic to process professional and outpatient facility claims for surgery, laboratory, radiology, maternity and dental services. This system logic is designed to identify the following: procedure unbundling (billing multiple procedure codes to represent a procedure that can be described with a more comprehensive code), separate billing for included (incidental) services, procedures not usually performed together (mutually exclusive) procedures, correct use of coding guidelines, member's age and sex edits. The system logic does not audit the diagnosis code to change or modify the intensity of service of office visit (evaluation and management) codes. BCBSAZ periodically updates its computer system claim edits.

Confidentiality and Release of Information

BCBSAZ takes confidentiality very seriously. We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with state and federal law. If you wish to authorize someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from www.azblue.com or call BCBSAZ customer service and request a hard copy of the CIRF form.

Court or Administrative Orders Concerning Dependent Children

When a member is not the custodial parent of a child, but is required by a court or administrative order to provide health benefits to that child, BCBSAZ will provide benefit information to the custodial parent, permit the custodial parent to submit claims for the child and make payments directly to the custodial parent, provider or state agency as applicable.

Access to Information Concerning Dependent Children

BCBSAZ is not a party to domestic disputes. Parental disputes over dependent coverage and information must be resolved between the parents of the dependent child. Under Arizona law, both parents have equal rights of access to information about their children, unless there is a court order denying such access. Absent a copy of such order and subject to the confidentiality provisions described above, BCBSAZ provides equal parental access to information.

Discretionary Authority

BCBSAZ has discretionary authority to determine extent of coverage under the terms of this benefit plan.

Provider Treatment Decisions and Disclaimer of Liability

While rendering services to you, in-network providers are independent contractors and not employees, agents or representatives of BCBSAZ. Their contracts with BCBSAZ address reimbursement and administrative policies. Each provider exercises independent medical judgment. BCBSAZ's role is limited to administration of the benefits under this benefit plan. Your provider may recommend services or treatment not covered under this benefit plan. You and your provider should decide whether to proceed with a service that is not covered.

BCBSAZ has no control over any diagnosis, treatment, care or other services rendered by any provider and disclaims any and all liability for any loss or injury to you caused by any provider by reason of the provider's negligence, failure to provide treatment or otherwise.

Lawsuits against BCBSAZ

BCBSAZ has an appeal process for resolving certain types of disputes with members. BCBSAZ encourages you to use the appeal process before filing a lawsuit, as issues can often be resolved when you give BCBSAZ more information through the appeal process.

Under Arizona's Health Care Insurer Liability Act, before suing BCBSAZ, a member must first either complete all available levels of the BCBSAZ appeal process or give BCBSAZ written notice of intent to sue at least thirty (30) days before filing the lawsuit. The written notice must set forth the basis for the lawsuit and must be sent by certified mail to the following address:

Attn: Legal Department
Mail Stop: C300
Blue Cross Blue Shield of Arizona, Inc.
8220 N. 23rd Avenue
Phoenix, AZ 85021-4872

Failure to comply with these provisions may result in dismissal of the lawsuit.

A member must complete all applicable levels of appeal before bringing a lawsuit other than a suit filed pursuant to the Health Care Insurer Liability Act. Failure to complete the mandatory levels of the appeal process may result in dismissal of the lawsuit for failure to exhaust BCBSAZ's administrative remedies.

By providing this notice BCBSAZ does not waive, but expressly reserves all applicable defenses available under Arizona and federal law.

Legal Action and Applicable Law

This contract is governed by, construed and enforced in accordance with the laws of the state of Arizona, without regard to conflict of laws principles, and applicable federal law.

This benefit book and the contract between BCBSAZ and the sponsor of your group health plan were issued in Arizona to a group headquartered in Arizona. The only state law governing the benefit book and the contract is the law of the state of Arizona. This benefit plan may not provide all benefits required by other state laws.

Jurisdiction and Venue

Maricopa County, Arizona shall be the site of jurisdiction and venue for any legal action or other proceeding that arises out of or relates to the contract or this benefit plan.

Lawsuits by BCBSAZ

Sometimes, BCBSAZ has an opportunity to join class action lawsuits, where third party payers (insurance companies) assert that an entity's conduct resulted in higher payments by the insurance company than otherwise would have been required. BCBSAZ reviews these cases and makes a good faith decision based on the unique facts of each case whether to join the case. BCBSAZ may also bring lawsuits against vendors or other entities to recover various economic damages. When BCBSAZ participates as a plaintiff and recovers damages, those funds are not returned to individual members, but are instead retained by BCBSAZ to reduce overall administrative costs. This paragraph is not intended to limit or waive any claims BCBSAZ may have against any person or entity.

Non-Assignability of Benefits

The benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against BCBSAZ and imposes no duty or obligation on BCBSAZ. BCBSAZ will not honor any such purported sale, assignment, pledge, transfer or grant.

Medicaid Reimbursement

Member acknowledges that state Medicaid agencies, including the Arizona Health Care Cost Containment System ("AHCCCS"), (collectively referred to as "Medicaid Agencies") are considered payers of last resort for health care expenses of individuals who are Medicaid beneficiaries. Member further acknowledges that AHCCCS does, and other state Medicaid Agencies may, have a legal right to reimbursement of expenditures that the Medicaid Agencies have made on behalf of a member who was also a Medicaid Beneficiary, not to exceed the lesser of the member's benefits under this plan or the Medicaid Agencies' payment. Member acknowledges and agrees that BCBSAZ shall reimburse Medicaid Agencies or their designees, for the health claims of a member who was also a Medicaid Beneficiary on the date of service, to the extent required by law.

Member Notices and Communications

BCBSAZ sends notices and other communications to members by U.S. mail to the last address on file with BCBSAZ Membership Services. BCBSAZ may also elect to send some notices and communications electronically if the member has consented to electronic receipt. Notice is deemed complete when sent to the member's last address of record, as follows: (1) on delivery, if hand-delivered; (2) if mailed, on the earlier of the day actually received by the member or five days after deposit in the U.S. mail, postage prepaid; or (3) if transmitted electronically, on the earlier of the day of actual receipt or 24 hours after electronic transmission to the member's email address of record.

Payments Made in Error

If BCBSAZ erroneously makes a payment or over-payment to you or on your behalf, BCBSAZ may obtain reimbursement from you or the provider or BCBSAZ may offset the amount owed against a future claim arising from any covered service. Payments made in error by BCBSAZ do not constitute a waiver concerning the claim(s) at issue or of any right of BCBSAZ to deny payment for noncovered services.

Plan Amendment

There is no guarantee of continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted or changed upon notice to the group and/or contract holder or as required to comply with state or federal laws. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available. Please review and retain this book, any replacement books, all schedule pages, all riders and amendments and other communications concerning your coverage.

Rebates

The Patient Protection and Affordable Care Act (health care reform) law has provisions requiring insurers to pay rebates if insurers do not achieve certain medical loss ratios. If BCBSAZ is required to pay rebates, BCBSAZ will pay the rebates to the sponsor of this group health plan. The plan sponsor is responsible for remitting payment to members covered under the plan.

Retroactive Changes

BCBSAZ reserves the right to make certain retroactive amendments to this benefit plan, as may be permitted under applicable federal and state law. You will receive notice of any such amendments.

Prescription Medication Rebates and Medication Level Assignments

BCBSAZ contracts with pharmaceutical manufacturers to receive rebate payments on pharmaceutical products used by BCBSAZ members.

The rebates vary based on factors such as utilization, the level to which a medication is assigned, absence of barriers to product availability, volume purchased and market share. As utilization and market share increase, the amount of the rebate payable to BCBSAZ may increase. BCBSAZ may enter into new rebate contracts and renegotiate or terminate existing rebate contracts at any time at BCBSAZ's sole discretion.

The rebates BCBSAZ receives on your pharmacy utilization are not reimbursable to you or your employer, including prescription costs applied to any deductible, coinsurance calculation or out-of-pocket maximum that may apply under your plan. This means that BCBSAZ will collect any rebate payments on medications for which you paid the full allowed amount that was credited toward your deductible. It also means that you will pay coinsurance, and receive credit toward any out-of-pocket maximum, based on the full allowed amount without reference to any rebate payment BCBSAZ may later collect. You acknowledge and agree BCBSAZ will retain all rebates. Rebates received by BCBSAZ may result in the overall cost of a particular medication falling below the amount you pay for the medication under the coverage terms of this contract.

BCBSAZ has a Pharmacy and Therapeutics (P&T) Committee which makes recommendations on coverage and level assignment for medications. The P&T Committee is comprised of BCBSAZ pharmacists, BCBSAZ medical directors, other BCBSAZ employees and other members as needed. Although some BCBSAZ employees who are P&T Committee members are aware of the potential rebate contracts or rebate payments when making decisions, any external community physician members of the P&T Committee are not informed of potential or current rebate contracts or rebate payments when deciding which medications to place on certain levels. P&T Committee decisions are not binding and can be overridden by BCBSAZ.

Provider Contractual Arrangements

The BCBSAZ allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors such as type and location of provider and other relevant information. For that reason, BCBSAZ network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate.

Release of Records

Subject to Arizona or federal law, the member agrees that BCBSAZ may obtain, from any provider, insurance company or third party, all records or information relating to the member's health, condition, treatment, prior health insurance claims or health benefit program.

Rescission of Coverage

In the event of fraud or intentional misrepresentation of material fact, coverage for any person ineligible to be on the benefit plan as described in the Group Master Contract will be rescinded, that is, as never having been in effect. Premiums paid for the coverage for the ineligible person will be refunded, minus any claims paid for that person. BCBSAZ is entitled to recover claim payments that exceed the amount of premium paid. Such rescission does not affect the coverage of those persons on the benefit plan who remain eligible for coverage.

BCBSAZ will give 30 days written notice of its intent to rescind, during which time the person may protest the decision by writing to BCBSAZ at the address indicated in the notice and explaining why a rescission is not appropriate or allowable.

A member's eligibility to enroll in the group's health plan is not based on the member's health status. An omission or misrepresentation of health information in your application for group coverage is not a basis for rescission of your group coverage.

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. In-network providers generally cannot charge you for providing BCBSAZ with health records needed to process claims, grievances or appeals. Noncontracted providers have no contractual obligation to provide records to BCBSAZ free of charge. If you receive services from a noncontracted provider who charges for record preparation, costs or copies, you will need to make arrangements with your provider to obtain any records required by BCBSAZ and pay any applicable fees.

Statement of ERISA Rights

(Does Not Apply to Government Plans, Church Plans or Other Non-ERISA Qualified Plans)

As a member of a group health insurance benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

For purposes of ERISA, your employer is the "Plan Administrator." BCBSAZ is not the Plan Administrator. ERISA provides that all members shall be entitled to:

- **Receive information about your plan and benefits**

Under ERISA, you are entitled to examine, without charge, at the Plan Administrator's office and other locations, such as worksites and union halls, all documents governing the Plan that are available from the Plan Administrator, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Upon written request to the Plan Administrator, you may obtain copies of the Plan documents, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may charge you for the copies.

- **Continue group health plan coverage**

COBRA is the abbreviation for a federal law that regulates continuation of health care coverage for you, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Unless you have an agreement with your employer to pay your COBRA premiums, you or your dependents will be responsible for full payment of the premium to continue coverage under your group plan. Review your benefit book and talk to your benefits administrator about your COBRA continuation coverage rights.

- **Receive credit for pre-existing condition waiting periods**

If you have creditable coverage from one health plan, you may receive credit toward meeting the pre-existing condition waiting period of another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ends. You must request such a certificate before losing coverage or within 24 months of losing your coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition waiting period of 11 months from your effective date (or 18 months, if you are a late enrollee in your group plan).

- **Prudent actions by plan fiduciaries**

In addition to creating certain rights for group members, ERISA also imposes certain duties on the "plan fiduciaries," those responsible for administration of the health plan. The plan fiduciaries have a duty to operate the plan prudently and in the interest of you and other members.

- **Enforce your rights**

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you have a right to know why it was denied, obtain copies of documents related to the decision (at no charge) and appeal any denial, all within the time periods required by ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Third-Party Beneficiaries

The provisions of this benefit plan are only for the benefit of those covered under this plan. Except as may be expressly set forth in this book, no third party may seek to enforce or benefit from any provisions of this benefit plan.

Your Right to Information

You have the right to inspect and copy your information and records maintained by BCBSAZ, with some limited exceptions required by law. This right is described in the Notice of Privacy Practices provided to you at the time of enrollment and available by request from BCBSAZ. If you choose to review your medical records in person, BCBSAZ will require a reasonable amount of time to research and retrieve the records before scheduling a time with you to review the records.