BlueSignature PROSANO

EPO Plan

Benefit Book

TSMC Arizona Corporation

Group # 44223

Effective January 1, 2024

azblue.com

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

TSMC Arizona Corporation
BlueSignature Prosano Exclusive Provider Organization Benefit Plan

Your employer sponsors a self-funded Employee Health Care Plan (“the Plan”) to provide its employees with healthcare coverage. The Plan is established by your employer and is maintained pursuant to a written document called a Plan Document.

Your employer has contracted with Blue Cross® Blue Shield® of Arizona (“BCBSAZ”) to provide certain administrative claims processing and utilization management services for this Exclusive Provider Organization (EPO) benefit plan. Benefits under the Plan are paid from the general assets of the Plan Sponsor*.

BCBSAZ, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BCBSAZ may also have a contract with your employer to provide stop-loss insurance to the Plan. The stop-loss insurance may be "aggregate" stop-loss, which reimburses the Plan whenever claims on all employees exceed a specified level in a Plan year, "specific" stop-loss, which reimburses the Plan whenever claims on any covered person exceeds a specified level; or a combination of both.

BCBSAZ is an independent contractor and shall not for any purpose be deemed an agent of your employer or the employer’s Plan Administrator*, nor shall BCBSAZ and your employer be deemed partners, joint-venturers or governed by any legal relationship other than that of independent contractor. In this book, BCBSAZ refers to the administrative services agreement and/or stop loss insurance agreement with your employer as a group master contract.

This book is a health benefits Summary Plan Description (SPD). Your employer is responsible for the Plan Document. This benefit book may use words used in an insured plan. All such references shall be read to indicate that the plan is self-insured.

This benefit plan gives you access to a network of providers that have agreed to negotiated discounts with BCBSAZ or a local Blue Cross and/or Blue Shield plan if covered services are rendered outside of Arizona.

The employer reserves the right to amend or terminate this benefit plan at any time at its sole discretion. In the event of termination of the benefit plan, claims incurred prior to the date of termination will be covered.

Please note: Not all services are covered. As this is a self-funded employer healthcare plan, benefits provided in this plan may not include all benefits required for those healthcare plans, which are not self-funded. Read this benefit book carefully to understand the benefits and limitations of the benefit plan.

*Plan Sponsor and Plan Administrator are terms defined under the Employee Retirement Income Security Act (ERISA).

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ERISA PLAN INFORMATION

Plan Name:	**TSMC Arizona Corporation Health and Welfare Plan**
Plan Sponsor:	**TSMC Arizona Corporation**
Employer Identification Number (EIN):	**85-3841596**
Plan Type:	Welfare
Plan Administrator:	**TSMC Arizona Corporation**
Agent for Service of Legal Process:	**TSMC Arizona Corporation**
Claims/Benefits Administrator:	Blue Cross Blue Shield of Arizona P.O. Box 2924 Phoenix, AZ 85062-2924 If you have questions, please call the Customer Service number on the back of your ID card.
Collective Bargaining Agreements:	Contact the plan administrator to obtain information and documents, if applicable, about collective bargaining agreements that may govern this plan.

CUSTOMER SERVICE INFORMATION

Welcome to BlueSignature Prosano, a health plan built around people and their communities. Blue Cross Blue Shield of Arizona (BCBSAZ) is pleased to provide you with this benefit book, which includes information about:

- Who is eligible
- Services that are covered, called Covered Services
- Services that are not covered, described in the *"What is Not Covered"* section of this benefit book
- Services that require precertification
- Your rights and responsibilities

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 numbers on the back of your ID card.

MyBlue℠

BCBSAZ also makes information available at www.azblue.com, and you may wish to look there before calling. MyBlue 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 MyBlue account. After you register for MyBlue, you can*:

- View claims and benefits information
- Track deductible, if applicable to your plan
- Update account information
- Verify enrollment status
- Order ID cards
- Search for providers
- Compare hospitals
- Research pharmacy benefits

*Access to MyBlue links and services will vary based on benefit plan type.

BCBSAZ Customer Service

Customer Service phone numbers for your plan are on the back of your member ID card.

Hours:	Monday through Friday, 8:00 a.m. to 5:00 p.m. Local AZ Time (except holidays)
If you lose your ID card and need a replacement:	1-855-776-7266 (1-855-PROSANO)
Hearing Impaired (TTY):	(800) 770-8973, TTY: 711
Mailing Address:	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466

Benefits Administrator Contact Information

Chiropractic Benefits Administrator (CBA):	(800) 678-9133
Pharmacy Benefit Customer Service:	(866) 325-1794 available 24/7
Telehealth Services Administrator (TSA):	Log in to MyBlue and click on the BlueCare Anywhere℠ link; download the BlueCare Anywhere app available on Google Play™ store or the App Store®; go to www.BlueCareAnywhereAZ.com; or call (844) 606-1612

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Claim Submissions

Mail New Claims to:	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix, AZ 85062-2924
Claims for Transplant Travel and Lodging:	Attention: Transplant Travel Claim Processor, Mail Stop: A223, 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, AZ 85002-3466
Claims for Chiropractic Services:	Claims Administration, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001

Disputes

Medical Appeals and Grievances:	Call the Customer Service number on the back of your ID card.
Prior Authorization Denial Appeals:	Call the Customer Service number on the back of your ID card.
Chiropractic Care Disputes:	Call the Chiropractic Care Customer Service number on the back of your ID card, or write: Appeals Coordinator, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001 Telephone (800) 678-9133; Fax (877) 248-2746

Social Media

Like us on Facebook: www.facebook.com/bcbsaz
Follow us on X: www.twitter.com/bcbsaz
Email complaints and concerns to socialcares@azblue.com

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. BCBSAZ uses the Allowed Amount to accumulate toward any 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. The table below shows how BCBSAZ determines the Allowed Amount.

Type of Provider	Type of Claim	Basis for Allowed Amount
Providers contracted with BCBSAZ as plan network providers	Emergency and non-emergency	Lesser of the provider's billed charges or the applicable plan network fee schedule, with adjustments for any negotiated contractual arrangements and certain *"Claims Editing Procedures and Pricing Guidelines."*
Providers contracted with a vendor	Emergency and non-emergency	Lesser of the provider's billed charges or the vendor's fee schedule, with adjustments for any negotiated contractual arrangements.
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.
Noncontracted providers, excluding air ambulance, in and outside Arizona	Emergency	The Qualifying Payment Amount, as defined by federal law, is the allowed amount.
Noncontracted ground ambulance in and outside Arizona	Emergency	The billed charges from the provider are the allowed amount.
Noncontracted air ambulance in and outside Arizona	Emergency and non-emergency	Lesser of the provider's billed charges or the applicable BCBSAZ fee schedule, with adjustments for certain *"Claims Editing Procedures and Pricing Guidelines."* The member's cost share will be based on the lesser of the provider's billed charges or the Qualifying Payment Amount, as defined by federal law.
Noncontracted providers in a network facility in and outside Arizona, including providers contracted with BCBSAZ as PPO or HMO providers but who are not in your plan's network	Non-emergency and non-ancillary	The Qualifying Payment Amount, as defined by federal law, is the allowed amount. If you sign a consent for a noncontracted provider to perform services at a network facility, you are responsible for the difference between the Qualifying Payment Amount and the provider's billed charges.

"Ancillary Services" are services that include emergency medicine, anesthesiology, pathology, radiology, neonatology, certain laboratory services, or as otherwise required by law.

"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 contracted vendors, when a contracted vendor is performing functions on behalf of BCBSAZ. Blue Cross Blue Shield of Arizona is an independent licensee of the Blue Cross and Blue Shield Association. BCBSAZ is a not-for-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 healthcare services organization as a line of business.

"Behavioral Health Benefits" means benefits for services to treat behavioral health conditions that are classified as behavioral health conditions based on generally recognized independent standards of current mental health, including the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or the most current version of the International Classification of Diseases (ICD).

"Benefit Book" means this document.

"Benefit 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 your summary of benefits and coverage (SBC), your application for coverage, any plan that is issued to replace this plan and any rider, amendment, or modification to this 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.

"Billed Charges" means:
- For a provider that has a participation agreement governing the amount of reimbursement, the amount the provider routinely charges for a service;
- For a provider that has no participation agreement governing the amount of reimbursement, the lowest amount that the provider is willing to accept as payment for a service.

"Blue Distinction®" is a national designation awarded by Blue Cross and Blue Shield (BCBS) Plans to recognize providers that demonstrate expertise in delivering quality specialty care—safely, effectively, and cost-efficiently.

"Cancer Treatment Medication" means prescription drugs and biologicals that are used to kill, slow, or prevent the growth of cancerous cells.

"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, and except as otherwise required by federal or state law, 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.

"Cost Share" means the member's financial obligation for a covered service. Depending on the plan type, Cost Share may include one or more of the following: access fee, coinsurance, copay, deductible, and pharmacy deductible.

"Custodial Care" means health services and other related services that meet any of the following criteria:
- Are for comfort or convenience;
- Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition, or other self-care;
- Are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as a licensed practical nurse (LPN), registered nurse (RN), or licensed therapist; **or**
- Do not seek to cure.

"Diagnosis Related Grouping (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.

"Domiciliary Care" is a supervised living arrangement in a home-like environment for individuals who are unable to live independently and who need assistance with activities of daily living, such as bathing, dressing, and food preparation.

"Evidence-based Criteria" means medical, pharmaceutical, dental, and administrative criteria, which are based on industry-standard research and technology. These criteria help BCBSAZ determine whether a service, procedure, device, or drug meets the industry standard for medical necessity and/or is a covered benefit. Criteria may include prescription medication or service limitations. BCBSAZ ensures that Evidence-based Criteria is reviewed regularly and updated in response to changes and advancements in the healthcare industry. Decisions are based on the Evidence-based Criteria in effect at the time of service. You can obtain additional information by calling the Customer Service number on your ID card. BCBSAZ contracted

vendor(s) may establish Evidence-based Criteria of their own for services the vendor provides or administers pursuant to the vendor's contract with BCBSAZ.

"Fee Schedule" means proprietary schedule 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 based on a Fee Schedule, a change to the Fee Schedule may result in higher member cost share.

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

"Group Master Contract" means the legal agreement between the group and BCBSAZ.

"Medical/Surgical Benefits" means benefits for services to treat medical conditions that are classified as medical/surgical based on generally recognized independent standards of current medical practice, including the most current version of the ICD.

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

"Pharmacy Coverage Guidelines" means pharmaceutical and administrative criteria that are developed from review of published peer-reviewed medical and pharmaceutical literature and other relevant information and to help determine whether a medication or other products, such as devices or supplies are eligible for benefits under the *"Pharmacy 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 Pharmacy Benefit Customer Service number listed on your ID card.

"Physician" for purposes of classifying benefits and member cost shares in this benefit plan, means a properly licensed MD, DO, DPM, or DC.

"Plan Network" means the network of providers contracted to provide services to members of this benefit plan. Plan Network providers are also referred to as network providers. See your SBC and ID card for the name of the Plan Network for this benefit plan.

"Primary Care Provider (PCP)" means a healthcare 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.

"**Prior Authorization**" is a review done by BCBSAZ to approve a service, treatment plan, doctor visit, or medication before you make the appointment or fill the prescription. Some services and medications require this review in order for the service or medication to be covered under your plan.

"Prosano Health Advanced Primary Care Center" means a facility where services are received from a Prosano Health Advanced Primary Care Provider.

"Prosano Health Advanced Primary Care Provider" means any properly licensed, certified, or registered person or facility furnishing Prosano Health Advanced Primary Care Services to you either virtually or in person at a Prosano Health Advanced Primary Care Center.

"Prosano Health Advanced Primary Care Services" means services provided at or by Prosano Health at an Advanced Primary Care Center. Prosano Health may elect to offer additional services that are not explicitly described in this benefit book in its sole and absolute discretion.

"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. A Provider can be related to a member.

"Rehabilitation Services" are services that help a person restore skills and functioning for daily living lost due to injury or illness.

“Respite Care” is the provision of short-term, temporary relief of the daily routine and stress to provide those who are caring for family members a personal break from their role as caregiver.

“Service” means a generic term referencing some type of healthcare treatment, test, procedure, supply, medication, technology, device, or equipment.

“Specialist” means either a physician or other healthcare professional who practices in a specific area other than those practiced by PCPs, or a properly licensed, certified, or registered individual healthcare provider whose practice is limited to rendering behavioral health services. For purposes of cost share, this definition of Specialist does not apply to dentists. BCBSAZ does not require you to obtain an authorization or referral to see a Specialist.

“Summary of Benefits and Coverage (SBC)” means a federally required document in a specified template with information on applicable access fees, coinsurance percentages, copays, deductible amounts, other cost-sharing amounts, benefits, exclusions, limitations, and other important information. BCBSAZ generally sends SBCs with member ID cards. Please keep your current SBC with your Benefit Book.

“Telehealth Services Administrator (TSA)” means Amwell, an independent company contracted with BCBSAZ to provide contracted providers, an interactive web platform allowing members to interact with providers, and technical support for telehealth services (i.e., BlueCare Anywhere) covered under this plan.

“Telehealth Services from BlueCare Anywhere” means medical and behavioral health services provided online via video using a computer, tablet, smartphone, or other mobile device through the telehealth services administrator. BlueCare Anywhere is BCBSAZ’s telehealth service.

“Telehealth Services from Network Providers” means services delivered through interactive qualified electronic media.

MEMBER COST SHARING

Members pay part of the costs for benefits received under this plan. Your cost share depends on your particular benefit plan, the service you receive, and the provider you choose. This section, the benefit descriptions in this book, and your SBC will explain which cost-share types apply to each benefit. BCBSAZ uses your claims to track whether you have met certain cost-share obligations. We apply claims based on the order in which we process the claims and not based on date of service.

About Prosano Health

Prosano Health Solutions, Inc. ("Prosano Health") provides health care services through an integrated medical care program at Prosano Health Advanced Primary Care Centers. Prosano Health is contracted with BCBSAZ as an in-network provider. Services are available at Prosano Health with no cost share to the member. See the "*Cost Share Table*" section for a list of specific services.

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 plus any other applicable cost share for the service. Access fees do not count toward meeting your calendar-year deductible.

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. Except for emergency services, and ancillary services provided in a network facility, noncontracted providers have no obligation to accept the allowed amount. You are responsible to pay a noncontracted provider's billed charges. Any amounts paid for balance bills do not count toward applicable deductible, coinsurance, or the out-of-pocket maximum.

Benefit Maximums

Some benefits may have a specific benefit maximum or limit based on the 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.

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for covered services each 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. The deductible is calculated based on the allowed amount. Amounts you pay for copays and access fees do not count toward the 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. When the family satisfies its calendar-year deductible, it also satisfies the deductible for all the individual members. An individual member cannot contribute more than his or her individual deductible toward the family's deductible.

Your deductible is waived for covered services provided at or by Prosano Health Advanced Primary Care Centers (Prosano Health).

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for certain covered services after meeting any applicable deductible. BCBSAZ subtracts any applicable access fees from the allowed amount before calculating coinsurance. Coinsurance applies to every covered service unless the specific benefit section says it does not apply.

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.

Your coinsurance is waived for covered services provided at or by Prosano Health Advanced Primary Care Centers (Prosano Health).

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. Different services may have different copay amounts and are shown on your SBC. Usually, if a copay does not apply, you will pay applicable deductible and coinsurance.

Out-of-Pocket Maximum (Individual and Family)

An out-of-pocket maximum is the amount each member must pay each year before the plan begins paying 100% 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

For services performed outside of Prosano Health, until you meet your out-of-pocket maximum, you will pay the applicable cost share for services. 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.

COST SHARE TABLE

The following services are available at Prosano Health with zero ($0) member cost share for covered services:

- **Primary Care:** Primary care services, including well visits for children over 5 years of age, both in person and virtual
- **Integrated Behavioral Health:** A behavioral health assessment and counseling, both in person and virtual
- **Urgent Care:** Same-day appointments available during normal clinic hours
- **Lab Services:** For labs ordered, drawn, and processed at Prosano Health locations
- **Care Guide:** A clinical resource for questions regarding follow-up care, referrals to non-primary care services, appointment support, and any other care concerns
- **Benefit Liaison:** Dedicated support for any questions regarding your benefits, cost share, or claims

The following tables show your cost share for covered services. See the *"Description of Benefits"* section for additional information about these covered services.

Description	COST SHARE
Calendar-Year Deductible	*Prosano Health: Deductible waived* $0 per member $0 family
Out-of-Pocket Maximum	$1,500 per member $3,000 family

BENEFIT	COST SHARE
AMBULANCE SERVICES	Plan pays 100% of the allowed amount.
BEHAVIORAL HEALTH SERVICES (Inpatient)	You pay 1 copay ($250) per inpatient admission, then Plan pays 100% of the allowed amount.
BEHAVIORAL HEALTH SERVICES (Outpatient Facility and Professional Services)	Prosano Health: You pay $0 for services you receive from Prosano Health providers. For visits and services outside of Prosano Health: You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. Plan pays 100% of the allowed amount for services received in locations other than the office, home, or walk-in clinic.
BEHAVIORAL THERAPY SERVICES FOR THE TREATMENT OF AUTISM SPECTRUM DISORDER	You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. Plan pays 100% of the allowed amount for services received in locations other than the office, home, or walk-in clinic.
CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES	For physician office visits, you pay a specialist copay ($35). Plan pays 100% of the allowed amount for outpatient professional and facility charges.
CATARACT SURGERY AND KERATOCONUS	Inpatient: You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and for inpatient facility charges. Outpatient: You pay 1 copay ($100) per outpatient surgery, then the Plan pays 100% of the allowed amount for professional services received in a facility and for outpatient facility charges.
CHIROPRACTIC SERVICES	You pay a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit, including physical medicine and rehabilitation services and for chiropractic services received in other locations.
CLINICAL TRIALS	Physician Office Visits: You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. Inpatient: You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and for inpatient facility charges.
DENTAL SERVICES – MEDICAL	Inpatient: You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and for inpatient facility charges.

BENEFIT	COST SHARE
	Outpatient: You pay 1 copay ($100) per outpatient surgery, then the Plan pays 100% of the allowed amount for professional services received in a facility and for outpatient facility charges.
DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS	For physician office visits, you pay a PCP copay ($15) or a specialist copay ($35). When DME is picked up in the physician's office but billed through a DME supplier, Plan pays 100% of the allowed amount. If you have a physician office visit at the time you pick up your DME, medical supplies, or prosthetic appliances or orthotics, you also pay a PCP or specialist copay. Plan pays 100% of the allowed amount for services received outside a physician's office. Your cost share is waived for 1 FDA-approved manual or electric breast pump and breast pump supplies per member, per calendar year.
EDUCATION AND TRAINING Diabetes and Asthma Education and Training; Nutritional Counseling and Training	Your cost share is waived.
EMERGENCY SERVICES You pay your in-network cost share for emergency services, even for services from out-of-network providers.	Emergency Room: You pay 1 emergency room access fee ($100) per member, per facility, per day for emergency room facility and ancillary charges. Admission to the Hospital From the Emergency Room *If you are admitted as an inpatient:* • The emergency room copay is waived. • You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and ancillary services related to the emergency, including facility and ancillary services provided while you were in the emergency room. • The Plan pays 100% of cost share for emergency professional services provided after admission. *If you are admitted for observation or as an outpatient:* • You pay the emergency room copay. • The Plan pays 100% of cost share for professional, facility, and ancillary services related to the emergency and provided after admission for observation or as an outpatient. 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 Qualifying Payment Amount, as defined by federal law.
EOSINOPHILIC GASTROINTESTINAL DISORDER (EGID)	The Plan pays 100% of the Cost for formula. **"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.
FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)	Implanted Devices: Your cost share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved female implanted contraceptive devices when the purpose of the procedure is contraception, as documented by your provider on the claim. Sterilization Procedures: Your cost share is waived for professional and facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim. For FDA-approved male sterilization procedures, you pay a PCP copay ($15) or a specialist copay ($35) for services received in a physician's office. The Plan pays 100% of cost share for services received in locations other than a physician's office. Hormonal Contraceptive Methods: Your cost share is waived for female oral contraceptives, patches, rings, and contraceptive injections. Emergency Contraception: Your cost share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a physician or other provider. Barrier Contraceptive Methods: Your cost share is waived for diaphragms, cervical caps, cervical shields, condoms, sponges, and spermicides.
FERTILITY AND INFERTILITY SERVICES	Physician Office Visits: You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit.

BENEFIT	COST SHARE
	Inpatient: You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and for inpatient facility charges. Outpatient: You pay 1 copay ($100) per outpatient surgery, then the Plan pays 100% of the allowed amount for professional services received in a facility and for outpatient facility charges.
HEARING SERVICES	Hearing Exams: You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for hearing exam services provided during an office, home, or walk-in clinic visit. Hearing Aids: Plan pays 100% of the allowed amount for hearing aids. Benefits are available up to the allowed amount only for a prescribed hearing aid meeting specifications for your need. BCBSAZ determines the covered model.
HOME HEALTH SERVICES	Plan pays 100% of the allowed amount.
HOSPICE SERVICES	Plan pays 100% of the allowed amount.
INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES	Physician Office Visits: You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. Inpatient: You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and for inpatient facility charges.
INPATIENT HOSPITAL	You pay 1 copay ($250) per inpatient admission. Your cost share is waived for facility charges from network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim.
INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR), LONG-TERM ACUTE CARE (INPATIENT), AND SKILLED NURSING FACILITY (SNF) SERVICES	Plan pays 100% of the allowed amount for up to 60 days of service in a calendar year. For claims submitted with a primary behavioral health diagnosis, the Plan will continue to pay 100% of the allowed amount after 60 days of services in a calendar year.
MATERNITY **"Global Charge"** is a fee charged by the delivering provider that includes certain prenatal, delivery, and postnatal services.	Inpatient: You pay 1 copay per admission ($250). Outpatient: You pay a PCP copay ($15) or a specialist copay ($35) for your first prenatal visit. You pay a physician visit copay for any maternity services not included in the delivering provider's Global Charge and provided by a physician during an office or home visit. Plan pays 100% of the allowed amount for other covered maternity services. Your cost-share obligations may be affected by the 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, addition of a child will result in a change from individual coverage to family coverage, and you may be required to pay additional premium. If you currently have individual coverage, when a child is added to your plan, you will also have a family deductible and out-of-pocket maximum.
MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS	Plan pays 100% of the Cost for medical foods. **"Cost"** is defined as either billed charges, if the member buys the medical foods from an out-of-network provider or the allowed amount, if the member buys the medical foods from an in-network provider.
MEDICATIONS FOR THE TREATMENT OF CANCER	Plan pays 100% of the allowed amount for medications received through your medical benefits. See the *"Pharmacy Benefit"* row to determine your cost share for services received through the *"Pharmacy Benefit."* For cancer treatment medications that are also classified as specialty medications, you pay the tier 1 retail/mail order pharmacy copay. BCBSAZ determines which

BENEFIT	COST SHARE
	cancer treatment medications are classified as specialty medications. Copays do not apply to deductibles. If you believe you have paid more for a self-administered version of a cancer treatment medication than for an injected or intravenously administered version of a cancer treatment medication, please contact Pharmacy Benefit Customer Service at the number on your ID card.
NEUROPSYCHOLOGICAL AND COGNITIVE TESTING	Physician Office Visits: You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. Inpatient: You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and for inpatient facility charges.
OUTPATIENT SERVICES	Outpatient Facility Services: *Surgical Outpatient Services:* You pay 1 copay ($100). *Non-surgical Outpatient Services*: Plan pays 100% of the allowed amount. Your cost share is waived for facility charges for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim. Laboratory: *Prosano Health*: You pay $0 for lab services ordered, drawn, and processed at Prosano Health locations. *For visits and services outside of Prosano Health:* You pay you pay a PCP copay ($15) or a specialist copay ($35) for services received in a physician's office (copay is waived if you receive only covered laboratory services during your visit). Plan pays 100% of the allowed amount for services received from clinical labs or hospital outpatient lab departments. For professional services, Plan pays 100% of the allowed amount at all locations. Radiology: *MRI, MRA, Nuclear Medicine, PET and CT scans*: You pay 1 copay ($100). *Radiology Services (other than MRI, MRA, Nuclear Medicine, PET and CT scans)*: You pay a PCP copay ($15) or a specialist copay ($35) for services received in a physician's office. Plan pays 100% of the allowed amount for services received from hospital radiology departments and free-standing radiology facilities. For professional services, Plan pays 100% of the allowed amount at all locations. Sleep Studies and Medications Administered in an Outpatient Facility: Plan pays 100% of the allowed amount.
PHARMACY BENEFIT If you are taking 2 or more prescription medications for a chronic condition, you may request early or short refills of eligible covered medications by contacting the Pharmacy Benefit Customer Service number on your ID card and requesting enrollment in the BCBSAZ Medication Synchronization program. If you are enrolled in the BCBSAZ Medication Synchronization program, your cost share for eligible covered medications will be adjusted for	Retail/Mail Order Pharmacy Medications (30-day supply): • Tier 1: You pay a $10 Copay • Tier 2: You pay a $20 Copay • Tier 3: You pay a $35 Copay You pay the greater of the tier 3 Copay or 50% coinsurance for Compounded Medications. You may obtain up to a 90-day supply of covered medications. Not all medications are available for more than a 30- or 60-day supply. Your cost share will vary depending on the type of pharmacy, the quantity, and tier of the medication. 90-Day Mail Order Medications (2 times the applicable cost share for a 30-day supply): • Level 1: You pay a $20 Copay • Level 2: You pay a $40 Copay • Level 3: You pay a $70 Copay

BENEFIT	COST SHARE
any early or short refills of those medications. For certain covered preventive medications and items obtained from an in-network pharmacy, your cost share is waived for the generic version of the medication or item and you pay applicable cost share for the brand-name version of the medication or item. You may request an exception for waiver of cost share for the brand name version of a preventive medication or item obtained from an in-network pharmacy. See the *"Preventive Services"* section for information about the exception process. Contact the Pharmacy Benefit Customer Service number on your ID card for information on whether a drug is considered a preventive medication.	90-Day Retail Medications (3 times the applicable cost share for a 30-day supply): • Level 1: You pay a $30 Copay • Level 2: You pay a $60 Copay • Level 3: You pay a $105 Copay If you purchase a brand-name medication when a generic equivalent is available, you will pay the tier 1 copay plus the difference between the allowed amount for the generic and the brand-name medication, unless the prescribing provider indicates on the prescription that the brand-name medication should be dispensed. If the provider prescribes the brand name medication, you pay the cost share applicable to the brand-name medication. If you have completed step therapy and are taking a brand-name medication with a generic equivalent as a result of the step therapy process, you pay the cost share applicable to the brand-name medication. Your cost share is based on the tier to which BCBSAZ has assigned the medication at the time the prescription is filled. No exceptions will be made regarding the assigned tier of a medication, regardless of the medical reasons requiring use of a particular medication, even when there is no equivalent medication on a lower tier or if you are unable to take a medication on the lower tier for any reason. BCBSAZ may change the tier of a medication at any time without notice. Go to www.azblue.com to view the lists of prescription drug tiers. To confirm the tier of a particular medication, you may also call Pharmacy Benefit Customer Service at the number on your ID card. Your cost share is waived for preventive medications and for covered vaccines. Under 45 CFR § 147.130, BCBSAZ will determine: 1) which medications are considered preventive and for which your cost share is waived; and 2) which vaccines are covered and for which your cost share is waived. For a list of covered preventive medications, go to the "Guidance Regarding Preventive Medications" section on www.azblue.com. Your cost share is waived for the following female contraceptive methods when prescribed by your provider: • Condoms • FDA-approved diaphragms, cervical caps, and cervical shields • FDA-approved emergency contraception for members of any age • 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 • Sponges and spermicides Contraceptives must be prescribed for or include the purpose of contraception and not be prescribed solely for some other medical reason to be covered with no member cost share.
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST), COGNITIVE THERAPY (CT) AND CARDIAC AND PULMONARY HABILITATIVE SERVICES	You pay a specialist copay ($35) per member, per provider, per day.
PHYSICIAN SERVICES	Prosano Health: You pay $0 for services you receive from Prosano Health providers. For visits outside of Prosano Health: You pay a PCP or a specialist copay ($15) per member, per provider, per day for office, home, and walk-in clinic visits. If you receive preventive services during these visits, your copay may be waived. Your copay will be waived if you receive any of the following covered services and no other covered service: • Allergy injections • Allergy serum • Immunizations • Laboratory services Plan pays 100% of the allowed amount for: • Allergy Serum • PCP and specialist services in locations other than a physician's office, home, or walk-in clinic • Professional services received from

BENEFIT	COST SHARE
	a radiologist or pathologist, including a dermapathologist • Professional services related to a sleep study, even when provided at a physician's office • Medications administered in a physician's office.
POST-MASTECTOMY SERVICES	Physician Office Visits: You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. Inpatient: You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and for inpatient facility charges. Outpatient: You pay 1 copay ($100) per outpatient surgery, then the Plan pays 100% of the allowed amount for professional services received in a facility and for outpatient facility charges.
PREGNANCY, TERMINATION	Physician Office Visits: You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. Inpatient: You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and for inpatient facility charges. Outpatient: You pay 1 copay ($100) per outpatient surgery, then the Plan pays 100% of the allowed amount for professional services received in a facility and for outpatient facility charges.
PREVENTIVE SERVICES You pay applicable cost share for any tests, procedures, or services not covered in the *"Preventive Services"* benefit section.	Your cost share is waived if: • You receive one of the services covered as explained in the *"Preventive Services"* benefit section; • The diagnosis codes, procedure codes, or combination of procedure and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive; **and** • The primary purpose of the visit at which you received services was preventive care. For certain covered preventive medications and items, cost share is waived for the generic version of the medication or item and you pay applicable cost share for the brand-name version. You may request an exception for waiver of cost share for the brand-name version of a preventive medication or item. See the *"Preventive Services"* benefit section.
RECONSTRUCTIVE SURGERY AND SERVICES	Physician Office Visits: You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. Inpatient: You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and for inpatient facility charges. Outpatient: You pay 1 copay ($100) per outpatient surgery, then the Plan pays 100% of the allowed amount for professional services received in a facility and for outpatient facility charges.
SPECIALTY MEDICATIONS If you are enrolled in the BCBSAZ Medication Synchronization program, your cost share for eligible covered medications will be adjusted for any early or short refills of those medications.	You pay the following cost share: • Tier A: $60 • Tier B: $110 • Tier C: $160 • Tier D: $210 Additional Information About Medication Tiers: Cost share is based on the tier to which BCBSAZ has assigned the medication at the time the prescription is filled. BCBSAZ may change the tier of a medication at any time without notice. Go to www.azblue.com to view the lists of prescription drug tiers. No exceptions will be made concerning the assigned tier 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 tier B, C, or D medication, you pay the applicable copay for that tier even if there is no equivalent medication on a lower tier or you are unable to take a medication on the lower tier for any reason. The assignment of a medication to any particular tier is not a recommendation on the use of a medication. To confirm the

BENEFIT	COST SHARE
	status and tier of a particular specialty medication, you may also call the Pharmacy Benefit Customer Service number on your ID card.
TELEHEALTH SERVICES – BLUECARE ANYWHERE	You pay a copay ($15) for telehealth medical consultations, for telehealth counseling sessions provided by a counselor, and for telehealth psychiatric consultations provided by a psychiatrist.
TELEHEALTH SERVICES – NETWORK PROVIDERS	Prosano Health: You pay $0 for services you receive from Prosano Health providers. For visits and services outside of Prosano Health: You pay the cost-share amounts applicable to the services provided via Telehealth Services from Network providers. Cost share applies for the service provided at your physical location and for the service rendered remotely by the telehealth provider.
TRANSPLANT OR GENE THERAPY TRAVEL AND LODGING	Your cost share is waived.
TRANSPLANTS – ORGAN – TISSUE – BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES 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.	Physician Office Visits: You pay a PCP copay ($15) or a specialist copay ($35) per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. Inpatient: You pay 1 copay ($250) per inpatient admission, then the Plan pays 100% of the allowed amount for professional services received in a facility and for inpatient facility charges. Outpatient: You pay 1 copay ($100) per outpatient surgery, then the Plan pays 100% of the allowed amount for professional services received in a facility and for outpatient facility charges.
TRANSPORTATION AND LODGING BENEFIT (NOT RELATED TO TRANSPLANT OR GENE THERAPY TRAVEL AND LODGING)	Your cost share is waived.
URGENT CARE	Prosano Health: You pay $0 for services you receive from Prosano Health providers. For visits and services outside of Prosano Health: You pay a copay ($50) per member, per provider, per day for urgent care services.

UNDERSTANDING THE BASICS

Your Responsibilities

Before you receive services:
- Check your provider's network status and know whether your provider is a plan network provider with BCBSAZ.
- Know how much cost share you will have to pay.
- Know the limits and exclusions on coverage.
- Know your coverage.
- Read your benefit materials.

After you receive services:
- Read your explanation of benefits (EOB) and monthly health statements.
- Tell BCBSAZ if you see any differences between the member cost share on your claims documents and what you actually paid.

Accessing Covered Services

You can receive covered services from network providers. Your cost share is waived for covered services provided at or by Prosano Health Advanced Primary Care Centers. You will pay network cost share for covered services provided by network providers other than Prosano Health Advanced Primary Care Centers.

Refer to the Summary of Benefits and Coverage (SBC) for detailed information about how your cost share will vary depending on the network status of a provider. The SBC is sent with your member ID card.

BCBSAZ ID Card

Bring your ID card with you each time you seek healthcare services, and have your ID card available for reference when you contact BCBSAZ for information. BCBSAZ will mail you an ID card with basic information about your coverage:
- Cost-share amounts
- Identification numbers
- Important phone numbers and addresses
- Who is covered

Changes

You will be notified of any changes to this plan as required by law. You will be provided with 60 days advance written notice of material modifications to this plan.

Covered Services

To be covered, a service or item must be all of the following:
- A benefit of this plan;
- Approved when prior authorization is required;
- Medically or dentally necessary as determined by BCBSAZ or BCBSAZ's contracted vendor(s);
- Not excluded under any provision of this plan;
- Not experimental or investigational as determined by BCBSAZ or BCBSAZ's contracted vendor(s) (does not apply to covered services as part of an approved clinical trial);
- Provided while this benefit plan is in effect and while the person claiming benefits is eligible for benefits; **and**
- Rendered by a network provider acting within the provider's scope of practice, as determined by BCBSAZ or BCBSAZ's contracted vendor(s) except a network provider is not required for emergency services.

Experimental or Investigational Services

BCBSAZ, or BCBSAZ's contracted vendor, in its sole and absolute discretion, decides whether a service or item is experimental or investigational. A service or item is considered experimental or investigational unless it meets all of the following criteria:
- The improvement resulting from the service or item must be attainable outside the investigational setting;

- The scientific evidence must permit conclusions concerning the effect of the service or item on health outcomes;
- The service or item must be as beneficial as any established alternative;
- The service or item must have final approval from the appropriate governmental regulatory bodies (unless otherwise required by applicable law, final approval of a regulatory body does not, in and of itself, qualify a service or item for coverage) if applicable; **and**
- The service or item must improve the net health outcome.

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

- 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;
- The provider rendering the service or item documents that the service or item is experimental or investigational; **or**
- The service or item 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 or item is submitted for prior authorization or rendered.

Medically Necessary

BCBSAZ, or BCBSAZ's contracted vendor, 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 or its contracted vendor's "Medical Necessity Guidelines and Criteria" in effect when the service gets prior authorization or is rendered. If no such guidelines or criteria are available, BCBSAZ or its contracted vendor will base its decision on the judgment and expertise of a medical professional or medical consultant retained by BCBSAZ or the vendor.

Medical Necessity Guidelines and Criteria

BCBSAZ uses evidence-based criteria to make medical necessity decisions. Call the Customer Service number on your ID card for additional information on evidence-based criteria. BCBSAZ contracts with vendors to administer some or all of the benefits covered under this plan. These contracted vendors make medical necessity determinations based on their own medical necessity criteria, which are also available to you on request.

Decisions 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. If you have an adverse determination, refer to the "*Explanation of Benefits (EOB) Form and Monthly Member Health Statement*" and the "*Appeal and Grievance Process*" sections. Also, not all medically necessary services are 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.

PROVIDERS

Know your provider's network and eligibility status before you receive services.

Provider Directory

The BCBSAZ provider directory is available online at www.azblue.com. If you do not have Internet access, would like to request a paper copy of the directory, or you have questions about a provider's network participation, call BCBSAZ Customer Service at the number on your ID card before you receive services.

Provider Eligibility and Network Status

To be eligible for coverage, a service must be rendered by an eligible individual provider acting within his or her scope of practice, and, when applicable, performed at an eligible facility that is licensed or certified for the type of procedure and services rendered.

Eligible Providers

Not all medical professionals are eligible providers. Eligible providers include the properly licensed, certified, or registered providers listed below, when acting within the scope of their practice and license. Scope of practice is determined by the regulatory oversight agency for each health profession. It means the procedures, actions, and processes that a licensed or certified medical professional is legally allowed to perform based on the individual's specific education and experience and demonstrated competency. For example, neurosurgery would not be within the scope of practice for a dentist.

Benefits may also be available from other healthcare professionals whose services are mandated by federal or Arizona 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. Not all eligible providers are contracted to participate in the plan network.

ELIGIBLE PROVIDER LIST	
Professional	**Facility Ancillary**
• Board Certified Applied Behavioral Analyst (BCABA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Certified Registered Nurse First Assist (CRNFA) • Doctor of chiropractic (DC) • Doctor of dental surgery (DDS) • Doctor of medical dentistry (DMD) • Doctor of medicine (MD) • Doctor of optometry (OD) • Doctor of osteopathy (DO) • Doctor of podiatry (DPM) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner (NP) • Licensed professional counselor • Perfusionist • Physician Assistant (PA) • Psychologist (PhD, EdD, and PsyD) • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational, or physical therapist • Surgical Assist (SA) • Surgical Technician (ST)	• Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long-term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Pain Management Clinic • Rehabilitation Treatment Center (inpatient substance use disorder treatment facility) • Retail, mail order, and specialty pharmacies • Skilled Nursing Facility • Sleep Lab • Specialty Laboratory • Sub-acute behavioral health facility (including residential treatment) • Urgent Care

Choosing a 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.

Network Providers

Network providers are Arizona healthcare providers who have a plan network contract with BCBSAZ and/or an out-of-state Blue Cross and/or Blue Shield plan. Network providers will file your claims with BCBSAZ and in most cases, are prohibited by their contracts from charging you more than the allowed amount for covered services. Their contracts do allow them to charge you for noncovered services. We recommend that you discuss costs with your provider before you obtain noncovered services.

BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan directly reimburse 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. Network providers must be licensed in the United States. Except for emergencies, network providers must render covered services in the United States.

Locating a Network Provider: Check the plan network provider directory at www.azblue.com to locate a network provider who offers the services you are seeking, and contact the provider for an appointment. If you cannot get an appointment with a network provider, contact Customer Service at the number on your ID card.

Out-of-Network Providers (Contracted and Noncontracted)

You have coverage for services from out-of-network providers only in emergency situations. Out-of-network providers are: (1) Providers who are contracted with BCBSAZ or a Host Blue plan as "Participating" only providers; (2) Providers who have no contract with BCBSAZ or a Host Blue plan (noncontracted providers); and (3) Providers who are contracted with the Blue Cross Blue Shield Global® Core.

- *Participating-only Providers:* Participating-only providers are contracted with BCBSAZ or a Host Blue plan as "Participating" and are not contracted as EPO providers. Participating-only providers are out-of-network providers. Participating-only providers will submit your claims to the plan with which they are contracted. Except for emergency services, and ancillary services provided in a network facility, if you receive covered services from a participating-only provider, you will not have to pay the balance bill because the provider is contracted.

- *Noncontracted Providers:* Providers who have no provider participation agreement with BCBSAZ or any Host Blue plan are noncontracted providers. Noncontracted providers are out-of-network providers. Except for emergency services, and ancillary services provided in a network facility, noncontracted providers may bill you up to their full billed charges.

  Except for claims covered by the No Surprises Act, or unless BCBSAZ agrees to pay the provider directly, BCBSAZ will send payment to you for whatever benefits are covered under your plan, and you will be responsible for paying the out-of-network provider.

- *Providers Contracted with Blue Cross Blue Shield Global® Core:* Providers who are contracted with Blue Cross Blue Shield Global Core are out-of-network providers. For covered services from these providers, you will pay your cost share amount.

Provider Status and Payment – Summary Table Subject to all terms and conditions noted in this section.				
Provider Contract Status	**Network Status**	**Provider Required to File Claim on Member's Behalf**	**Accept BCBSAZ Allowed Amount and Do Not Balance Bill**	**Payee for Reimbursement**
Providers contracted with the plan network	Network	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*	Network	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 Cross	Out-of-network	Yes	No	Blue Cross Blue Shield Global Core reimburses the

Blue Shield Global Core				provider the allowed amount less any member cost share
Noncontracted providers for non-emergency or non-ancillary services rendered in a network facility in and outside Arizona, including providers who are contracted with BCBSAZ but not for your plan network (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.	BCBSAZ reimburses the member or the provider the allowed amount, less any member cost share.
Noncontracted emergency service providers—in and outside Arizona (must be eligible providers)	Out-of-network	No (provider may elect to do so as a courtesy to member)	Yes. If the provider disputes the allowed amount, the provider must resolve the dispute with BCBSAZ directly.	BCBSAZ reimburses the provider the allowed amount, minus your cost share.

*Except as noted in this Benefit Book

Sample Differences in Financial Responsibility Based on Provider Choice

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. In this example, the member has already satisfied the calendar-year deductible and has a 20% coinsurance.

Billed Charges	**Allowed Amount**	**Financial Responsibility**	**Network Providers 20% Coinsurance**	**Out-of-Network (Noncontracted) Providers**
$1,000	$400	This benefit plan pays:	$320	$0
		You pay:	$ 80 coinsurance amount	$1,000

Prior Authorization for Out-of-Network Providers

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

Continuing Care from an Out-of-Network Provider

You may be able to receive benefits at the network level for services provided by an out-of-network provider under the circumstances described below. Continuity of care benefits (explained below) are subject to all other applicable provisions (terms) of your benefit plan. To request continuity of care, call the Customer Service number on your ID card.

<u>New Members</u>

A new member may continue an active course of treatment with an out-of-network provider during the transitional period after the member's effective date if the member has:

- A life-threatening disease or condition, in which case the transitional period is not more than 30 days from the effective date of coverage; or
- Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered provider services for the delivery and any care related to the delivery for up to 6 weeks from the delivery date; **and**

The member's provider agrees, in writing, to:
- Accept the BCBSAZ allowed amount applicable to covered services as if provided by a network provider, subject to the cost-share requirements of this benefit plan;
- Provide BCBSAZ with any necessary medical information related to your care; **and**
- Comply with BCBSAZ's policies and procedures as applicable, including those surrounding prior authorization, network referrals, claims processing, quality assurance, and utilization review.

Current Members

If a network provider's contract with BCBSAZ is terminated or non-renewed (except for reasons of medical incompetence or unprofessional conduct) a member may continue an active course of treatment with that provider until the treatment is complete or for 90 days from the notice provided to the member, whichever is shorter. This continuity of care timeframe extends through a new policy year period if the member remains enrolled in this benefit plan.

An active course of treatment means the member is:
- Determined to be terminally ill and is receiving treatment for such illness from such provider or facility;
- In the third trimester of pregnancy on the effective date of the provider's termination, in which case the transitional period includes the covered Provider services for the delivery and any care related to the delivery for up to six weeks from the delivery date;
- Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility;
- Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Undergoing a course of institutional or inpatient care from the provider or facility; **or**
- Undergoing a course of treatment for a serious and complex condition from the provider or facility.

The member's provider agrees, in writing, to:
- Accept the BCBSAZ allowed amount applicable to covered services as if provided by a network provider, subject to the cost-share requirements of this benefit plan;
- Provide BCBSAZ with any necessary medical information related to your care; **and**
- Comply with BCBSAZ's policies and procedures as applicable, including those surrounding prior authorization, network referrals, claims processing, quality assurance, and utilization review.

Out-of-Area Services

Overview

BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever you obtain healthcare services outside of BCBSAZ's service area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of BCBSAZ's service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") do not contract with the Host Blue. We explain below how BCBSAZ pays both kinds of providers.

Your plan covers healthcare services received outside of our service area ("Out-of-Area Covered Healthcare Services"). Emergency services, EGID formula, and medical foods are covered when provided by providers contracted with a Host Blue and when provided by noncontracted providers. All other covered services must be obtained from providers contracted with a Host Blue.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits (except when paid as medical claims/benefits), and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by BCBSAZ to provide the specific service or services.

BlueCard® Program

Under the BlueCard Program, when you receive Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for your cost-share amount, as stated in your plan documents.

Emergency Care Services: If you experience an emergency medical condition while traveling outside BCBSAZ's service area, go to the nearest emergency or urgent care facility. When you receive Out-of-Area Covered Healthcare Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for the Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed charges for your Out-of-Area Covered Healthcare Services; **or**
- The negotiated price that the Host Blue makes available to us.

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 also take into account adjustments to correct for over- or under-estimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to insured and/or self-funded accounts. If applicable, we will include any such surcharge, tax, or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside BCBSAZ's Service Area

- *Liability Calculation:* When Out-of-Area Covered Healthcare Services are provided outside of BCBSAZ's service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

- *Exceptions:* In certain situations, BCBSAZ may use other payment methods, such as billed charges for Out-of-Area Covered Healthcare Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services provided by nonparticipating providers.

Blue Cross Blue Shield Global® Core Program

If you are outside the United States (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

- *Inpatient Services:* In most cases, if you contact the Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the Service Center to begin claims processing. However, if you paid in

full at the time of service, you must submit a claim to receive reimbursement for covered services. You must contact BCBSAZ to obtain prior authorization for non-emergency inpatient services.

- *Outpatient Services:* Physicians, urgent care centers, and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services.

- *Submitting a Blue Cross Blue Shield Global Core Claim:* When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. The claim form is available from BCBSAZ, the Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, 7 days a week.

Services Received on Cruise Ships

If you receive healthcare services while on a cruise ship, you will pay 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 Blue Cross Blue Shield Global Core program. Please call the Customer Service number on the back of your ID card for more information, or mail copies of your receipts to the BCBSAZ general correspondence address listed at the front of this book.

PRIOR AUTHORIZATION

When Is Prior Authorization Required

Not all services or medications require prior authorization. Prior authorization is not required for emergency services or urgent care services. If it is required, your treating provider must obtain it on your behalf before rendering services. If prior authorization is not obtained for medications that require it, the medications will not be covered. Prior authorization may be required for services to be covered when provided in certain settings.

On the BCBSAZ website, you'll find a list of services that need prior authorization at www.azblue.com/individualsandfamilies/resources/forms and medications that need prior authorization at azblue.com/Pharmacy, or call the Customer Service number on your ID card. BCBSAZ may change the services that require prior authorization by posting a revised listing of medications and services at www.azblue.com.

How to Obtain Prior Authorization

Ask your treating provider to contact BCBSAZ for prior authorization before you receive services and medications that require it. 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 decision on your claim.

Factors BCBSAZ Considers in Evaluating a Prior Authorization Request for Services or Medications

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

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

Prescription Medication Exception

If a covered medication requires prior authorization, but you must obtain the medication outside of BCBSAZ's prior authorization 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 treating provider request prior authorization on the next business day. Your claim for the medication will not be denied for lack of prior authorization, but all other exclusions and limitations of your plan will apply.

Prior Authorization for Network Cost Share for Services from an Out-of-Network Provider

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

Prior authorization for network cost share for services from an out-of-network provider is a process separate from prior authorization for services. If you want an out-of-network provider to render services that require prior authorization, and you also want to be eligible for the network cost share, you must ensure that your provider makes two separate prior authorization requests: one for the service itself and one for use of the out-of-network provider. If BCBSAZ provides you prior authorization for the network cost share, your services will be subject to the network cost share. You will still be responsible for any balance bill, plus your network cost share.

If BCBSAZ Provides Prior Authorization for Your Service

You and your provider will receive a letter explaining the scope of the prior authorization.

If BCBSAZ Denies Your Prior Authorization Request

Denial of prior authorization is an adverse benefit determination. As explained in the *"Notice of Determination"* section of this book, BCBSAZ will send you a notice explaining the reason for the denial, and your right to

appeal the BCBSAZ decision. Information on where to file an appeal is in the BCBSAZ Appeal and Grievance Guidelines.

If your request for prior authorization 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 prior authorization.

If BCBSAZ denies your request for biomarker testing, go to www.azblue.com for information on how to request an exception.

CLAIMS INFORMATION

Filing Claims

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.

If you choose to pay a provider on a direct pay basis and submit a receipt to BCBSAZ, BCBSAZ will credit your deductibles and out-of-pocket maximums as required by applicable law. You must submit a receipt that includes the amount paid, the procedure and diagnosis codes for the services rendered, and a notation indicating direct payment. If you choose to pay a contracted provider for a covered service on a direct pay basis, the provider will not submit the claim to BCBSAZ for processing under this benefit plan.

Time Limit for Claim Filing

A complete claim, as described below, must be filed within 1 year from the date of service. Any claim not filed with all required content within the 1-year period is an untimely claim. BCBSAZ will deny untimely claims from contracted providers based on the terms of the provider's contract. BCBSAZ will deny untimely claims from members except for the following situations:

- Medicare or another carrier was the primary payer on a claim where BCBSAZ was secondary payer, and the delay was caused by the need to coordinate benefits with the primary payer.
- The member can show good cause for delay.
  Examples of good cause:
  - ♦ BCBSAZ gave the member wrong information about the filing date;
  - ♦ The member did not have legal capacity;
  - ♦ The member had an extended illness that prevented the member from filing the claim; **or**
  - ♦ Other similar situations outside the member's reasonable control.

Complete Claims

Claim forms are available from BCBSAZ. Go to the "Forms" section of the "Member" area of www.azblue.com or call the Customer Service number on your ID card. 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. 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

Medical and Dental Records and Other Information Needed to Process a Claim

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

Explanation of Benefits (EOB) Form and Monthly Member Health Statement

After your claim is processed, BCBSAZ and/or any contracted vendors that process claims will send you an EOB. Most EOBs are consolidated and sent to you in a monthly Member Health statement rather than as single EOBs. 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. Carefully review your EOB for any discrepancies or inconsistencies with

the amounts your provider actually collects from you or bills to you. If you paid more cost share than required for a covered service, the provider will be responsible for refunding you. BCBSAZ and/or any contracted vendors will also send your network provider the information that appears on your EOB. Save the EOB for your personal records. BCBSAZ or any contracted vendor may charge a fee for duplication of claims records.

Notice of Determination

If your request for prior authorization is denied, or your claim is denied in whole or in part, you will receive a notice of adverse benefit determination. In most cases, your EOB or monthly statement will serve as the notice and will:

- 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),
- Reference the specific plan provision on which the determination is based, **and**
- 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).

Pharmacy Prescriptions; Submission of Claims by Members

When you submit a prescription to a retail, mail order, or specialty pharmacy, it is possible that the pharmacy could tell you that you are not eligible for coverage, that your medication is not covered, or that you have to pay more for the medication than you think you should pay. If this happens, you can:

- Call the Pharmacy Benefit Customer Service number on your ID card for assistance, **or**
- Pay the pharmacy for the medication, and then submit a claim to BCBSAZ for reimbursement.

If you submit a claim to BCBSAZ, BCBSAZ will review your request to determine if you should be reimbursed for some or all of the money you paid to the pharmacy and will send you an EOB. If BCBSAZ denies your claim, you will receive a document describing your appeal rights along with the EOB. Submitting a prescription to a pharmacy is not considered to be a claim and will not result in an EOB.

Coupons, patient assistance programs, and other discount programs are occasionally used by members, providers, and pharmacies to reduce out-of-pocket member costs associated with prescription medications. Coupons, patient assistance programs, and other discount programs do not count toward your deductible and out-of-pocket maximum. Your deductible and out-of-pocket maximum balances may be adjusted at any time to reflect the actual amount paid for that prescription after discounts have been applied.

Time Period for Claim Decisions

Post-Service Claims

Within 30 days of receiving your claim for a service that was already rendered, BCBSAZ will send you an 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 30 days, BCBSAZ may extend the initial processing time by 15 days by notifying you, within the initial 30-day period, of the need for an extension, the decision date, and any additional information that may be needed for the decision. You or your provider will have at least 45 days to submit any requested information.

Pre-Service Claims

When you request coverage for a service that has not yet been rendered (prior authorization), BCBSAZ will make a prior authorization decision within a reasonable time period considering the medical circumstances, but not later than 10 business days from receipt of the prior authorization request. If BCBSAZ requires more time to make a prior authorization decision, BCBSAZ may extend the time by an additional 15 days by notifying you, within the initial 10-day period of need for an extension, the decision date, and any additional information needed for the decision. You and your provider will have at least 45 days to submit any requested information.

Concurrent Care Decisions

BCBSAZ may require that your provider submit a plan of care. Based on that plan, BCBSAZ may provide prior authorization for a certain number of visits or services over a certain period of time. You may request prior authorization for additional periods of care. If your request involves urgent care and is made at least 24 hours prior to the expiration of the existing plan of care, BCBSAZ will make a determination as soon as possible in accordance with medical exigencies, but no later than 24 hours after receipt of the request. If your request is not made at least 24 hours prior to the expiration of the existing plan of care, BCBSAZ will make a determination as soon as possible in accordance with medical exigencies but no later than 72 hours after receipt of the request. If prior authorization is denied, you may appeal the denial in the same way you appeal any other coverage denial.

Urgent Requests for Prior Authorization

When your provider submits an urgent prior authorization request, a determination will be made as soon as possible, but no later than 72 hours after receipt of the request. Federal law defines an “urgent” medical situation as the following:

- 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**
- 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.

DESCRIPTION OF BENEFITS

Please review this section for an explanation of covered services and benefit-specific limitations and exclusions. Also, be sure to review the information about covered services in "*Understanding the Basics*" and refer to *"What is Not Covered"* for general exclusions and limitations that apply to all benefits. 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. The SBC sent with your member ID card shows the actual cost-share amounts for the cost-share types shown for each benefit, such as deductible amounts, copays, and coinsurance percentages. See the "*Cost Share Table*" in this Benefit Book for the cost-share amounts, such as deductible amounts, copays, and coinsurance percentages.

A. AMBULANCE SERVICES

Benefit Description: All factors for coverage are determined by BCBSAZ at its sole and absolute discretion. Benefits are available for:

- Air or water 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; or
- 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, water, or air ambulance transfer for admission to a facility when the transferring facility is unable to provide the level of service required.

Benefit-Specific Exclusions:

- Air ambulance transfers to any facility that is not an acute care facility, such as a skilled nursing facility or an extended active rehabilitation facility.
- All other expenses for travel and transportation are not covered, except for the benefits described in *"Transplant or Gene Therapy Travel and Lodging."*

B. BEHAVIORAL HEALTH SERVICES (Includes Treatment for Mental Health, Chemical Dependency, or Substance Use Disorder)

B.1 Inpatient Hospital

Changing Types of Inpatient Care (applicable to B.1 and B.2 below): Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation, and other inpatient care). 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 prior authorization, you will also need to obtain a new prior authorization for the different level of care.

Benefit Description: Benefits are available for:

- Diagnostic testing
- Intensive care units and other special care units
- Medications, biologicals, and solutions
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Treatment and recovery rooms and equipment for covered services

Benefit-Specific Exclusions (applicable to B.1 and B.2 below):

- Domiciliary care
- Medications dispensed at the time of discharge from a hospital
- Respite care

B.2 Subacute Inpatient Behavioral Health Hospitalization (Including Residential Treatment)

Benefit Description: Benefits are available for:

- Diagnostic testing
- Medications, biologicals, and solutions
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Treatment and recovery rooms and equipment for covered services

Benefits are available for inpatient behavioral health services that meet all the following criteria:

- A physician or RN practitioner is present on the premises of the facility or on-call at all times;
- The facility has sufficient behavioral health professional staff to provide appropriate treatment;
- The facility has 24/7 onsite RN coverage;
- The facility is licensed to provide behavioral health services to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time;
- The facility's designated clinical director is a behavioral health professional and provides direction for the behavioral health services provided at the facility;
- The facility's designated medical director is a physician or RN practitioner and provides direction for physical health services provided at the facility; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

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
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

B.3 Behavioral Health Services (Outpatient Facility and Professional Services)

Benefit Description: Non-emergency outpatient behavioral health services are available in an individual, group, or structured group therapy program. Those services include psychotherapy, outpatient therapy for chemical dependency or substance use disorder, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, intensive outpatient services, counseling for personal and family problems, electroconvulsive therapy (ECT), and partial hospitalization.

B.4 Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder

Benefit-Specific Definitions: "**Autism Spectrum Disorder**" means Autistic Disorder, Asperger's Syndrome, or Pervasive Developmental Disorder (not otherwise specified), as defined in current Evidence-based Criteria 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. Covered behavioral therapy services must be delivered by a provider who is licensed or certified as required by law.

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

- Activity therapy, milieu therapy, and any care primarily intended to assist an individual in the activities of daily living
- Custodial Care
- Development of a learning plan and treatment and education for learning disabilities (such as reading and arithmetic disorders)
- Inpatient and outpatient facility charges for services provided by the following facilities: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes.
- IQ testing
- Lifestyle and work-related education and training and management services
- Neurofeedback
- Sensory integration and music therapy
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

Exception: Behavioral health services for minors that are otherwise covered under this section will not be denied solely on the basis that the services are provided in a school setting or are ordered by a court.

C. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

Benefit-Specific Maximum: Benefits are limited to a maximum of 36 cardiac therapy visits per member, per calendar year. This limit does not apply to claims submitted with a primary behavioral health diagnosis.

Benefit Description: Benefits are available for outpatient Phase 1 and 2 cardiac rehabilitation programs and pulmonary rehabilitation services.

D. CATARACT SURGERY AND KERATOCONUS

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 and for the first pair of contact lenses for treatment of keratoconus.

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

E. CHIROPRACTIC SERVICES

Benefit Description: Benefits are available for chiropractic services.

Benefit-Specific Exclusion: Maintenance or preventive treatment consisting of routine, long-term, or non-medically necessary care provided to prevent reoccurrences or to maintain the patient's current status.

F. CLINICAL TRIALS

Benefit-Specific Definition: **"Approved Clinical Trial"** means a Phase 1, 2, 3, or 4 clinical trial conducted for the prevention, detection, or treatment of cancer or other life-threatening disease or condition and also approved or funded by at least one of the following:

- A panel of qualified, recognized clinical research experts within an Arizona academic health institution
- Food and Drug Administration (FDA) reviewed investigational new drug application
- The National Institutes of Health (NIH), including a NIH health cooperative group or center or a qualified research entity that meets the criteria established by NIH for grant eligibility
- The U.S. Department of Defense
- The U.S. Department of Veterans Affairs

Benefit Description: Benefits are available for covered services directly associated with an Approved Clinical Trial meeting all requirements specified by applicable federal and Arizona law. Benefits are limited to those services covered under this plan that would be required if you received standard, non-investigational treatment. Services may include laboratory, radiology, physician services, medical diagnostic, and/or surgical procedures.

For services associated with an Approved Clinical Trial to be covered, 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 only covers clinical trials as required by law and will administer your benefits according to the other terms of your benefit plan, which may result in a denial of benefits. If you have any questions about whether a particular service is covered, please call Customer Service at the number on your ID card.

Benefit-Specific Exclusions:

- 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
- Clinical trials not required by law to be covered
- Costs and services customarily paid for by government, biotechnical, pharmaceutical and device industry sources
- Costs related to clinical trials that do not meet the applicable requirements

- Costs to manage the clinical trial research
- Investigational medications (except as stated in *"Medications for the Treatment of Cancer")* and devices
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services otherwise not covered under this plan

G. DENTAL SERVICES – MEDICAL

Not all dentists who are contracted with the plan network are contracted to provide medical-related dental services. Call Customer Service at the number on your ID card with questions.

G.1 Dental Accident Services

Benefit-Specific Definitions: "**Accidental dental injury**" is an accidental 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:
- Not in need of the treatment provided for any reason other than as the result of an Accidental Dental Injury;
- 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); or
- Whole or virgin; **and**
- Without current periodontal (tissue supporting the tooth) disease or current endodontal (tooth pulp or root) disease.

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

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

G.2 Dental Services Required for Medical Procedures

Benefit Description: Benefits are available for dental services required 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:
- Diagnostic services prior to planned organ or stem cell transplant 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

- Repair and replacement of fixed or removable complete or partial dentures
- Routine dental care
- Routine extractions

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

Benefit Description: Benefits are available for facility and professional anesthesiologist charges to perform dental services under anesthesia in an inpatient or outpatient facility for a patient having 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
- Dental extractions due to cancer related conditions
- Diabetes
- Heart problems
- Hemophilia
- Intellectual Disability
- Malignant hypertension
- Other conditions that could increase the danger of anesthesia
- Probability of allergic reaction
- Senility or dementia
- Uncontrolled seizure disorder
- Unstable cardiovascular condition
- Other conditions for which these services are required by federal or state law to be covered

H. DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, AND PROSTHETIC APPLIANCES AND ORTHOTICS

Benefit-Specific Maximum: Benefits are limited to 1 breast pump and breast pump supplies per member, per calendar year per Health Resources and Services Administration guidelines (see the "*Preventive Services*" section). This limit does not apply to claims submitted with a primary behavioral health diagnosis.

H.1 Durable Medical Equipment (DME)

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

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

Benefits are available for DME rental or purchase, as determined by BCBSAZ, and for DME repair or replacement, as determined by BCBSAZ, 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 determines 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:

- Charges for continued rental of a DME item after the purchase price is reached
- Repair costs that exceed the allowed amount 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

H.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 current Evidence-based Criteria
- Blood glucose monitors, including monitors for the legally blind and visually impaired
- Diabetic injection aids and drawing-up devices, including drawing-up devices for the visually impaired
- Diabetic syringes and lancets, including automatic lancing devices

- Insulin cartridges, including insulin cartridges for the legally blind
- Insulin preparations and glucagon
- Insulin pumps and insulin pump supplies
- Ostomy and urinary catheter supplies
- Peak flow meters
- Prescribed oral agents for controlling blood sugar that are included on the plan
- Supplies associated with oxygen or respiratory equipment
- Test strips for glucose monitors and visual reading and urine test strips
- Volume nebulizers
- Other medical supplies required by federal or state law to be covered

Benefits are limited to the allowed amount for the medical supply base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded medical supplies may be eligible for coverage based upon BCBSAZ medical necessity criteria. Note that certain equipment and supplies are covered under the Pharmacy benefit at the discretion of BCBSAZ (see the "Pharmacy Benefit" section).

H.3 Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

- Cochlear implants
- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- External and internal prosthetic devices, which are used as a replacement or substitute for a missing body part and are necessary for the support or function of a body part or for the alleviation or correction of illness, injury, or congenital defect. External prosthetic appliances shall include artificial arms and legs, wigs, hairpieces, and terminal devices such as a hand or hook. Wigs and hairpieces are covered:
  - For individuals diagnosed with alopecia (absence of hair) caused by chemotherapy, radiation therapy, or second- or third-degree burns;
  - For individuals diagnosed with a behavioral health condition; **and**
  - For individuals with any other condition for which coverage is required under federal or state law.
- Orthopedic shoes that are:
  - Attached to a brace;
  - Covered in accordance with BCBSAZ medical necessity criteria; **and**
  - Depth inlay or custom-molded, along with inserts, for individuals with diabetes.
- Podiatric appliances, including foot orthotic devices and inserts (therapeutic shoes: including depth shoes or custom-molded shoes, as defined below) for prevention of complications associated with diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg. Custom-molded Shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and any of the following complications of diabetes involving the foot: peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. Depth shoes and custom-molded shoes are defined as follows:
  - **"Depth Shoes"** shall mean the shoe has a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of 3 widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.
  - **"Custom-Molded Shoes"** shall mean constructed over a positive model of the member's foot; made from leather or other suitable material of equal quality; have removable inserts that can be altered or replaced as the member's condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.
- Other prosthetic appliances and orthotics required by federal or state law to be covered.

Benefits are limited to the allowed amount for the prosthetic appliance or orthotic base model. BCBSAZ determines 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 Exclusions for all DME, Medical Supplies, and Prosthetic Appliances and Orthotics:

- Biomechanical devices, which are any external devices operated through or in conjunction with nerve conduction or other electrical impulses
- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, corsets, cushions, dentures, diatherapy machines, disposable hygienic items, dressing aids and devices, elastic/support/compression stockings (except TED hose), elevators, exercise equipment, foot stools, garter belts, grab bars, health spas, hearing aid batteries, 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, mineral baths, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas, and vehicle or home modifications.
- Hair transplants
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for help in daily living, socialization, personal comfort, convenience, or other nonmedical reasons
- Replacement of external prosthetic devices due to loss or theft
- Strollers of any kind
- Supplies used by a provider during office treatments
- Tilt or inversion tables or suspension devices
- Wigs and hair pieces for alopecia caused by anything other than chemotherapy, radiation therapy, second- or third-degree burns, or a behavioral health diagnosis

I. EDUCATION AND TRAINING

I.1 Diabetes and Asthma Education and Training

Benefit Description: Benefits are available for diabetes and asthma education and training from providers whose services are:

- Conducted in person or through telehealth services;
- Prescribed by a patient's healthcare provider as part of a comprehensive plan of care to enhance therapy compliance and improve self-management skills and knowledge for a patient diagnosed with diabetes or asthma; **and**
- Provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health)).

I.2 Nutritional Counseling and Training

Benefit-Specific Maximum: Benefits are limited to 6 nutritional counseling and training visits per member, per calendar year.

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

- Behavioral health
- Cardiovascular Disease
- Coronary Artery Disease
- Diabetes
- Eating Disorders
- Food Allergies
- Gastrointestinal Disorders
- Heart Failure
- High Cholesterol
- Hypertension
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

J. EMERGENCY SERVICES

Benefit-Specific Definition: **"Emergency Medical Condition"** means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that failing to get immediate medical attention would result in serious jeopardy to the patient's life, health or ability to completely recover, serious impairment to a bodily function or part, or permanent disability.

Benefit Description: Benefits are available for services needed to treat an Emergency Medical Condition.

K. EOSINOPHILIC GASTROINTESTINAL DISORDER (EGID)

Benefit-Specific Definition: **"Formula"** is amino acid-based Formula.

Benefit Description: Benefits are available for Formula for members who are:
- At risk of mental or physical impairment if deprived of the Formula;
- Diagnosed with EGID; **and**
- Under the continuous supervision of a physician or a RN practitioner.

L. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Benefit Description: Benefits are available for FDA-approved contraceptive methods, devices, and sterilization procedures when prescribed by the member's provider. At least one contraceptive in each of the methods approved by the FDA is covered without cost share when obtained from a network provider.

For a list of covered contraceptives covered without cost share, see the "Guidance Regarding Preventive Medications" section on www.azblue.com, or call the Pharmacy Benefit Customer Service number on your ID card.

If your medication is not listed, you can ask for what is called an exception for waiver of cost share for a contraceptive medication or item you would get from a network pharmacy. This is a request that either you or your provider can make that, if approved, could mean you would not have to pay your normal cost share for this medication. To make this request, either you or your provider can call the Pharmacy Benefit Customer Service number on your ID card anytime, 24 hours a day, seven days a week, 365 days a year. There is no guarantee that BCBSAZ and/or the Pharmacy Benefit Manager (PBM) will okay an exception.

More information about contraceptives can be found on the FDA's website at www.fda.gov/consumers/free-publications-women/birth-control.

Benefit-Specific Exclusion: All prescription and over-the-counter contraceptive medications and devices for male members.

M. FERTILITY AND INFERTILITY SERVICES

Benefit-Specific Maximum: Benefits are limited to a combined medical and pharmacy lifetime maximum of $50,000 per member for fertility and infertility services.

Benefit Description: Benefits are available for:
- Services and medications to improve or achieve fertility (ability to conceive)
- Services and medication to diagnose and treat infertility (inability to conceive)
- Artificial insemination
- GIFT
- In-vitro fertilization
- ZIFT

Benefit-Specific Exclusions:
- Cryopreservation of donor sperm and eggs; and any experimental, investigational, or unproven infertility procedures or therapies;
- Donor charges and services;

- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Reversal of male and female voluntary sterilization.

N. HEARING SERVICES

Benefit-Specific Maximums:
- Benefits are limited to 1 hearing aid (single purchase) per member, per ear, per every 3 years, including repair and replacement of existing hearing aids.
- Benefits are limited to 1 hearing exam per member, per every 1 year

These limits do not apply to claims for hearing services submitted with a primary behavioral health diagnosis.

Benefit Description: Routine hearing exams, (except hearing screenings performed as part of a routine well exam) Hearing Aids, new or replacement Hearing Aids no longer under warranty, cleaning and repair of Hearing Aids, and dispensing fees for Hearing Aids.

Benefit Specific Exclusions:
- Assistive listening devices, including but not limited to, hearing aids that sync wirelessly with MP3 players, laptops, televisions and/or other wireless devices
- Disposable hearing aids
- Batteries or battery replacement for hearing aids
- Additional warranties for hearing aids
- Replacement of lost, stolen or damaged hearing aids when the member has already met the benefit maximum of 1 hearing aid per member, per ear, per year
- Earmolds
- Direct audio input, Bluetooth capability or other additional features
- Return or exchange fees for hearing aids that are returned or exchanged
- Follow-up visits in addition to the original hearing exam

O. HOME HEALTH SERVICES

Benefit-Specific Definition: "**Sole source of nutrition**" is defined as the inability to orally receive more than 30% of daily caloric needs.

Benefit Description: Benefits are available for the following services:
- Enteral nutrition (tube feeding) when it is the sole source of nutrition
- Home infusion medication administration therapy, including:
  - Blood and blood components
  - Hydration therapy
  - Intravenous catheter care
  - Intravenous, intramuscular, or subcutaneous administration of medication
  - Specialty medications, as defined by BCBSAZ and not covered under the *"Specialty Medications"* benefit
  - Total parenteral nutrition
- Physical therapy, occupational therapy, and speech therapy
- Private duty nursing when deemed medically necessary
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition, and other services that require skilled nursing care
- Other home health services required by federal or state law to be covered.

Each service must meet all of the following criteria:
- A healthcare provider must order the service pursuant to a specific plan of home treatment;
- A licensed home health agency must provide the service in the member's residence;
- The healthcare provider must review the appropriateness of the service at least once every 30 days or more frequently, if appropriate under the treatment plan; **and**
- The service must be provided by an LPN, RN, or another eligible provider.

Benefit-Specific Exclusions:
- Custodial Care
- Domiciliary Care
- Respite Care

P. HOSPICE SERVICES

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, inpatient rehabilitation, and other inpatient care). 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 prior authorization, you will also need to obtain a new prior authorization for the different level of care.

Benefit-Specific Maximum: Benefits are limited to a maximum of up to 5 days of respite care, once every 21-day period. This limit does not apply to claims for respite care services submitted with a primary behavioral health diagnosis.

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 provisions of this benefit plan. Once the member selects the hospice benefit, the hospice agency coordinates all of the member's healthcare 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 LPN or RN 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
- Home health services
- Individual and family counseling provided by a psychologist, social worker, or family counselor
- *Inpatient Acute Care:* Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- Outpatient services
- *Respite Care:* Admission of the member to an approved facility to provide rest to the member's family or primary caregiver
- *Routine Care:* Intermittent visits provided by a member of the hospice team

Q. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

Benefit-Specific Definition: "**Detoxification services**" mean 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 detoxification services needed to stabilize a member who has developed substance intoxication due to the ingestion, inhalation, or exposure to one or more substances.

R. INPATIENT HOSPITAL

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation, and other inpatient care). 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 prior authorization, you will also need to obtain a new prior authorization for the different level of care.

Benefit Description:

- Blood transfusions, whole blood, blood components, and blood derivatives
- Covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction® Center.
- Diagnostic testing, including radiology, laboratory services, and biomarker testing
- Gender-affirming care
- 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 or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Other inpatient services required by federal or state law to be covered

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

S. INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR), LONG-TERM ACUTE CARE (LTAC), AND SKILLED NURSING FACILITY (SNF) SERVICES

Benefit-Specific Maximum: Benefits are limited to 60 days of EAR, LTAC, and SNF services per member, per calendar year. This limit does not apply to claims for services submitted with a primary behavioral health diagnosis. If you have questions about the benefit maximum, contact BCBSAZ Customer Service at the number on your ID card.

S.1 EXTENDED ACTIVE REHABILITATION (EAR) SERVICES

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation, and other inpatient care). 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 prior authorization, you will also need to obtain a new prior authorization for the different level of care.

Benefit Description: Benefits are available for an intense therapy program which is provided in a facility licensed to provide EAR services and which meets the following criteria:
- A physician or RN practitioner is present on the premises of the facility or on-call at all times;
- Room and board in a semi-private room or a standard private room (not deluxe) is covered if the hospital only has private rooms or if a private room is medically necessary;
- Services must be for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time;
- The facility has 24/7 onsite RN coverage;
- The facility has sufficient professional staff to provide appropriate treatment;
- The facility's designated medical director is a physician or RN practitioner and provides direction for services provided at the facility; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

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
- Custodial care
- Domiciliary care
- Medications dispensed at the time of discharge from a facility
- Respite care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

S.2 LONG-TERM ACUTE CARE (LTAC) (INPATIENT)

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation, and other inpatient care). 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 prior authorization, you will also need to obtain a new prior authorization for the different level of care.

Benefit Description: Benefits are available for specialized acute, medically complex care for patients who require extended hospitalization and treatment in a facility that is licensed to provide long-term acute care and which offers specialized treatment programs and aggressive clinical and therapeutic

interventions. Room and board is only covered in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary.

Benefit-Specific Exclusions:
- Custodial care
- Domiciliary care
- Medications dispensed at the time of discharge from the facility
- Respite care

S.3 SKILLED NURSING FACILITY (SNF) SERVICES

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation, and other inpatient care). 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 prior authorization, you will also need to obtain a new prior authorization for the different level of care.

Benefit Description: Benefits are available for inpatient SNF services, which are provided in a facility licensed to offer 24-hour skilled nursing services and which meet the following criteria:
- A physician or RN practitioner is present on the premises of the facility or on-call at all times;
- Room and board in a semi-private room or a standard private room (not deluxe) is covered if the hospital only has private rooms or if a private room is medically necessary;
- Services must be provided to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time;
- Skilled nursing services must be provided by and under the supervision of qualified and licensed professionals, such as an LPN or RN, and provided at a level of complexity and sophistication requiring assessment, observation, monitoring, and/or teaching or training to achieve the medically desired outcome;
- The facility has 24/7 onsite RN coverage;
- The facility has sufficient professional staff to provide appropriate treatment;
- The facility's designated medical director is a physician or RN practitioner and provides direction for services provided at the facility; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

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
- Custodial care
- Domiciliary care
- Medications dispensed at the time of discharge from a facility
- Respite care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

T. MATERNITY

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 number on your ID card. Covered maternity services are available from birthing centers.

Maternity benefits are available for the expense incurred by a birth mother, including a surrogate, 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 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 Customer Service at the number on your ID card 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 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 healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours for the mother and newborn child following a normal vaginal delivery or 96 hours for the mother and newborn child following a cesarean section delivery. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, call the Customer Service number on your ID card.

U. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

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" mean 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 MD or DO physician or a RN practitioner;
- Processed or formulated to be deficient in 1 or more of the nutrients present in typical foodstuffs (metabolic formula only); **and**
- Processed or formulated to contain less than 1 gram of protein per unit of serving (modified low protein foods only).

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

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 MD or DO physician or RN practitioner
- Foods and formulas that do not require supervision by an MD or DO physician or a RN practitioner
- Food thickeners, baby food, or other regular grocery products
- Medical foods and formulas for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
- Nutrition for a diagnosis of anorexia
- Nutrition for nausea associated with mood disorder, end stage disease etc.
- Spices and flavorings
- Standard oral infant formula

Claims for Reimbursement: 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 RN 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.

Medical Foods claim forms are available from BCBSAZ. Submit the completed 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 Services"* benefit. Medical Foods are not covered under the *"Pharmacy Benefit.*"

V. MEDICATIONS FOR THE TREATMENT OF CANCER

Benefit-Specific Definition: "**Off-label Prescription Medication**" means a medication that is FDA approved for treatment of a diagnosis, or condition other than the cancer diagnosis or condition for which it is being prescribed, and which meets all requirements of Arizona law for mandated coverage of off label use. These requirements include, but are not limited to, scientific evidence 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 also for services directly associated with the administration of such medications. 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 prior authorization, 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.

W. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

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

X. OUTPATIENT SERVICES

Benefit Description: Benefits are available for the following outpatient services and include, but are not limited to, any services that would be covered if performed as an inpatient service:

- Allergy testing, antigen administration, and desensitization treatment
- Blood transfusions, whole blood, blood components, and blood derivatives
- Covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction Center
- Diagnostic testing, including radiology, laboratory services, and biomarker testing
- Dialysis
- End-stage renal disease services
- Epidural and facet injections and radio frequency ablation for pain management
- Gender-affirming care
- Infusion/IV therapy in an outpatient setting
- Maternity services provided in birthing centers
- Medications and the administration of medications in an outpatient setting
- Orthognathic treatment and surgery, including but not limited to dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)
- Outpatient and ambulatory cardiac testing, angiography, sleep testing (including sleep studies and polysomnography), and video EEG
- Pre-operative testing

- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant
- Surgery and other invasive procedures

Benefit-Specific Exclusion: Treatment of Temporomandibular Joint Disorders (TMJ)

Y. PHARMACY BENEFIT

Information about this Benefit: BCBSAZ works with a Pharmacy and Therapeutics (P&T) Committee to review new medications and certain devices and supplies, as well as new information about medications, devices, and supplies that are already on the market. The P&T Committee is comprised of licensed pharmacists and doctors from within the community. The P&T Committee takes into consideration safety, effectiveness, and current use in therapy information when making decisions regarding coverage. Call the Pharmacy Benefit Customer Service number on your ID card to request any of the following:

- A list of covered medications that require prior authorization;
- A list of covered vaccines;
- A list of specialty medications;
- An exception to BCBSAZ prescription medication limitations;
- Information on the assigned cost-share tier of a covered medication;
- Information regarding Maintenance Medications;
- Other information about this pharmacy benefit.

Benefit-Specific Definitions: **"Compounded Medications"** are medications that contain at least 1 FDA-approved component and are custom-mixed by a pharmacist.

"**Designated Prescription Network Program**" is a program that requires certain members taking certain medications to obtain prescriptions for all covered medications from one designated eligible provider and to obtain all medications designated by BCBSAZ or the PBM from one network pharmacy or provider.

"Generic Medications" are medications defined as generic by the national database system used by BCBSAZ to pay prescription claims.

"Maintenance Medications" are medications taken on an extended and continual basis for treatment of a chronic or ongoing health condition, and which are not subject to frequent dosage or other adjustments, all as determined by BCBSAZ or the PBM. BCBSAZ and/or the PBM may designate or use national databases to designate certain medications as Maintenance Medications.

"Medication Synchronization" is defined as the coordination of medication refills for a patient taking two or more medications for a chronic condition that are being dispensed by a single network pharmacy to facilitate the synchronization of the patient's medications for the purpose of improving medication adherence.

"PBM" means the independent pharmacy benefit manager that contracts with BCBSAZ to administer the prescription medication benefits covered under this benefit plan.

"Step Therapy" is a program that requires members to take the generic version of certain medications before BCBSAZ and/or the PBM will consider coverage of the brand-name version of that medication. BCBSAZ and/or the PBM determines which medications are part of the Step Therapy program.

Benefit-Specific Maximum: Benefits are limited to a combined medical and pharmacy lifetime maximum of $50,000 per member for fertility and infertility services.

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

- Except as otherwise required by applicable law, the medication must be approved by the FDA for the diagnosis for which the medication has been prescribed;
- The medication is not excluded by a different provision in this plan; **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 most prescription medications from network retail pharmacies or the network mail order pharmacy. Compounded Medications must be obtained from retail pharmacies that have been credentialed by BCBSAZ (or BCBSAZ's vendor) to dispense Compounded Medications. Please call Pharmacy Benefit Customer Service at the number on your ID card for a list of pharmacies credentialed to dispense Compounded Medications.

Certain vaccines are covered when obtained from network retail pharmacies and administered by a certified, licensed pharmacist. Limited supplies and devices are also covered under this benefit, such as diabetic test strips, lancets, diabetic syringes/needles for insulin, certain insulin pumps and monitoring devices, and spacer devices for asthma medications. Certain medications are not medically necessary unless the member participates in the Step Therapy program.

Covered medications are subject to limitations including, but not limited to, quantity, age, gender, dosage, and frequency of refills. BCBSAZ and/or the PBM determine which medications are subject to limitations. Medication limitations are subject to change at any time without prior notice.

Certain medications are subject to Step Therapy (see definition in the Benefit-Specific Definitions of this section). You can go to www.azblue.com/pharmacy to find information on how to request an exception for Step Therapy.

If a medication is not processing at the pharmacy, you or your physician/provider may request an exception by calling the Pharmacy Benefit Customer Service number on your ID card 24 hours per day, 7 days per week, 365 days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception. Reasons for requesting an exception include but are not limited to the following: quantity, age, gender, dosage and/or frequency of refill limitations, and requests for waiver of cost share for brand name medications or devices taken or used for a preventive purpose.

If you are currently obtaining a covered medication from the network mail order pharmacy, you have the option to receive that medication from a network retail pharmacy. Please call Pharmacy Benefit Customer Service at the number on your ID card if you need assistance with this issue. Also, if you are currently obtaining a covered specialty medication from a specialty pharmacy and need to receive that medication from a retail pharmacy instead, please contact Pharmacy Benefit Customer Service. BCBSAZ will decide whether you are eligible to receive the specialty medication from a retail pharmacy instead of a specialty pharmacy.

Certain members, as determined by BCBSAZ or the PBM, will be required to participate in the Designated Prescription Network Program to obtain coverage of certain medications under this benefit plan. BCBSAZ or the PBM decide which network pharmacies or providers are eligible to dispense designated medications to members in the Designated Prescription Network Program.

Benefit-Specific Exclusions:

- Abortifacient medications
- Administration of a covered medication
- All prescription and over-the-counter contraceptive medications and devices for male members.
- Biologic serums
- Compounded Medications obtained from a mail order pharmacy
- Designated medications prescribed by an ineligible provider or dispensed by an unapproved pharmacy or provider to members enrolled in the Designated Prescription Network Program
- Medical devices, except as stated in this benefit
- Medication delivery implants
- Medications designated as clinic packs
- Medications designed for weight gain or loss, regardless of the condition for which it is prescribed
- Medications, devices, equipment and supplies lawfully obtainable without a prescription, except as stated in this benefit plan
- Medications dispensed to a member who is an inpatient in any facility
- Medications for athletic performance
- Medications for lifestyle enhancement
- Medications for sexual dysfunction
- Medications for which the principal ingredient(s) are already available in greater and lesser strengths and/or combinations, as described in the BCBSAZ medication benefit exclusion policy, in addition to all other exclusions in this Benefit Book. Go to www.azblue.com/Pharmacy for a list of these specific exclusion details.

- Medications labeled “Caution – Limited by Federal Law to Investigational Use” or words to that effect and any experimental medications as determined by BCBSAZ and/or the PBM, except as stated in this benefit plan
- Medications obtained from an out-of-network pharmacy, except for emergencies or urgent care
- Medications packaged with 1 other or multiple other prescription products
- Medications packaged with over-the-counter medications, supplies, vitamins or other excluded products
- Medications that exceed BCBSAZ and/or the PBM’s limitations, including, but not limited to, quantity, age, gender and refill limits.
- Medications used for any cosmetic purpose including, but not limited to, Tretinoin for members age 26 and older
- Medications used to treat a condition not covered under this plan
- Medications which modify the dosage form (tablet, capsule, liquid, suspension, extended release, tamper resistant) of drugs already available in a common dosage form, as described in the BCBSAZ medication benefit exclusion policy in addition to all other exclusions in this Benefit Book. Go to www.azblue.com/Pharmacy for a list of these specific exclusion details.
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging, or name
- 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 medications

Z. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), AND SPEECH THERAPY (ST), COGNITIVE THERAPY (CT) AND CARDIAC AND PULMONARY HABILITATIVE SERVICES

Benefit-Specific Definitions: **“Cognitive Therapy”** is treatment that focuses on present thinking, behavior, and communication, rather than on past experiences, and is oriented toward problem solving.

“Habilitative Services” are healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

“Occupational Therapy” is treatment of neuromusculoskeletal dysfunction (injuries or disorders of the musculoskeletal system, such as muscles, tendons, ligaments, nerves, discs, and blood vessels) using specific tasks or goal-directed activities to improve functional performance.

“Physical Therapy” is treatment of disease or injury using therapeutic exercise and other measures to improve posture, locomotion, strength, endurance, balance, coordination, range of motion, flexibility, and ability to perform activities of daily living, and to help reduce pain.

“Speech Therapy” is treatment of communication impairment and swallowing disorders.

Benefit Description: Benefits are available for PT, OT, ST, CT, and Cardiac and Pulmonary habilitative services related to a specific illness or injury and includes coverage for members diagnosed with autism spectrum disorder.

Benefit-Specific Exclusions:
- Activity therapy and milieu therapy including community immersion or integration and home independence
- Any care for comfort and convenience
- Custodial care
- Domiciliary care
- Massage therapy
- Occupational therapy for any purpose other than training the member to perform the activities of daily living
- Phase 3 cardiac rehabilitation programs
- 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
- Work re-entry therapy, services or programs

AA. PHYSICIAN SERVICES

Benefit Description: Benefits are available for the following:

- Abortifacient medications for the abortions covered under this plan, including oral medications as described in current evidence-based criteria
- Allergy testing, antigen administration, and desensitization treatment
- Foot care, including trimming of nails or treatment of corns or calluses, when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg
- Gender-affirming care
- Inpatient medical visits
- Medications and the administration of medications in a physician's office
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics) for the diagnosis and treatment of a sickness or injury
- Orthognathic treatment and surgery
- Second diagnostic surgical opinions
- Services for FDA-approved patches, rings, and contraceptive injections; FDA-approved diaphragms, cervical caps, cervical shields, condoms, sponges, and spermicides; and FDA-approved emergency contraception. See the "Guidance Regarding Preventive Medications" section on www.azblue.com for a list of contraceptive methods covered as preventive services under the pharmacy benefit.
- Services for FDA-approved female sterilization procedures
- Services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices
- Services for FDA-approved female implanted contraceptive devices
- Sleep studies
- Surgical procedures (including assistance at surgery). Call Customer Service at the number on your ID card to verify that the surgical assistant chosen by your physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your physician are network providers.

Benefit-Specific Exclusion: Treatment of Temporomandibular Joint Disorders (TMJ)

The following circumstances may impact member cost share for physician services:

- If multiple surgical procedures are performed during a single operative session, the secondary procedures are usually reimbursed at reduced amounts. Noncontracted providers may bill the full amount for secondary, incidental or mutually exclusive procedures, in addition to the primary surgical procedure.
- You may receive services in a physician's office that incorporate services or supplies from a provider other than your physician. If the other provider submits a separate claim for those services or supplies, you will pay the cost share for the other provider plus the cost share for your office visit. Examples of services or supplies from another provider include DME from a medical supply company, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

BB. POST-MASTECTOMY SERVICES

Benefit Description: Benefits are available, to the extent required by applicable federal and state 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 the mastectomy-related benefits described above under "Benefit Description," coverage will be provided in a manner determined in consultation between the attending physician and the member being treated. These benefits are subject to the same cost share generally applicable to other medical and surgical benefits provided under this plan, as described in the "Member Cost Share" section of your SBC. If you would like more information on WHCRA benefits, call BCBSAZ Customer Service at the number listed on your ID card.

CC. PREGNANCY, TERMINATION

Benefit Description: Benefits are available for elective and non-elective abortions. Benefits are also available for abortifacient medications for the abortions covered under this plan, including some oral medications, as described in current evidence-based criteria.

DD. PREVENTIVE SERVICES

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 procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.

Benefit-Specific Maximum: Benefits are limited to 1 manual or electric (not hospital grade) breast pump and breast pump supplies per member, per calendar year. This limit does not apply to claims for Preventive Services submitted with a primary behavioral health diagnosis.

Benefit Description: Benefits are available at no charge when obtained from a network provider. Coverage is provided for the following services recommended by your provider and as appropriate for the member's age and gender, and as recommended by:

- Advisory Committee on Immunization Practices (ACIP) routine immunization recommendations at https://www.cdc.gov/vaccines/hcp/acip-recs/index.html
- Health Resources and Services Administration (HRSA) guidelines for pediatric and adolescent preventive care and screening at https://mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html
- HRSA guidelines for women's healthcare services at www.hrsa.gov/womens-guidelines/index.html
- U.S. Preventive Services Task Force (USPSTF) A or B graded services at https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

Benefits are also specifically available at no charge when obtained from a network provider for the following services:

- Contraceptives and sterilization as described in the *"Family Planning (Contraceptives and Sterilization)"* section
- Mammograms for routine breast cancer screening
- Preexposure prophylaxis (PrEP) and related services for members at high risk for HIV
- Prostate specific antigen (PSA) testing and digital rectal examination (DRE) for members age 40 and older, or for members under age 40 who are at high risk due to:
  - Family history (such as multiple first-degree relatives diagnosed at an early age);
  - African-American race; **or**
  - Previous borderline PSA levels
- Smoking cessation counseling and aids, including over-the-counter aids
- Well-baby/childcare up to 47 months; childhood immunizations

Benefits will be provided for any other preventive service required by federal or state law. For a list of covered preventive medications, go to the "Guidance Regarding Preventive Medications" section on www.azblue.com. For questions about Preventive Services covered under this benefit, call Customer Service at the number on your ID card or log in to your MyBlue account on www.azblue.com for more preventive health information and links.

If a preventive service has been denied due to your gender on file with BCBSAZ, and you are undergoing or have undergone gender transition, please contact Customer Service at the number on your ID card for assistance. BCBSAZ covers all gender-specific Preventive Services that are deemed

medically necessary for a member, as determined by the member's attending provider, without regard to the member's gender identity, gender assigned at birth, or gender that is on file with BCBSAZ.

Services or tests included 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 also are available through the *"Maternity"* benefit.

Benefit-Specific Exclusions:
- Abortifacient medications
- All prescription and over-the-counter contraceptive medications and devices for male members

EE. RECONSTRUCTIVE SURGERY AND SERVICES

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, to the extent required by federal and state law
- Medically necessary breast implant removal
- Other services required by federal or state law to be covered

FF. SPECIALTY MEDICATIONS

Benefit-Specific Definitions: **"Specialty Medications"** are medications that treat chronic or complex conditions. BCBSAZ and/or the PBM determine which medications are Specialty Medications.

"Specialty Pharmacy" is a pharmacy contracted with BCBSAZ and/or the PBM to dispense Specialty Medications to members.

Benefit Description: Benefits are available for Specialty Medications obtained from a Specialty Pharmacy contracted with BCBSAZ. Coverage of Specialty Medications and limitations on these medications are determined by current Evidence-based Criteria and Pharmacy Coverage Guidelines, and may change at any time without prior notice. If a member obtains a Specialty Medication from a network provider other than a 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 prior authorization requirements of that benefit.

If you are currently obtaining a specialty medication from a Specialty Pharmacy, you may be able to receive that medication from a retail pharmacy instead. Please contact Pharmacy Benefit Customer Service. BCBSAZ and/or the PBM will determine whether you are eligible to receive the specialty medication from a retail pharmacy instead of a Specialty Pharmacy.

If you are taking 2 or more prescription medications for a chronic condition, you may request early or short refills of eligible covered medications by calling the Pharmacy Benefit Customer Service number on your ID card and requesting enrollment in the BCBSAZ medication synchronization program.

Benefit-Specific Exclusions:
- All benefit-specific exclusions listed under the *"Pharmacy Benefit,"* except for the exclusion for Specialty Medications
- Medications obtained from a pharmacy not specifically contracted with BCBSAZ as a Specialty Pharmacy

GG. TELEHEALTH SERVICES – BLUECARE ANYWHERE

Benefit Description: Remote medical and behavioral health consultations between a provider and a patient are offered by the TSA through BlueCare Anywhere, including:

- Counseling with a psychologist or other licensed therapist
- Medical consultations with a physician, physician's assistant, or nurse practitioner
- Psychiatry consultations with a psychiatrist

To use BlueCare Anywhere, see the Customer Service section of this benefit book for information on how to contact the TSA. After you connect with a provider, if he or she determines that your condition is not appropriate for Telehealth Services, the provider will suggest that you seek in-person treatment.

Benefit-Specific Exclusions:

- Emergency services
- Preventive services
- Services covered under the *"Telehealth Services – Network Providers"* benefit
- Services not provided through the TSA

HH. TELEHEALTH SERVICES – NETWORK PROVIDERS

Benefit Description: Benefits are available for telehealth services delivered by a network provider through interactive electronic media. Benefits are also available for emergency or urgent telehealth services from out-of-network providers.

Benefit-Specific Exclusions:

- Non-emergency and non-urgent telehealth services from an out-of-network provider
- Services delivered through the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages, or electronic mail, unless otherwise required by law
- Services provided through the *"Telehealth Services – BlueCare Anywhere"* benefit
- Telehealth services for noncovered diseases or disorders

II. TRANSPLANT OR GENE THERAPY TRAVEL AND LODGING

Benefit-Specific Definition: "**Caregiver**" is the individual primarily responsible for providing daily care, basic assistance and support to a member who is eligible for transport, lodging, and reimbursement. Caregivers may perform a wide variety of tasks to assist the member 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-Specific Maximum: Benefits are limited to a maximum of $10,000 per member, per transplant or gene therapy treatment. Covered expenses incurred by a Caregiver or donor accumulate toward the member's $10,000 maximum.

Benefit Description: Transplant travel and lodging expenses are eligible for reimbursement during evaluation, transplant, post-transplant care, and complications directly related to the transplant. Reimbursement is available for transplant or gene therapy travel and lodging expenses when all the following criteria are met:

- BCBSAZ has given prior authorization for the service or, if BCBSAZ did not give prior authorization for the service, upon review we determine the service meets the requirements of this benefit plan;
- The distance from the member's, donor's, or caregiver's residence must be more than 60 miles from the facility;
- The expenses are for any of the following:
  - Meals;
  - 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;
  - Room charges from hotels, motels and hostels or apartment rental; **and**
- The expenses are incurred by the member or the member's Caregiver.

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 incurred by a donor or the donor's Caregiver
- All travel and lodging expenses in excess of the benefit-specific maximum
- Ambulance transportation (ground or air)
- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with services that do not qualify for coverage under this benefit plan
- 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 60 miles for authorized transplant- or gene therapy-related services
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement: To request reimbursement of eligible 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 is listed in the Customer Service section at the front of this book. To request a claim form, call the Customer Service number on your ID card.

JJ. TRANSPLANTS – ORGAN – TISSUE – BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES

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: Covered transplant services are available from plan network providers and Blue Distinction Centers for transplants in Arizona. The following transplants are eligible for coverage if they meet current evidence-based criteria:
- Allogeneic and autologous bone marrow or stem cell
- Autologous islet cell transplant (AICT)
- Cornea
- Heart; heart-lung; kidney; kidney-liver; kidney-pancreas; liver; lung (lobar, single, and double lung); pancreas; small bowel; small bowel-multivisceral

Benefits are available for the following services in connection with, or in preparation for, a covered transplant:
- 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
- Inpatient and outpatient facility and professional services
- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ. Covered donor expenses include complications and follow-up care related to the donation for up to 6 months post-transplant, as long as the recipient's BCBSAZ coverage remains in effect
- Pre-transplant testing and services
- Procurement of an organ from a cadaver or live donor, including surgery to remove the organ; transportation, hospitalization, and surgery of a live donor

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 current Evidence-based Criteria

KK. TRANSPORTATION AND LODGING BENEFIT (NOT RELATED TO TRANSPLANT OR GENE THERAPY TRAVEL AND LODGING)

Benefit-Specific Definition: **"Companion"** is an individual who is traveling with the member on the same day(s) to and/or from the site of the procedure for an evaluation, the procedure, or necessary post-discharge follow-up.

Benefit-Specific Maximum: Benefits are limited to a combined overall maximum of $2,000 per member, per calendar year. Covered expenses incurred by a member receiving the service and 1 companion accumulate toward the member's $2,000 maximum.

Benefit Description: Benefits are available for the following services:
- Behavioral health services
- Cancer treatment
- Cardiac services
- Maternity/reproductive health services
- Musculoskeletal (MSK) procedures
- Pregnancy termination services
- Transgender services, including gender affirmation treatment

Travel and lodging expenses are eligible for reimbursement related to a covered procedure received at a network facility when all of the following criteria is met:
- Upon review BCBSAZ determines the service meets the requirements of this benefit plan;
- Travel and lodging must be primarily for and essential to obtaining medical care; the member may be required to submit supporting documentation;
- Travel and lodging expenses are only available if a network facility that can provide the covered service is not available within the same state where the member resides, and not available within 100 miles from where the member resides regardless of state;
- Transportation is covered, including expenses for personal car mileage at the current federal rate of reimbursement, for the member and 1 companion who is traveling on the same day(s) to and/or from the site of the procedure for an evaluation, the procedure, or necessary post-discharge follow-up; Additional transportation is included for:
  - Taxi fares (not including limos or car services); economy or coach airfare; parking; trains; boat; bus; tolls;
  - Reasonable and necessary expenses for lodging for the member (while not confined) and 1 companion. Benefits are paid at a per-diem rate of $50 for one person or $100 a day for two people (a maximum of $50 per person — $100 for member and companion combined — per night is paid toward lodging expenses); this includes room charges from hotels, motels, 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 benefit-specific maximum
- Childcare expenses
- Entertainment/souvenirs
- Expenses for travel or lodging incurred in connection with services that do not qualify for coverage under this benefit plan
- Lodging in any location other than a hotel, motel, hostel or apartment rental
- Lost wages
- Meals
- Personal care items
- Taxes
- Tips/gratuities
- Tobacco

For information about the transportation and lodging benefits listed above, please contact Customer Service at the number on the back of your ID card. Please note this benefit is separate from the Transplant or Gene Therapy Travel and Lodging benefit. For information regarding that benefit, please see the *"Transplant or Gene Therapy Travel and Lodging"* section of this benefit book.

LL. URGENT CARE

Benefit-Specific Definition: "**Urgent Care**" means treatment for conditions that require prompt medical attention, but are not emergencies.

Benefit Description: Benefits are available for Urgent Care services. Providers contracted with the plan network as Urgent Care centers are listed on the BCBSAZ website at www.azblue.com under "Urgent Care Centers."

WHAT IS NOT COVERED

Notwithstanding any other provision in this plan, no benefits will be paid for expenses associated with the following services. These exclusions do not apply to services that must be covered according to federal or state law:

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

Bariatric Surgeries

Benefit-specific exclusions and limitations, listed in this book under particular benefit sections

Biofeedback

Blood Administration for the purpose of general improvement in physical condition

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

Care for health conditions that are required by state or local law to be treated in a public facility

Care required by federal or state law to be supplied by a public school system or school district

Certain Types of Facility Charges – Inpatient and outpatient facility charges for treatment provided by group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes

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, except as stated in this plan

Complications of Noncovered Services – Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under this plan. Medical complications arising from an abortion are covered under this plan

Consumable Medical Supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as stated in this plan

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
- Medically necessary breast implant removal
- Medically necessary surgery to improve or restore the impaired function of a body part or organ
- Surgery to correct a congenital defect

Cosmetics and health and beauty aids

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 or as otherwise required under applicable law

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

Domiciliary Care

Expenses for services that exceed benefit limitations

Experimental or Investigational Services or Items, except as stated in this plan

Fees that are –

- Associated with the collection or donation of blood or blood products
- Other than for medically necessary, in-person, direct member services, except as stated in this plan
- For concierge medicine services, **or**
- For direct primary care

Flat Feet – Services for treatment of flat feet, weak feet, and fallen arches

Foot Care – Services for foot care, including trimming of nails or treatment of corns or calluses

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

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

Growth Hormone – Growth hormone to treat Idiopathic Short Stature (ISS)

Hearing Services and Devices, except as stated in this plan

Hypnotherapy

Inpatient or Outpatient Non-acute Long-term Care

Laboratory Services Provided Without an Order from an Eligible Provider

Lifestyle and work-related education and training, and management services

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, except as stated in this plan

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

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; or at garage sales, swap meets, and flea markets

Medications that 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 current evidence-based criteria or Pharmacy Coverage Guidelines
- Off-label, unlabeled, and orphan medications, except as stated in this plan
- Used to treat a condition not covered by BCBSAZ

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

Member Costs or Fees associated with health clubs and weight loss programs.

Neurofeedback

Non-Medically Necessary Services – Services that are not medically necessary as determined by BCBSAZ or BCBSAZ's contracted vendor. BCBSAZ and/or the contracted vendor may not be able to determine medical necessity until after services are rendered

Non-Medical Ancillary Services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy

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

Payments for exclusions imposed by any certification requirement

Payments for services that are unlawful in the location where the service is performed at the time the expenses are incurred

Personal Comfort Services – Services intended primarily for assistance in daily living, socialization, personal comfort and convenience, homemaker services, services primarily for rest, domiciliary, or convalescent care; costs for television, telephone, newborn infant photographs, meals other than meals provided to a member by an inpatient facility while the member is a patient in the inpatient facility, birth announcements, and other services and items for other non-medical reasons

Phase 3 Cardiac Rehabilitation

Private Duty Nursing, except as stated in this plan

Refills or Replacements – Refills or replacements for medications covered under this benefit plan that are lost, stolen, spilled, spoiled or damaged

Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic, or custodial evaluations.

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, except as stated in this plan

Respite Care, except as covered in the *"Hospice Services"* benefit

Reversal of Surgical Procedures, except as stated in current Evidence-based Criteria and other criteria as determined by BCBSAZ

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, or as required by law

Sensory Integration and Music Therapy

Service Animals and related costs, including but not limited to food, training and veterinary costs

Services for Children of a Dependent, unless the child is also eligible as a Dependent

Services for the administration of drugs that can be self-administered, except when medically necessary

Services for Conditions Medicare Identifies as Hospital-Acquired Conditions (HACs), and/or National Quality Forum (NQF) "Never Events"

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 Ineligible Providers (see *"Eligible Providers"* section of this book)

Services Paid for by Other Organizations or Those Required by Law to be Paid for by Other Organizations – Other organizations include, but are not limited to, the government, a school, and/or biotechnical, pharmaceutical, medical, or dental device industry organizations.

Services Prior to Member's Coverage Effective Date

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

Services Provided by Out-of-Network Providers, except for emergencies, EGID, and Medical Foods formulas

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, regardless of the cause, and medications for the treatment of sexual dysfunction

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

Therapy to Improve General Physical Condition including, but not limited to, inpatient and outpatient routine long-term care

Training and Education, except as stated in this plan

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

Vision – Routine vision exams, except for preventive vision screenings for members under age 5; vision therapy; eye exercises; all types of refractive keratoplasties including but not limited to radial keratotomy and/or lasik surgery; any other procedures, treatments, and devices for refractive correction; eyeglass frames and lenses, 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

Wigs and hairpieces, except as stated in this plan

Workers' Compensation – Services to treat illnesses and injuries that are:

- Covered by workers' compensation; **and**
- Expressly identified as workers' compensation claims when submitted to BCBSAZ.

This exclusion does not apply if the member has made a statutory opt-out election and/or is exempt from workers' compensation coverage.

GENERAL PROVISIONS

Appeal and Grievance Process

Members may participate in BCBSAZ's appeal and grievance processes, which are described in detail in the BCBSAZ Appeal and Grievance Guidelines, a separate document provided to you. You may obtain another copy of the BCBSAZ Appeal and Grievance Guidelines by visiting us at www.azblue.com or by calling Customer Service at the number on your ID card.

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 prior authorization for urgently needed services you have not yet received, please call the BCBSAZ prior authorization 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, 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.

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 ("Association"), an association of independent Blue Cross and Blue Shield Plans 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 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.

Claims Editing Procedures and Pricing Guidelines

BCBSAZ uses systems to verify benefits, eligibility, claims accuracy, and compliance with BCBSAZ coding and pricing guidelines and Evidence-based Criteria. BCBSAZ uses claims coding and editing logic to process claims and determine allowed amounts. BCBSAZ regularly updates its systems, claims and pricing guidelines and edits, and Evidence-based Criteria.

Confidentiality and Release of Information

We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with federal and state 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, 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

There is an appeal process for resolving certain types of disputes with members. You are encouraged to use the appeal process before filing a lawsuit, as issues can often be resolved when you provide more information through the appeal process. By providing this notice BCBSAZ does not waive, but expressly reserves all applicable defenses available under federal and Arizona law.

Legal Action and Applicable Law

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

Any dispute arising directly or indirectly out of the plan must be resolved by binding arbitration to the fullest extent permitted by applicable law. You agree that neither class or collective claims, nor class action or collective action procedures, will be asserted in, or will apply to, any dispute that arises out of this benefit plan. You irrevocably and unconditionally waive, to the fullest extent permitted by applicable law, any right to a trial by jury in any dispute arising out of or relating to this benefit plan.

Jurisdiction and Venue: Jurisdiction and venue for any legal action or other proceeding that arises out of or relates to the contract or this benefit plan shall be in any court of competent jurisdiction in the state of Arizona.

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

Except as otherwise specified in this section, 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. If you receive Covered Services from an

out-of-network Provider and wish to assign your payment to the Provider, you or the Provider may submit the documents requesting assignment to BCBSAZ. BCBSAZ, at our sole discretion, will determine whether to honor the assignment and, if approved, remit any payment due directly to the Provider.

No Surprises Act

The federal "No Surprises Act" protects you from surprise balance bills from out-of-network providers in certain situations.

- **Emergencies:** When you receive emergency care from out-of-network providers, your financial responsibility will be determined in the same way as if you received the care from network providers. Also, out-of-network providers can't balance bill you for the difference between the allowed amount and the billed charge.
- **Non-emergency service at network facilities:** The same emergencies rule above applies if you receive services from out-of-network providers while you are at a network facility, such as a hospital or outpatient surgery center, unless the provider gives you a legally-required notice and you give consent in accordance with the law. If you give this consent, you will pay the out-of-network cost share and any balance bill, and the No Surprises Act dispute process won't apply.
- **Disputes:** If out-of-network Providers want to dispute the amount BCBSAZ pays them, they are required to resolve the dispute with us. As long as you pay your required cost-share amount, they can't collect any other amounts from you.

If you would like more information on the No Surprises Act, or if you feel that you have incorrectly received a balance bill, the federal government has created the following website:

www.cms.gov/nosurprises

You can also call (800) 985-3059.

To view a statement of Your Rights and Protections Against Surprise Medical Bills, go to www.azblue.com/individualsandfamilies/resources/forms. You can also call the number on the back of your ID card to have a copy of the statement mailed to you.

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 healthcare 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 Customer Service. 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:

- On delivery, if hand-delivered;
- If mailed, on the earlier of the day actually received by the member or 5 days after deposit in the U.S. mail, postage prepaid; **or**
- 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 federal or state laws. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the 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 SBCs, all riders and amendments, and other communications concerning your coverage.

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

BCBSAZ participates in contracts with pharmaceutical companies to receive rebate payments based on the volume and/or market share of pharmaceutical products utilized by BCBSAZ members. These rebate contracts are subject to renegotiation and/or termination from time to time at BCBSAZ's sole discretion.

The rebates BCBSAZ receives are not reimbursable to you. Your group receives either: (a) a credit against administrative costs/fees or (b) the prescription medication rebate dollar amount attributable to your group. Rebates received by BCBSAZ may result in the overall cost of a particular medication falling below the amount you pay for such medication pursuant to the coverage described in this benefit plan. Other discount programs offered by a pharmacy may result in members of the public paying a lower cost for some medications than you pay under this benefit plan.

Provider Contractual Arrangements

The BCBSAZ allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors. For that reason, plan network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate. This means that your network cost share for a particular service can vary based on the network provider you choose, because not all providers have the same negotiated reimbursement rate for the same service. For information on your estimated cost share for a particular service, please call Customer Service at the number on your ID card. You will need to provide the name of the provider and the diagnosis and procedure code to receive an estimated cost share. The estimated cost share is only an estimate and the actual cost share may vary from the estimated cost share based on factors such as the services actually performed and the place where the services are actually rendered.

Release of Records

Subject to federal or Arizona 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. Failure to provide records needed to adjudicate a claim can result in denial of the claim.

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. Network providers generally cannot charge you for providing BCBSAZ with health records. 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 or the cost of copies, you will need to arrange with your provider to obtain any records required by BCBSAZ and pay any applicable fees.

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 a 30-day 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.

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 group 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 term we use for federal and state laws that regulate continuation of healthcare 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.

- 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 a fee for any delay 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 federal or state 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; Availability of Notice of Privacy Practices

You have the right to inspect and copy your information and records maintained by BCBSAZ, with some limited exceptions required by law. 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.

The BCBSAZ "Notice of Privacy Practices" describes how BCBSAZ may use and disclose your information to administer your health plan. It also describes some of your individual rights and BCBSAZ's responsibilities under federal privacy regulations. BCBSAZ mails a copy of this Notice of Privacy Practices to your address shortly after you enroll for coverage with BCBSAZ. You can also view the "Notice of Privacy Practices" by visiting the BCBSAZ website, www.azblue.com, and clicking on the Legal link at the bottom of the home page. If you would like BCBSAZ to mail you another copy of the "Notice of Privacy Practices," please call the Customer Service number on your ID card, or call (602) 864-4400 or (800) 232-2345 to make your request.

Subrogation

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") that provides its employees and their dependents ("Participants") with healthcare coverage. BCBSAZ performs claims administration for the Plan and now also provides subrogation recovery services for the Plan as described in this section. Here is the way subrogation works. Sometimes you and/or your dependent ("you") require hospital and/or medical services due to an injury in an accident or due to a condition caused by another person's negligence. In such cases, the person causing the accident ("third party") is responsible for payment of your hospital and medical expenses. The Plan, who pays for your covered hospital and medical services, has the right to recover these payments from the third party or from you if you have recovered from the third party. When the Plan exercises its rights to be reimbursed, the process is known as subrogation, recovery and/or reimbursement ("subrogation").

During the subrogation process, BCBSAZ, on behalf of the Plan, will continue to pay your covered hospital and medical services on behalf of the Plan just as it always has. However, if a third party is legally obligated to pay for your expenses, the Plan will then exercise its rights to be reimbursed for 100% of what the Plan paid without any reduction for attorneys' fees and/or court costs and regardless of whether you were made whole. In addition, the Plan has first priority from any judgment, payment or settlement.

The Plan's rights apply to any settlement of a claim regardless of whether anyone has started litigation. Any right a Participant might have to be "made whole", (i.e., to be fully compensated for his/her injuries prior to any right the Plan has to recover its cost) is superseded by the Plan's subrogation rights. The Plan may subrogate against all money that you or anyone recovers regardless of the source of the money and regardless of where the money is located and/or regardless of how it is held. The Plan will also have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of recovery or settlement.

You must promptly execute and deliver any documents relating to settlement of claims, settlement negotiations or litigation when the Plan asks you to so the Plan can exercise its subrogation rights. Also, you or your legal representative must (1) promptly notify the Plan in writing of any settlement negotiations before you enter into any settlement agreement, (2) disclose to the Plan any amount recovered from any person or entity that may be liable and (3) not make any distributions of settlement or judgment proceeds without the Plan's prior written consent. No waiver, release of liability or other documents executed by you without such written notice to the Plan shall be binding upon the Plan.

PLAN ADMINISTRATION

Changes to Your Information

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.

Notify Customer Service about changes to the following:

- A disabled Dependent age 26 or older who is no longer disabled
- Eligibility of you or your Dependents for Arizona Health Care Cost Containment System (AHCCCS) or other Medicaid coverage during the term of this contract
- Eligibility of you or your Dependents for basic health plan (BHP) coverage during the term of this contract
- Eligibility of you or your Dependents for individual coverage purchased through a federal or state Exchange.
- Eligibility of you or your Dependents for Medicare during the term of this contract
- Eligibility of you or your Dependents for the Children's Health Insurance Program (CHIP) coverage during the term of this contract
- Individuals being added to the benefit plan: Spouse, newborns, adopted children, children placed for adoption, stepchildren
- Individuals removed from the benefit plan due to divorce or death
- Other medical coverage that you or your Dependents add or lose, including any changes in benefits
- Your mailing address or phone number

Coordination of Benefits (COB)

If you have benefits under another group health plan, and the other group plan is the primary payer, then the combined benefit payments from all coverages cannot be more than the greater of the primary payer's or BCBSAZ's allowed amount. If your other group health insurance does not include a COB provision, the other group coverage pays first. If your other group health insurance provides for COB, the following rules will be used to determine which coverage will pay first:

- If the person who received care is covered as an active employee under one plan and as a dependent under another, the employee coverage pays first.
- If the person who received care is a dependent child, then the plan of the parent whose birthday occurred earlier in the calendar year covers the child first.
- If both parents have the same birthday, the benefits of the plan that has covered a parent longer covers the dependent child first.
- If the dependent child's parents are legally separated or divorced, the following applies:
  - ♦ 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, then the plan of the parent whose birthday occurred earlier in the calendar year pays first.
  - ♦ If a court decree specifies the parent who is financially responsible for the child's healthcare expenses, the specified parent's 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 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.

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"*).

If you have coverage under Medicare, Medicare guidelines will be used to determine the primary payer. If the provider accepts assignment from Medicare, the combined payments by Medicare and BCBSAZ will not exceed the Medicare allowed amount. If the provider does not accept assignment from Medicare the combined payments by Medicare and BCBSAZ will not exceed the provider's billed charges. If the provider opts-out of Medicare, BCBSAZ is the primary payer.

BCBSAZ does not coordinate benefits for services covered by the *"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 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% 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 *"Pharmacy Benefit."* For this benefit, BCBSAZ will pay primary, without regard to the member's other coverage.

Definitions Related to Plan Administration

- **"Dependents"** are the following individuals:
  - The contract holder's spouse under a legally valid existing marriage; **and**
  - The contract holder's children or the children of the contract holder's spouse, including natural children, legally adopted children, stepchildren, 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.
  - A domestic partner and the children of the domestic partner as defined below, if the domestic partnership satisfies the eligibility requirements.

- **"Children of a Domestic Partner"** are 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.

- **"Disabled Dependent Child"** is a child who has reached age 26 and who meets criteria for coverage under this plan described in "Eligibility Requirements."

- **"Domestic Partner"** is a consenting adult 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.

- **"Domestic Partnership"** is a relationship between an eligible employee and his/her domestic partner that meets eligibility requirements.

- **"Employee"** refers to the person eligible for this benefit plan because of his/her employment relationship or affiliation to the Group. An employee is also the contract holder under this plan.

- **"Open Enrollment"** is an annual period during which the contract holder and dependents are eligible to enroll for coverage or change benefit plan options. Your Group's plan administrator will notify the contract holder of the Group's open enrollment period. contract holders and/or any dependents can change benefit plans only during an open enrollment period, except as set forth in this Benefit Book or as allowed under applicable law.

Eligibility Requirements

- Contract Holder – A contract holder becomes eligible to enroll for coverage after meeting the Group's eligibility requirements outlined in the group master contract.

- Children – Children, including children of a domestic partner who meets the domestic partnership eligibility criteria, are eligible for dependent coverage until their 26th birthday.

- Disabled Dependent Child – 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 totally disabled due to a continuous physical or intellectual disability or condition, as defined in current evidence-based criteria, 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 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, but not more than annual, 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.

- Domestic Partnership**:** Contact your Plan administrator for domestic partnership eligibility requirements.

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 31 days of becoming eligible.

- 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 Periods"* 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 is the date of marriage, if the contract holder completes an application within 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 Periods."*

- 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 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 Periods."*

- Newborn/Adopted Child/Child Placed for Adoption **–** A child is automatically eligible for coverage for the first 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 31-day period if the group receives a completed application for the child within 31 days of the birth, adoption or placement for adoption. Contact Customer Service at the number listed on your ID card 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 31 days of that date. If an application is not completed within 31 days, the child may not enroll until the next open enrollment period, unless the child qualifies under *"Special Enrollment Periods."*

Loss of Eligibility

Contract holder eligibility ends on the following days:

- The end of the month in which the contract holder was entitled to receive compensation from the Group, regardless of the date such compensation is actually paid and for which BCBSAZ has received payment from the Group.

- The end of the month in which an approved leave of absence expires, if the contract holder fails to return to active employment.
- The date on which the contract holder's death occurs.
- The end of the month in which the Group and/or contract holder fails to pay amounts due and any grace period available under Arizona law is exhausted.

Dependent eligibility ends on the following days:
- For a dependent spouse and any children of that spouse who are not the natural or adopted children of the contract holder, the end of the month in which the final divorce decree is effective.
- The end of the month in which a child turns age 26, if the child is not a disabled child.
- The end of the month in which disability or dependency ceases for a disabled child over age 26.
- The end of the month in which a child covered by a medical support order is no longer eligible under the court order or administrative order.
- The end of the month in which the contract holder's death occurs.
- The date on which the dependent's death occurs.

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 end of the month in which the domestic partner who is the eligible employee loses coverage under this benefit plan.
- The end of the month in which the domestic partnership is terminated or dissolved.
- The end of the month in which the Group discontinues eligibility for domestic partners and/or eligible children of the domestic partner.
- The end of the month in which the child of a domestic partner turns age 26, if the child is not a disabled dependent child.

The date coverage terminates for a domestic partner and/or the children of the domestic partner is as described in the Benefit Book for employees and dependents. A domestic partner 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.

Some Groups have up to 31 days to notify BCBSAZ that a contract holder or dependent has become ineligible. Until BCBSAZ receives notice and processes the termination of eligibility, BCBSAZ may quote benefits, give prior authorization or pay claims that ultimately will be recouped from members or providers, if it is later determined the member was ineligible on the date services were received. Such benefit quotations or prior authorizations become null and void, regardless of whether the Group has notified the contract holder that eligibility terminated.

Special Enrollment Periods

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 31 days of the loss of other coverage:
- A dependent child ceases to be a dependent child under the generally applicable requirement of the plan.
- 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 gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption
- A person has coverage through his or her spouse and a divorce or legal separation occurs
- A person has coverage through his or her spouse and the spouse dies
- A person loses minimum essential coverage, as that term is defined in applicable law
- 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
- 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 covered employee's eligibility for coverage
- Termination of the employer's contribution toward coverage
- The covered employee becomes entitled to Medicare
- 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

- The covered employee's employer terminates coverage
- The death of the covered employee
- The divorce or legal separation of the covered employee from the covered employee's spouse.
- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of the covered employee's employment

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

Termination of Coverage

Reasons for Termination: The contract holder and/or any dependents' coverage under this benefit plan may terminate for the following reasons, including but not limited to:
- The contract holder and/or any dependent(s) die
- The contract holder and/or dependent(s) request termination of coverage
- Nonpayment of amounts due by the Group and/or contract holder, after expiration of any applicable grace period available under Arizona law
- Coverage for the contract holder and/or dependents is rescinded

Termination Date of Coverage: BCBSAZ will notify the Group and/or the contract holder of any termination dates of coverage for the contract holder and/or any dependents. The contract holder and/or dependents' coverage ends no later than the date the Group Master Contract terminates. If the contract holder's coverage terminates, coverage for all dependents also terminates on same day.

Benefits after Termination: Except as described below, you have no coverage on and after the date coverage ends, regardless of the reason for termination. This applies even if the expense was incurred because of an accident, injury or illness that occurred or existed while this coverage was in effect, except as described under *"COBRA Continuation of Coverage."*

COBRA Continuation of Coverage

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. COBRA continuation coverage can become available to you and your dependents when group health coverage would otherwise end.

COBRA continuation coverage is a continuation of plan coverage when it would otherwise end because of a life event. This is also called a qualifying event. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

If you're an employee: You'll become a qualified beneficiary if you lose your coverage under the plan because of the following qualifying events:
- Your hours of employment are reduced, **or**
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee: You'll become a qualified beneficiary if you lose your coverage under the plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); **or**
- You become divorced or legally separated from your spouse.

Your dependent children: Dependent children will become qualified beneficiaries if they lose coverage under the plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; **or**
- The child stops being eligible for coverage under the plan as a dependent child.

Sometimes, if the plan offers retiree coverage, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer, if the Plan offers retiree coverage; **or**
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator at the address listed in the front of this benefit book under *"ERISA Plan Information."*

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- *Disability extension of 18-month period of COBRA continuation coverage:* If you or anyone in your family covered under the plan is determined by Social Security to be disabled and you notify the plan administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

- *Second qualifying event extension of 18-month period of continuation coverage:* If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified in the "ERISA Plan Information" in the front of this book. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting Group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **https://www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Leave of Absence

In accordance with employer policy.

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.

Benefit-Specific Eligibility

Under the following limited circumstances, a nonmember 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 description for *"Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures."*)
- If a non-member is pregnant with a baby that is to be adopted by a member of this plan, the non-member may be eligible for maternity benefits under the following circumstances:
  - The child is adopted by a member within 1 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.

Nondiscrimination Statement

BCBSAZ complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to enable people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and (877) 475-4799 for all other languages and other aids and services.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hólǫ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 877-475-4799.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 877-475-4799
.[تماس حاصل نمایید.

Assyrian:
ܐܢ ܐܢܬܘܢ، ܝܢ ܚܕ ܦܪܨܘܦܐ ܕܩܐܗܘܝܬܘܢ ܗܝܪܐ ܠܗ، ܐܝܬܠܗ ܫܘܐܠܐ ܒܘܬ Blue Cross Blue Shield of Arizona، ܐܝܬܠܘܟܘܢ ܙܕܩܐ ܕܡܩܒܠܬܘܢ
ܗܝܪܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܢܝܢܐ ܥܠ ܗܕ 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคณ หรอคนทคณกาลงชวยเหลอมคาถามเกยวกบ Blue Cross Blue Shield of Arizona คณมสทธทจะไดรบความชวยเหลอและขอมลในภาษา ของคณไดโดยไมมคาใชจาย พดคยกบลาม โทร 877-475-4799