BluePreferred®

Benefit Book

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BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact Blue Cross® Blue Shield® of Arizona (BCBSAZ) at one of the phone 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
- Search for Providers
- Compare hospitals
- Research pharmacy benefits
- Order ID cards

*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 4:30 p.m. MST (except holidays)
If you lose your ID card and need a replacement:	(602) 864-4400 (within the Phoenix Metro area) (800) 232-2345 (outside of Phoenix Metro)
Hearing Impaired (TTY):	(800) 770-8973, TTY: 711
For assistance in Spanish (en Español):	(602) 864-4884
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 Hours of Operation: 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

Words defined in this *"Definitions"* section or sections that appear in the *"Table of Contents"* will be capitalized throughout this Benefit Book.

"Allowed Amount" means the total amount of reimbursement allocated to a covered Service and includes both the BCBSAZ payment and the Member Cost-share payment. BCBSAZ calculates deductible and Coinsurance based on the Allowed Amount, less any access fees or Prior Authorization Charges. BCBSAZ uses the Allowed Amount to accumulate toward any Out-of-pocket Coinsurance Maximum or Out-of-pocket Maximum that applies to the member's Benefit Plan. The Allowed Amount does not include any balance bills from noncontracted Providers. The Allowed Amount is neither tied to, nor necessarily reflective of, the amounts Providers in any given area usually charge for their services. The table below shows how BCBSAZ determines the Allowed Amount:

Type of Provider	Type of Claim	Basis for Allowed Amount
Providers contracted with BCBSAZ	Emergency and non-emergency	Generally, the lesser of the provider's Billed Charges or the applicable BCBSAZ 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	Generally, the 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 (in Arizona)	Non-emergency	Lesser of the provider's Billed Charges or the applicable Fee Schedule, with adjustments for certain *"Claims Editing Procedures and Pricing Guidelines."*
Noncontracted Providers (outside Arizona)	Non-emergency	Lesser of the provider's Billed Charges or the amount the Host Blue would pay the nonparticipating Provider. In the event that the Host Blue has not established an amount it would pay the nonparticipating Provider, the Allowed Amount is based on the applicable Fee Schedule, with adjustments for certain *"Claims Editing Procedures and Pricing Guidelines*."
Noncontracted ground ambulance Providers, including Providers contracted with another BCBSAZ network, but not contracted as a plan network Provider for this Benefit Plan (in and outside Arizona)	Emergency	The Allowed Amount is based upon the ambulance provider's Billed Charges.
Noncontracted Providers in an in-network facility (in and outside Arizona)	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 an in-network facility, you are responsible for the difference between the Qualifying Payment Amount and the provider's Billed Charges.
Noncontracted Providers, excluding air ambulance (in and outside Arizona)	Emergency	The Qualifying Payment Amount, as defined by federal law is the Allowed Amount.
Noncontracted air ambulance Providers (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.

"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.

"Bariatric Surgery" means a surgical procedure to promote weight loss for the treatment of morbid obesity. Bariatric Surgery also includes any revisions to a bariatric surgical procedure.

"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 Benefit Plan includes this book, your Summary of Benefits and Coverage (SBC), your application for coverage, any Benefit Plan that is issued to replace this Benefit Plan, and any rider, amendment, or modification to this Benefit 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.

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.

"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 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.

"Blue Distinction®" is a national designation awarded by Blue Cross 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 American Specialty Health Networks, Inc., 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: deductible, Copay, Access Fee, and Coinsurance.

"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 a 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.

"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 in-network pharmacy to facilitate the synchronization of the patient's medications for the purpose of improving medication adherence.

"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 used 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 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.

“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. If an out-of-network Provider does not get a Prior Authorization from BCBSAZ for a Service that requires it, you are subject to either a Prior Authorization charge or a complete loss of benefit. If you have to pay a Prior Authorization charge, it does not count toward the Calendar-year Deductible or Out-of-pocket Coinsurance Maximum.

“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. 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, copays, Coinsurance percentages, 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 that is 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 Benefit 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 In-network Providers” means services delivered through interactive qualified electronic media.

UNDERSTANDING THE BASICS

Your Responsibilities

Before you receive services:
- Check your provider's network status and know whether your Provider is a 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.

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 (Contract Holder and dependent names)

Changes

You will be notified of any Changes to this plan as required by law. 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.

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 Necessary as determined by BCBSAZ or BCBSAZ's contracted vendor;
- Not excluded under any provision of this plan;
- Not experimental or investigational as determined by BCBSAZ or BCBSAZ's contracted vendor (does not apply to Covered Services as part of an eligible cancer clinical trial);
- Provided while this Benefit Plan is in effect and while the person claiming benefits is an eligible Member; and
- Rendered by an eligible Provider acting within the provider's scope of practice, as determined by BCBSAZ or BCBSAZ's contracted vendor(s).

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.

Grandfathered Status of Plan

BCBSAZ believes this plan is a "grandfathered health plan" under the Affordable Care Act (ACA). As permitted by ACA, a grandfathered health plan can preserve coverage that was already in effect when that law was enacted. Since this plan is a grandfathered plan, it will not be subject to certain mandatory benefit changes required by ACA for non-grandfathered plans. However, ACA will require grandfathered health plans to make certain benefit revisions. You may contact BCBSAZ with questions regarding which changes apply and which changes do not apply to a grandfathered health plan by calling the number located on the back of your BCBSAZ ID Card.

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.

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 (see "*Covered Services"* section).

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 Medical Necessity Criteria, which are also available to you on request.

MEMBER COST SHARING

Members pay part of the costs for benefits received under this plan. Depending on your particular Benefit Plan, the Service you receive and the Provider you choose, you may have an Access Fee, Balance Bill, Coinsurance, Copay, deductible, or some combination of these payments. Each Cost-share type is explained below. This section, the benefit descriptions in this book, and your 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.

Access Fee

An Access Fee is a fixed fee you pay to a Provider for certain Covered Services, usually at the time of Service. If an Access Fee applies to a particular Service, you must pay the Access Fee in addition to any other applicable Cost Share for the Service. Access fees do not count toward meeting your Calendar-year Deductible or toward satisfaction of the Out-of-pocket Coinsurance Maximum.

Balance Bill

The Balance Bill refers to the amount you may be charged for the difference between a noncontracted provider's Billed Charges and the Allowed Amount. Any amounts paid for balance bills do not count toward deductible, Coinsurance, or the Out-of-pocket Coinsurance Maximum.

Except for Emergency Services, and Ancillary Services provided in an in-network facility, noncontracted Providers have no obligation to accept the Allowed Amount. You are responsible to pay a noncontracted provider's Billed Charges, even though BCBSAZ will reimburse your claims based on the Allowed Amount. Depending on what billing arrangements you make with a noncontracted Provider, the Provider may charge you for full Billed Charges at the time of Service or seek to Balance Bill you for the difference between Billed Charges and the amount that BCBSAZ reimburses you on a claim.

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. An individual Member cannot contribute more than his or her individual Calendar-year Deductible toward a family Calendar-year Deductible. When the family satisfies its Calendar-year Deductible, it also satisfies the deductible for all the individual members. If the amount of your Calendar-year Deductible increases on your annual renewal date, you must pay the additional deductible amount during the calendar year in which the increased deductible takes effect.

Carry Over Deductible

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

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

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

Coinsurance

Coinsurance is a percentage of the Allowed Amount that you pay for Covered Services after meeting any applicable deductible. BCBSAZ subtracts any applicable access fees or Prior Authorization Charges from the Allowed Amount before calculating Coinsurance. Coinsurance applies to every covered Service unless the specific benefit section says it does not apply. In most cases, your Coinsurance percentage is higher when you use an out-of-network Provider.

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.

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 Coinsurance Maximum (Individual & Family)

An Out-of-pocket Coinsurance Maximum is the amount each Member must pay as Coinsurance each year before BCBSAZ begins paying 100 percent of the Allowed Amount on most Covered Services with Coinsurance, for the remainder of the calendar year. You are still responsible for other types of Cost-share payments, even after you have met your Out-of-pocket Coinsurance Maximum.

The payments listed below do not count toward the Out-of-pocket Coinsurance Maximum. Other than the deductible, which must be met before Coinsurance applies, you must keep paying the following even after you have met your Out-of-pocket Coinsurance Maximum:

- Amounts above a benefit maximum
- Amounts for Medical Foods
- Any amounts for balance billing
- Any amounts for noncovered services
- Any charges for lack of Prior Authorization
- Coinsurance and copays for *"Pharmacy Benefit"* medications
- For plans with in-network Coinsurance, Coinsurance for 61 or more days of *"Inpatient Rehabilitation Services"* in a calendar year*
- For plans with in-network Coinsurance, Coinsurance for 91 or more days of skilled nursing services in a calendar year*
- Coinsurance for 366 or more days of *"Long-term Acute Care"**
- Copays for *"Specialty Medications"*
- Copays and access fees
- For plans with no in-network Coinsurance, Coinsurance for 121 or more days of *"Inpatient Rehabilitation Services"* received from in-network Providers and Coinsurance for days 61 or more of *"Inpatient Rehabilitation Services"* received from out-of-network Providers in a calendar year*
- For plans with no in-network Coinsurance, Coinsurance for 181 or more days of skilled nursing services received from in-network Providers and Coinsurance for days 91 or more of skilled nursing services received from out-of-network Providers in a calendar year*
- For plans with only an out-of-network Coinsurance maximum, Coinsurance for Ambulance Services

*Coinsurance for services submitted with a primary behavioral health diagnosis applies to the Out-of-pocket Coinsurance Maximum.

If you have family coverage, there is an Out-of-pocket Coinsurance Maximum for your family; amounts applied to each member's Out-of-pocket Coinsurance Maximum also apply to the family Out-of-pocket Coinsurance 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 Coinsurance Maximum, it also satisfies the Out-of-pocket Coinsurance Maximum requirements for all the individual members.

Prior Authorization Charges

If your out-of-network Provider does not obtain required Prior Authorization from BCBSAZ, you are subject to a Prior Authorization charge or complete loss of your benefit. Applicable Prior Authorization Charges are shown on your SBC. Amounts applied as Prior Authorization Charges do not count toward the Calendar-year Deductible or Out-of-pocket Coinsurance Maximum.

PROVIDERS

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 if you have any questions about a provider's network participation with BCBSAZ, please call Customer Service before you receive services.

Provider Eligibility and Network Status

Know your provider's network and eligibility status before you receive services. 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 following are examples of ineligible Providers: acupuncturists and doctors of naturopathy and homeopathy. Other Provider types may also be ineligible. 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 with BCBSAZ.

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

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

In-Network Providers (Contracted)

- In-network Providers are the following: (1) healthcare Providers licensed in the United States who have a PPO contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ members); and (2) out-of-state Providers licensed in the United States who have a PPO contract with a Host Blue plan.

- In-network Providers will file your claims with BCBSAZ or the Host Blue plan with which they are contracted. The provider's contract generally prohibits the Provider from charging more than the Allowed Amount for Covered Services. However, when there is another source of payment, such as liability insurance, all Providers may be entitled to collect their Balance Bill from the other source, or from proceeds received from the other source. The provider's contract does allow the Provider to charge you up to the provider's Billed Charges for noncovered services. We recommend that you discuss costs with the Provider before you obtain noncovered services.

- BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan directly reimburse in-network Providers for your benefit plan's portion of the Allowed Amount for Covered Services. You are responsible to pay your Member Cost Share directly to the Provider.

- Except for emergencies, in-network Providers must render Covered Services in the United States for the services to be considered in-network and subject to in-network Member Cost Share. If an in-network Provider renders Covered Services outside the United States, the Covered Services will be considered out-of-network and subject to out-of-network Member Cost Share, including balance bills (except for emergencies).

Out-of-Network Providers (Contracted and Noncontracted)

Out-of-network Providers are: (1) Providers who are contracted with BCBSAZ or a Host Blue plan as "Participating" only Providers; (2) Eligible Providers who have no contract with BCBSAZ or a Host Blue plan (Noncontracted Providers); and (3) Providers who are contracted with the Blue Cross Blue Shield Global® Care.

- *Participating-only Providers*

  Participating-only Providers are contracted with BCBSAZ or a Host Blue plan as "Participating" and are not contracted as PPO or preferred Providers. Participating-only Providers are out-of-network Providers. Participating-only Providers will submit your claims to the plan with which they are contracted. Except for Emergency Services, and Ancillary Services provided in an in-network facility, if you receive Covered Services from a Participating-only Provider, you will pay out-of-network deductible, Coinsurance, and access fees. However, you will not have to pay the Balance Bill because the Provider is contracted.

- *Noncontracted Providers*

  Eligible Providers who have no Provider participation agreement with BCBSAZ or any Host Blue plan are noncontracted Providers. Noncontracted Providers are out-of-network Providers. Except for Emergency Services, and Ancillary Services provided in an in-network facility, if you receive Covered Services from an eligible noncontracted Provider, you will pay out-of-network deductible, Coinsurance, access fees, and the Balance Bill. Noncontracted Providers may bill you up to their full Billed Charges. The difference between the noncontracted Provider's Billed Charges and payment under this Benefit Plan may be substantial. Please check with the noncontracted Provider regarding the amount of your financial responsibility before you receive services.

  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 out-of-network deductible, Coinsurance, and access fees (except for Emergency Services), plus the Balance Bill.

Provider Status and Payment – Summary Table Subject to all terms and conditions noted in this section.				
Provider Contract Status	**Network Status and Applicable Cost-Share**	**Provider Required to File Claim on Member's Behalf**	**Accept BCBSAZ Allowed Amount and do not Balance Bill**	**Payee for Reimbursement**
Providers contracted with BCBSAZ	In-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	In-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 Blue Shield Global Core	Out-of-network	Yes	No	Blue Cross Blue Shield Global Core reimburses the Provider the Allowed Amount less any Member Cost Share.
Noncontracted Providers for non-emergency or non-ancillary services rendered in an in-network facility (in and outside Arizona) (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 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.

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. Your savings may vary depending on your Benefit Plan and your chosen Provider. In this example, the Member has already satisfied the Calendar-year Deductible and has a 20 percent Coinsurance for an in-network Provider and 40 percent Coinsurance for an out-of-network Provider.

Billed Charges	**Allowed Amount**	**Financial Responsibility**	**In-Network Providers 20% Coinsurance**	**Out-of-Network (Noncontracted) Providers 40% Coinsurance**
$1,000	$400	BCBSAZ pays:	$320	$240
		You pay:	$ 80 Coinsurance	$160 Coinsurance +600 Balance Bill $760

Locating an In-Network Provider

Check the BCBSAZ Provider Directory at www.azblue.com to locate an in-network Provider who offers the services you are seeking, and contact the Provider for an appointment. If you cannot get an appointment with the in-network Provider, contact Customer Service at the number on your ID card.

Prior Authorization for Out-of-Network Providers

BCBSAZ does not guarantee that every Specialist or facility will be in our network. Not all Providers will contract with health insurance plans. If you believe or have been told there is no in-network Provider available to render Covered Services that you need, you may ask your treating Provider to request *"Prior Authorization for In-Network Cost Share for Services from an Out-of-Network Provider."* BCBSAZ will not issue Prior Authorization if we find that an in-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 in-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.

New Members

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 an in-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 an in-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 an in-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 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 access healthcare services outside the geographic area BCBSAZ serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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.

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 Covered 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.

When you receive Covered Services outside BCBSAZ's service area and the claim is processed through the BlueCard program, the amount you pay for Covered Services is calculated based on the lower of:
- The Billed Charges for Covered Services; or
- The negotiated price that the Host Blue makes available to BCBSAZ.

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

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

Special Cases: Value-Based Programs

BlueCard program

If you receive Covered Services under a value-based program inside a Host Blue's service area, you will not be responsible for paying the Provider for any of the Provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSAZ through average pricing or Fee Schedule adjustments. Additional information is available upon request. Provider incentives, risk-sharing and care coordinator fees are incorporated into the premium and/or contribution percentage members pay for coverage.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

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, BCBSAZ 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 Covered 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. In these situations, you may be responsible for the difference between the amount that the nonparticipating Provider bills and the payment BCBSAZ will make for the Covered Services as set forth in this paragraph. 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 Covered 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 BCBSAZ will pay for services provided by nonparticipating Providers. In these situations, you may be liable for the difference between the amount that the nonparticipating Provider bills and the payment BCBSAZ will make for the Covered Services as set forth in this paragraph.

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 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.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, 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. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- *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. Following the instructions on the claim form will help ensure timely processing of your claim. 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 in-network Cost Share, and the Allowed Amount will be based on Billed Charges. A cruise ship claim is not considered an out-of-country claim. Claims should be submitted and processed through BCBSAZ, not through the Blue Cross Blue Shield Global Core program. Please call the BCBSAZ 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 www.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 or location of Service is in-network;
- 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 In-Network Cost Share for Services from an Out-of-Network Provider

If there is no in-network Provider available to deliver Covered Services, your treating Provider may contact BCBSAZ and ask for Prior Authorization for the in-network Cost Share for services from an out-of-network Provider. BCBSAZ will evaluate whether there is an in-network alternative. If BCBSAZ determines that an in-network Provider is available to treat you, BCBSAZ will not provide Prior Authorization for in-network Cost Share for services from your out-of-network Provider of choice.

Prior Authorization for In-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 in-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 in-network Cost Share, your services will be subject to the in-network Cost Share. You will still be responsible for any Balance Bill, plus your in-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.

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.

A. AMBULANCE SERVICES

Your Cost Share: Deductible is waived. You pay 20 percent of the Allowed Amount. If your plan has an in-network Out-of-pocket Coinsurance Maximum, your Coinsurance counts toward this maximum.

Benefit Description: 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

Your Cost Share:

Professional services: Your Cost Share is waived for services from an in-network Provider. You pay deductible and out-of-network Coinsurance for services from an out-of-network Provider. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Facility charges: You pay deductible and applicable Coinsurance. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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:
- 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
- Other inpatient services required by federal or state law to be covered

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

Your Cost Share:

Professional services: Your Cost Share is waived for services from an in-network Provider. You pay deductible and out-of-network Coinsurance for services from an out-of-network Provider. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Facility charges: You pay deductible and applicable Coinsurance. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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:
- Diagnostic testing
- Medications, biologicals and solutions
- Room and board in a semi-private room or a standard private room (not deluxe) if the facility only has private rooms or if a private room is Medically Necessary
- Treatment and recovery rooms and equipment for Covered Services
- Other inpatient services required by federal or state law to be covered

Benefits are available for inpatient Behavioral Health Services that meet all the following criteria:
- A Physician or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- The facility has 24/7 onsite RN coverage;
- The facility has sufficient behavioral health professional staff to provide appropriate treatment;
- 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; and
- The facility's designated medical director is a Physician or registered nurse practitioner and provides direction for physical health services provided at the facility.

Benefit-Specific Exclusions (applicable to B.1 and B.2 above):
- Custodial Care
- Medications dispensed at the time of discharge from a hospital
- Respite Care

B.3 Outpatient Facility and Professional Services

Your Cost Share:

In-network: Your Cost Share is waived.

Out-of-network: You pay deductible and out-of-network Coinsurance. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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, 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

Your Cost Share:

In-network: Your Cost Share is waived.

Out-of-network: You pay deductible and out-of-network Coinsurance. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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

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

Benefit Description: Behavioral Therapy services for the treatment of Autism Spectrum Disorder are available for members who have been diagnosed with Autism Spectrum Disorder. 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
- 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

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. CANCER CLINICAL TRIALS

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

Benefit-Specific Definition: **"Eligible Cancer Clinical Trial"** means a Phase 1, 2, 3, or 4 clinical trial conducted for the prevention, detection, or treatment of cancer and also approved or funded by at least one of the following:
- 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
- Food and Drug Administration (FDA) reviewed investigational new drug application
- The U.S. Department of Defense
- The U.S. Department of Veterans Affairs
- A panel of qualified, recognized clinical research experts within an Arizona academic health institution

Benefit Description: Benefits are available for Covered Services directly associated with an Eligible Cancer Clinical Trial meeting all requirements specified by applicable 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 Eligible Cancer Clinical Trial to be covered, you or your Provider must inform BCBSAZ that you are enrolled in a cancer clinical trial, that the trial meets the

requirements of Arizona law, and that the services to be rendered are directly associated with the trial. Otherwise, BCBSAZ only covers Cancer 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 investigational medication (except as stated in *"Medications for the Treatment of Cancer"*) or device
- Costs and services customarily paid for by government, biotechnical, pharmaceutical, and device industry sources
- Costs of managing the research of the clinical trial
- Non-health services that might be required for a person to receive treatment or intervention, such as travel and transportation and lodging expenses
- Services otherwise not covered under this plan
- Treatment and services provided outside Arizona

D. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

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

Benefit Description: Benefits are available for outpatient Phase 1 and 2 Cardiac Rehabilitation programs and Pulmonary Rehabilitation services.

E. CATARACT SURGERY

Your Cost Share: You pay deductible and applicable Coinsurance for the Cataract Surgery and any associated services. The Cost-share amount will depend on the provider's network status. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Benefit Description: Benefits are available for the removal of cataracts. This includes the placement of a single intraocular lens at the time of the cataract removal. Following surgery, benefits are available for eyeglasses or external contact lenses. The eyeglasses or external contact lenses must be prescribed and purchased within 6 months of the surgery.

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

F. CHIROPRACTIC SERVICES

Your Cost Share: You pay deductible and applicable Coinsurance. Your Cost-share amount will depend on the provider's network status. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Benefit Description: Benefits are available for Chiropractic Services.

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

G. DENTAL SERVICES – MEDICAL

Not all dentists who are contracted with BCBSAZ 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

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

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

Benefit Description: Benefits are only available for the following services to repair or replace a Sound Tooth 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
- Other services required by federal or state law to be covered

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

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

Benefit Description: Benefits are available for Dental Services 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
- Other services required by federal or state law to be covered

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)

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

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

- Children 5 years or younger who, in the opinion of the treating dental Provider, cannot be safely treated in the dental office
- Intellectual disability
- Malignant hypertension
- 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 (DME), MEDICAL SUPPLIES, AND PROSTHETIC APPLIANCES AND ORTHOTICS

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

H.1 DME

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

- Be designed for appropriate 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, if applicable
- Repair costs that exceed the Allowed Amount for 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 permitted under current Evidence-based Criteria
- Blood glucose monitors
- Blood glucose 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; and
  - 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
  - Depth inlay or custom-molded along with inserts, for individuals with diabetes
- Podiatric appliances for prevention of complications associated with diabetes, including foot orthotic devices and inserts (therapeutic shoes: including Depth Shoes or Custom-molded Shoes, as defined below.) 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 three 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 (apply to 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, breast pumps, 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.
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for assistance in daily living, socialization, personal comfort, convenience, or other non-medical 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

I. EDUCATION AND TRAINING

Your Cost Share: See descriptions under subheadings.

I.1 Diabetes and Asthma Education and Training

Your Cost Share: Waived for services provided by an in-network Provider. You pay deductible and out-of-network Coinsurance for services provided and billed by out-of-network Providers. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Benefit Description: Benefits are available for diabetes and asthma Education and Training that meet the following criteria:
- Education and Training are provided in an outpatient setting (outpatient hospital, Physician office, or other Provider (excluding Home Health));
- Training is conducted in person or through telehealth services; and
- Your healthcare Provider prescribes the training as part of a comprehensive plan of care related to your condition to enhance therapy compliance and improve self-management skills and knowledge.

I.2 Nutritional Counseling and Training

Your Cost Share: Waived for services provided and billed by an in-network dietician, regardless of the location where services are provided. You pay a Physician visit Copay for services provided in an in-network physician's office or received during a home visit and billed by the in-network Physician. You pay deductible and in-network Coinsurance for services provided and billed by any other in-network Providers. You pay deductible and out-of-network Coinsurance for services provided and billed by out-of-network Providers. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Benefit Description: Nutritional counseling and training is available only for members diagnosed with the following conditions:
- Behavioral health
- Coronary artery disease
- Diabetes and pre-diabetes
- Eating disorders
- Heart failure
- High cholesterol
- Hypertension
- Obesity
- Renal failure/renal disease
- Other conditions required by federal or state law to be covered

J. EMERGENCY SERVICES

Your Cost Share: For Emergency Services, you pay your in-network Cost Share, even for services from out-of-network Providers.

Emergency room: You pay an emergency room Access Fee per Member, per facility, per day, plus deductible and in-network Coinsurance.

Admission to the hospital from the emergency room: The emergency room Access Fee is waived if you are admitted to the hospital as an inpatient. Following admission, you pay deductible and in-network Coinsurance for all hospital and professional services related to the emergency.

If you are admitted for observation or as an outpatient: You pay an emergency room Access Fee. You pay deductible and in-network Coinsurance 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.

Benefit-Specific Definitions: **"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.

"Teletrauma Consultation" means telephonic or electronic communications between Providers and video presentation of the member's condition between Providers, where all consulting Providers are located in facilities with the specialized equipment needed to facilitate Teletrauma communications.

"Trauma" means a physical wound or injury that results from a sudden accident or violent cause and which, if not immediately treated, is likely to result in death, permanent disability or severe pain.

Benefit Description: Benefits are available for services needed to treat an Emergency Medical Condition, and Teletrauma Consultation services that meet the following criteria:

- The Teletrauma Consultation is between a Provider at the facility where the Member is physically located and being treated and one or more Providers at certain level 1 trauma centers.
- The Member is receiving emergency treatment in a facility that is not equipped to handle the member's medical condition;
- The treating Provider needs the consultation to appropriately treat or stabilize the Member.

K. EOSINOPHILIC GASTROINTESTINAL DISORDER (EGID)

Your Cost Share:

Plans with in-network Coinsurance: Deductible is waived. You pay the lesser of applicable Coinsurance or 25 percent of the Cost of amino acid-based formula (**"Formula"**).

Plans without in-network Coinsurance: Deductible is waived. BCBSAZ pays 100 percent of the Allowed Amount for Formula purchased from in-network Providers. You pay the lesser of applicable Coinsurance or 25 percent of the Cost for Formula purchased from out-of-network Providers.

Benefit-Specific Definition: **"Cost"** is defined as either the Allowed Amount, if the Formula is purchased from an in-network Provider, or Billed Charges, if purchased from an out-of-network Provider.

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

- 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 registered nurse practitioner.

L. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

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

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

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices, even if the contraceptive method or device is FDA-approved and prescribed by a Physician or other Provider, including but not limited to condoms, sponges, and spermicides, except FDA-approved over-the-counter emergency contraceptives when prescribed by a Physician or other Provider.

M. HOME HEALTH AND HOME INFUSION – MEDICATION ADMINISTRATION THERAPY

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

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 the Pharmacy Benefit Customer Service number on your ID card.

Benefit-Specific Definition: **"Sole Source of Nutrition"** is defined as the inability to orally receive more than 30 percent 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
  - Total parenteral nutrition
- Physical Therapy, Occupational Therapy, and Speech Therapy
- 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

The services covered under this section must meet the following criteria:
- A healthcare Provider must order the services pursuant to a specific plan of home treatment;
- A licensed Home Health agency must provide the services;
- Services must be provided in the member's residence;
- The healthcare Provider must regularly review the appropriateness of the services ("regularly" means at least every 30 days or more frequently if appropriate under the treatment plan); and
- The services must be provided by an LPN, RN, or another eligible Provider.

Benefit-Specific Exclusions:
- Continuous Home Health services or shift nursing, including 24-hour continuous nursing care
- Custodial Care
- Respite Care

N. HOSPICE SERVICES

Your Cost Share: Deductible and Coinsurance are waived for in-network and out-of-network Hospice Services. If you receive services from a noncontracted Provider, you may pay the Balance Bill.

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

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, 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: When a Member elects to use the hospice benefit, it is in lieu of other medical benefits available under this plan, except for care unrelated to the terminal illness or related complications. The hospice agency determines the required level of care, which is subject to the medical necessity provision of the Benefit Plan. Once the Member selects the hospice benefit, the hospice agency coordinates all of the member's 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

O. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

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

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

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

P. INPATIENT HOSPITAL

Your Cost Share: You pay deductible and applicable Coinsurance for all inpatient admissions. You pay an Access Fee for all bariatric surgeries, in addition to deductible and applicable Coinsurance. See your SBC for the amount of the Access Fee, which applies toward the professional charges for the Bariatric Surgery. The Cost-share amount will depend on the provider's network status. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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
- Diagnostic testing, including radiology, laboratory services, and biomarker testing
- General, spinal, and caudal anesthetic provided in connection with a covered Service
- In-network benefits are available for covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction Center
- 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.

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

Your Cost Share:

In-network:
Plans without in-network Coinsurance: You pay deductible for the first 120 days of services in a calendar year. You pay deductible and 50 percent Coinsurance for services received after the first 120 days of care in a calendar year. Your Coinsurance payments do not count toward any Out-of-pocket Coinsurance Maximum. However, for claims submitted with a primary behavioral health diagnosis, you pay deductible.

Plans with in-network Coinsurance: You pay deductible and in-network Coinsurance for the first 60 days of services in a calendar year. You pay deductible and 50 percent Coinsurance after the first 60 days in a calendar year, regardless of whether you have met your applicable Out-of-pocket Coinsurance Maximum. However, for claims submitted with a primary behavioral health diagnosis, you continue to pay Deductible and in-network Coinsurance after the first 60 days of services in a calendar year. Such services count toward the Out-of-pocket Coinsurance Maximum.

Out-of-network: You pay deductible and out-of-network Coinsurance for the first 60 days of services in a calendar year. You pay deductible and 50 percent Coinsurance after the first 60 days in a calendar year, regardless of whether you have met your applicable Out-of-pocket Coinsurance Maximum.

Your 50 percent Coinsurance after the first 60 days of services in a calendar year, does not count toward any Out-of-pocket Coinsurance Maximum. However, for claims submitted with a primary behavioral health diagnosis, you continue to pay deductible and out-of-network Coinsurance after the first 60 days of services in a calendar year. Such services count toward the Out-of-pocket Coinsurance Maximum. If you receive EAR services at a noncontracted Provider, you also pay the Balance Bill, in addition to deductible and applicable Coinsurance.

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, and which meets the following criteria:

- A Physician or registered nurse 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 registered nurse 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

R. LONG-TERM ACUTE CARE (INPATIENT)

Your Cost Share: You pay deductible and applicable Coinsurance for the first 365 days of services. The Cost-share amount for the first 365 days of services will depend on the provider's network status. After you receive 365 days of Long-term Acute Care services, you pay deductible and 50 percent Coinsurance for services from in-network and out-of-network Providers, regardless of whether you have met your Out-of-pocket Coinsurance Maximum. Your 50 percent Coinsurance does not count toward the Out-of-pocket Coinsurance Maximum. However, for claims submitted with a primary behavioral health diagnosis, you continue to pay deductible and applicable Coinsurance after the first 365 days of services. Such services count toward the Out-of-pocket Coinsurance Maximum. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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:
- Domiciliary Care
- Medications dispensed at the time of discharge from the facility

S. MATERNITY

Your Cost Share:

In-network: BCBSAZ pays 100 percent of the delivering provider's Global Charge. For other services, you pay deductible and any applicable in-network Coinsurance.

*Out-of-network: Y*ou pay deductible and out-of-network Coinsurance. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Your Cost-share obligations may be affected by the automatic addition of a newborn or adopted child, as described in the "*Plan Administration"* section of this book. If you have coverage only for yourself and no Dependents, automatic addition of a child will result in a change from individual coverage to family coverage, 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 be required to meet a family deductible and Out-of-pocket Coinsurance Maximum.

Benefit-Specific Definition: **"Global Charge"** A fee charged by the delivering Provider that may include certain prenatal, delivery, and postnatal services.

Benefit Description: Maternity benefits are available for Covered Services related to pregnancy. This includes certain screening tests such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases, and others, as determined by BCBSAZ. Certain tests, including some genetic screening, may not be covered. For a complete listing of covered prenatal screening, please call Customer Service at the number on your ID card.

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 1 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.

T. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Your Cost Share:

Plans with in-network Coinsurance: Deductible is waived. You pay the lesser of applicable Coinsurance or 50 percent of the Cost of Medical Foods.

Plans without in-network Coinsurance: Deductible is waived. BCBSAZ pays 100 percent of the Allowed Amount for Medical Foods purchased from in-network Providers. You pay the lesser of applicable Coinsurance or 50 percent of the Cost for Medical Foods purchased from out-of-network Providers. Your payments for Medical Foods do not count toward any out-of-pocket coinsurance maximums.

Benefit-Specific Definitions: **"Cost"** is defined as either the Allowed Amount, if the Member buys the Medical Foods from an in-network Provider, or Billed Charges, if the Member buys the Medical Foods from an out-of-network Provider.

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

"Medical Foods" means modified low protein foods and metabolic formulas that are all of the following:
- Administered for the medical and nutritional management of a Member who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation;
- Essential to the member's optimal growth, health, and metabolic homeostasis;
- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an MD, DO, or a registered nurse 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 disorders.

Benefit-Specific Exclusions:
- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available for purchase without a prescription or order from an MD, DO, or registered nurse practitioner
- Foods and formulas that do not require supervision by an MD, DO, or a registered nurse practitioner
- Food thickeners, baby food, or other regular grocery products
- Medical food benefits are not available for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
- 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 registered nurse practitioner;
- The amount paid for the Medical Foods;
- The dated receipt or other proof of purchase; and
- The name, telephone number and address of the medical food supplier.

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 in the Customer Service section of this book. Medical Foods also may be covered under the *"Home Health and Home Infusion – Medication Administration Therapy"* benefit. Medical Foods are not covered under the *"Pharmacy Benefit"* or the *"Specialty Medications"* benefits.

U. MEDICATIONS FOR THE TREATMENT OF CANCER

Your Cost Share: You pay applicable deductible, Coinsurance, and copays. The Cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted Provider, you also pay the Balance Bill. For cancer treatment medications that are also classified as Specialty Medications, you pay the tier 1 retail/mail order pharmacy Copay. BCBSAZ determines which cancer treatment medications are classified as Specialty Medications. Copays do not apply to deductibles or out-of-pocket coinsurance maximums.

For certain cancer treatment medications, as determined by BCBSAZ, you will receive a 15-day supply, and pay one-half of the tier 1 retail/mail order pharmacy Copay the first time you receive the medication. You will be able to refill the medication every 15 days, and you will continue to pay one-half of the tier 1 Copay for each refill during your first 3 months of treatment with the medication. If you experience side effects from the medication during the 3-month period, your prescribing Provider may change your medication. If you tolerate the medication, you will be able to refill the Cancer Treatment Medication for up to 30 days after 3 months of treatment.

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 number on your ID card.

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

Benefit Description: Benefits are available, to the extent required by applicable state law, for off-label use of prescription medications and services directly associated with the administration of Medications for the Treatment of Cancer. All other applicable benefit limitations and exclusions will apply to this benefit. In administering claims for an Off-label Prescription Medication, BCBSAZ does not represent or warrant that the prescribed medication is safe or effective for the purpose for which your treating Provider has prescribed the medication.

Decisions regarding whether the medication is safe and effective for the type of cancer for which it has been prescribed and whether it is appropriate for you, are decisions to be made by your Provider using his or her independent medical judgment. If the medication is subject to 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.

V. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

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

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

W. OUTPATIENT SERVICES

Your Cost Share: You pay deductible and applicable Coinsurance. The Cost-share amount will depend on the provider's network status. If you receive services from a noncontracted Provider, you also pay the Balance Bill. You pay an Access Fee for all bariatric surgeries, in addition to deductible and applicable Coinsurance and any Balance Bill for a noncontracted Provider. The Access Fee applies toward the professional charges for Bariatric Surgery. You may be responsible for separate professional and facility charges. Cost Share is waived for diagnostic laboratory services received at an in-network clinical laboratory. Deductible is waived for diagnostic mammography services received from an in-network Provider.

Benefit Description: Benefits are available for the following Outpatient Services, including but not limited to any services that would be covered if performed as an inpatient Service:

- Blood transfusions, whole blood, blood components, and blood derivatives
- Diagnostic testing, including radiology, laboratory services, and biomarker testing
- Dialysis
- In-network benefits are available for covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction Center
- Maternity services provided in birthing centers
- Medications and the administration of medications in an outpatient setting
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant
- Surgery and other invasive procedures
- Other Outpatient Services required by federal or state law to be covered

X. 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 medication 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; or
- Other information about this Pharmacy Benefit.

Your Cost Share: You pay a tier 1, 2, 3, or 4 prescription Copay for most medications. You pay the greater of the tier 3 Copay or 50 percent Coinsurance for Compounded Medications. If you obtain medications from a noncontracted pharmacy, you also pay the Balance Bill. Pharmacy Copay, Coinsurance, and Balance Bill payments do not apply toward deductibles or out-of-pocket coinsurance maximums. 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.

Some pharmacies may charge you a lower price if the pharmacy's regular price for the medication is less than your Copay. If your prescription exceeds BCBSAZ quantity limits, your total Cost Share may be higher than the amount of your Copay.

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 the Pharmacy Benefit Customer Service number on your ID card.

If you are taking two 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 any early or short refills of those medications.

Additional information about medication tiers
Copays are 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. Many medications and the tier to which BCBSAZ has assigned the medication are available at www.azblue.com or by calling the Pharmacy Benefit Customer Service at the number on your ID card. You or your Provider may contact BCBSAZ to check on the status of a medication.

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, even if the prescribing Provider indicates on the prescription that the brand-name medication should be dispensed. 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.

No exceptions will be made concerning the assigned tier of a medication or the Copay or Coinsurance that will apply, regardless of the medical reasons requiring use of a particular medication. This means if you are taking a tier 2, 3, 4, or compounded medication, you pay the applicable Cost Share for the tier 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. The assignment of a medication to any particular tier is not a recommendation on the use of a medication.

Benefit-Specific Definitions: **"Compounded Medications"** are medications that contain at least one 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 those 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.

"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 Description: Benefits are available for prescription medications that meet the following criteria:
- The medication is not excluded by a different provision in this plan;
- 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; 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 retail pharmacies or the in-network mail order pharmacy. Certain vaccines are covered when obtained from in-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. Compounded Medications must be obtained from pharmacies that have been credentialed by BCBSAZ (or BCBSAZ's vendor) to dispense Compounded Medications. Please call Pharmacy Benefit Customer Service number on your ID card for a list of pharmacies credentialed to dispense Compounded Medications.

Prescription medications are subject to BCBSAZ limitations, including but not limited to quantity, age, gender and refill limits. BCBSAZ prescription medication limitations are subject to change at any time without prior notice. You can check the list of prescription medications subject to BCBSAZ prescription medication limitations at www.azblue.com or by calling the Pharmacy Benefit Customer Service at the number on your ID card.

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.

Members or Providers can ask BCBSAZ to review coverage of a medication when the use of the medication exceeds or differs from BCBSAZ prescription medication limitations by contacting the Pharmacy Benefit Customer Service number on your ID card. There is no guarantee that a review will result in coverage of a medication or an increase in quantity. Certain medications are not Medically Necessary unless the Member participates in the Step Therapy program.

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 over-the-counter contraceptive methods and devices, even if the contraceptive method or device is FDA-approved and prescribed by a Physician or other Provider, including but not limited to condoms, sponges, and spermicides, except FDA-approved over-the-counter emergency contraceptives when prescribed by a Physician or other Provider.
- Biological 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.
- Medications, devices, equipment, and supplies lawfully obtainable without a prescription
- 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 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. See the “Other Forms and Resources” section within the pharmacy information on www.azblue.com 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
- Medications obtained from an out-of-network mail order pharmacy
- Medications packaged with one other or multiple other prescription products
- Medications packaged with over-the-counter medications, supplies, vitamins, or other excluded products
- Medications to improve or achieve fertility or treat infertility
- Medications used for any Cosmetic purpose
- Medications used to treat a condition not covered under this plan
- Medications 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. See the “Other Forms and Resources” section within the pharmacy information on www.azblue.com 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

- Smoking cessation medications and devices of any kind
- Specialty Medications, as defined by BCBSAZ

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

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

Benefit-Specific Definitions: **"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, and ST services related to a specific illness or injury.

Benefit-Specific Exclusions:
- Activity therapy and milieu therapy, including community immersion or integration, home independence and work re-entry therapy, or any care intended to assist an individual in the activities of daily living or for comfort and convenience, except for limited hospice benefits
- Cognitive therapy
- Custodial Care
- Massage therapy
- Services rendered after a Member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to improve or maintain posture
- Services to prevent future injury
- Services to prevent regression to a lower level of function
- Strength training, cardiovascular endurance training, fitness programs, strengthening programs, and other services designed primarily to improve or increase strength

Z. PHYSICIAN SERVICES

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

Benefit Description: Benefits are available for the following:
- Abortifacient medications, including oral medications as described in current Evidence-based Criteria
- FDA-approved diaphragms, cervical caps, and cervical shields
- FDA-approved emergency contraception
- FDA-approved implanted contraceptive devices
- FDA-approved patches, rings, and contraceptive injections
- Inpatient medical visits
- Medications and the administration of medications in an outpatient setting
- Office, home, or walk-in clinic visits (Urgent Care facilities are not walk-in clinics) for diagnosis and treatment of a sickness or injury
- Professional Physician Services for FDA-approved sterilization procedures
- Professional Physician Services for fitting, implantation, and/or removal of FDA-approved contraceptive devices
- Second diagnostic surgical opinions
- Surgical procedures (including assistance at surgery). Only certain surgical assistants are Eligible Providers. 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 in-network Providers.
- Other services required by federal or state law to be covered

Multiple surgical procedures may be performed during a single operative session. In general, covered secondary procedures are reimbursed at reduced levels. Noncontracted Providers may Balance Bill you 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 those services or supplies are rendered and billed by a Provider other than your Physician, you will pay the Cost Share applicable to the billing Provider, in addition to the Cost Share for your office visit. Examples of services or supplies from another Provider include Durable Medical Equipment from a medical supply company, Specialty Medications provided by a pharmacy, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices, even if the contraceptive method or device is FDA-approved and prescribed by a Physician or other Provider, including but not limited to condoms, sponges, and spermicides, except FDA-approved over-the-counter emergency contraceptives when prescribed by a Physician or other Provider.

AA. POST-MASTECTOMY SERVICES

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

Benefit Description: Benefits are available, 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 mastectomy-related benefits, coverage, as described above under *"Benefit Description,"* will be provided in a manner determined in consultation between the attending Physician and the Member being treated. These benefits are provided subject to the same deductibles and Coinsurance generally applicable to other medical and surgical benefits provided under this plan, as described above in *"Your Cost Share"* and in the SBC for this Benefit Plan. If you would like more information on WHCRA benefits, call Customer Service at the number on your ID card.

BB. PREGNANCY, TERMINATION

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

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

- The fetus is or will be nonviable, as defined by current Evidence-based Criteria; or
- The treating Provider certifies in writing the abortion is Medically Necessary because the pregnancy would endanger the life or health of the mother.

Benefits are also available for abortifacient medications, including some oral medications as described in current Evidence-based Criteria.

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

CC. PREVENTIVE SERVICES

Your Cost Share:

In-network: Deductible is waived. You pay any applicable in-network Coinsurance.

Out-of-network mammography services: Deductible is waived. You pay out-of-network Coinsurance. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Out-of-network (except mammography services): You pay deductible and out-of-network Coinsurance. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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

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

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

1. Preventive physical examination, i.e. routine physical examination, including the following services when done for screening purposes only:
    a. Lung function test (spirometry)
    b. Vision and hearing screening (this may include newborn audiological evaluation in the hospital)
    c. Fecal occult blood test
    d. General health laboratory panel (bilirubin, calcium, carbon dioxide, chloride, creatinine, alkaline phosphatase, potassium, total protein, sodium, ALT, SGPT, AST, SGOT, BUN, TSH)
    e. Thyroid function testing (TSH)
    f. Complete blood count (CBC)
    g. Lipid panel (cholesterol panel and triglycerides)
    h. Fasting glucose (blood sugar)
    i. Urinalysis
    j. Blood lead
    k. Sexually transmitted disease (STD) testing
    l. Prostate specific antigen (PSA)
    m. TB testing
2. Screening for abdominal aortic aneurysm for members ages 65 to 75 who have ever smoked
3. Routine gynecologic exam including Pap test and other cervical cancer screening test
4. Mammogram
5. Bone density testing for osteoporosis
6. Screening sigmoidoscopy and colonoscopy, including related anesthesia services and prescription prep kits
7. Routine immunizations and immunizations for foreign travel, as determined by BCBSAZ
8. Any other preventive Service required by federal or state law to be covered

Benefit-Specific Exclusions:
- Abortifacient medications
- All over-the-counter contraceptive methods and devices, even if the contraceptive method or device is FDA-approved and prescribed by a Physician or other Provider, including but not limited to condoms, sponges, and spermicides, except FDA-approved over-the-counter emergency contraceptives when prescribed by a Physician or other Provider.
- Any Service or test not specifically listed in this benefit description, such as chest X-rays, will not be covered when performed for preventive or screening purposes.

Services or tests listed under this benefit and provided to a Member with a specific diagnosis, signs, or symptoms of a condition or disease for which the test is being performed may be covered through another benefit section of this plan.

DD. RECONSTRUCTIVE SURGERY AND SERVICES

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

Benefit Description: Benefits are available for 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
- Therapeutic intervention
- Other services required by federal or state law to be covered

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, Medically Necessary breast implant removal, or surgery to correct a congenital defect. This exclusion does not apply to services required by federal or state law to be covered.

EE. SKILLED NURSING FACILITY (SNF)

Your Cost Share:

In-network:
Plans without in-network Coinsurance: You pay deductible for the first 180 days of services in a calendar year. You pay deductible and 50 percent Coinsurance for services received after the first 180 days of care in a calendar year. Your Coinsurance payments do not count toward any Out-of-pocket Coinsurance Maximum. However, for claims submitted with a primary behavioral health diagnosis, you continue to pay deductible after the first 180 days of services in a calendar year.

Plans with in-network Coinsurance: You pay deductible and in-network Coinsurance for the first 90 days of services in a calendar year. You pay deductible and 50 percent Coinsurance after the first 90 days of services in a calendar year, regardless of whether you have met your applicable Out-of-pocket Coinsurance Maximum. However, for claims submitted with a primary behavioral health diagnosis, you continue to pay deductible and in-network Coinsurance after the first 90 days of services in a calendar year. Such services count toward the Out-of-pocket Coinsurance Maximum.

Out-of-network: You pay deductible and out-of-network Coinsurance for the first 90 days of services in a calendar year. You pay deductible and 50 percent Coinsurance after the first 90 days of services in a calendar year, regardless of whether you have met your Out-of-pocket Coinsurance Maximum.

Your 50 percent Coinsurance after the first 90 days of services in a calendar year does not count toward any Out-of-pocket Coinsurance Maximum. However, for claims submitted with a primary behavioral health diagnosis, you continue to pay deductible and out-of-network Coinsurance after the first 90 days of services in a calendar year. Such services count toward the Out-of-pocket Coinsurance Maximum. If you receive SNF services at a noncontracted Provider, you also pay the Balance Bill, in addition to deductible and applicable Coinsurance.

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 registered nurse 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 registered nurse 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:
- Custodial Care
- Domiciliary Care
- Medications dispensed at the time of discharge from the facility

FF. SPECIALTY MEDICATIONS

Your Cost Share: You pay a tier A, B, C or D Copay for most medications.

If a Member obtains a specialty medication from an eligible Provider other than a pharmacy contracted with BCBSAZ for the Specialty Medications benefit ("Specialty Pharmacy"), the medication may be covered under another benefit and subject to the cost-sharing provisions and Prior Authorization requirements of that benefit, rather than the cost-sharing provisions and Prior Authorization requirements applicable under this benefit.

If you are taking two 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 any early or short refills of those medications.

Additional information about medication tiers
Copays are 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 a list of contracted specialty pharmacies and the specialty medication list. To confirm the status and tier of a particular specialty medication, you may also call the Pharmacy Benefit Customer Service at the number on your ID card.

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.

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. Go to www.azblue.com to view a list of contracted specialty pharmacies and the specialty medication list. To confirm the status and tier of a particular specialty medication, you may also call Pharmacy Benefit Customer Service number on your ID card. Specialty Medications are subject to limitations contained in current Evidence-based Criteria and Pharmacy Coverage Guidelines, and may change at any time without prior notice.

If you are currently obtaining a specialty medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit Customer Service number on your ID card. BCBSAZ will decide whether you are eligible to receive the specialty medication from a retail pharmacy instead of a Specialty Pharmacy.

Benefit-Specific Exclusions:
- All benefit-specific exclusions listed under *"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

Your Cost Share:

In-network telehealth medical: You pay deductible and in-network Coinsurance.

In-network telehealth counseling or telehealth psychiatry: Your Cost Share is waived.

Out-of-network: Not covered.

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 Telehealth Services, 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 – In-network Providers"* benefit
- Services not provided through the TSA

HH. TELEHEALTH SERVICES – IN-NETWORK PROVIDERS

Your Cost Share: You pay Cost-share amounts applicable to the services provided via Telehealth Services from In-network Providers. You will always pay in-network Cost Share for Emergency Services provided via this Telehealth Services benefit. Cost Share applies for the Service provided at your physical location, and also for the Service rendered remotely by the telehealth Provider. To illustrate: if you are in a PCP's office and receiving a consultation from a remote Specialist, you will pay the Cost Share applicable for a PCP office visit and the Cost Share applicable for a Specialist office visit or consultation. If you are at home and receiving a consultation from a remote Specialist, you would pay only the Cost Share for the Specialist because no other Provider is involved at your location.

Benefit Description: Benefits are available for Telehealth Services delivered by an in-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

II. TRANSPLANT OR GENE THERAPY TRAVEL AND LODGING

Your Cost Share: Not applicable.

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

Benefit-Specific Maximum: Maximum of $10,000 per Member, per transplant or gene therapy treatment. Covered expenses incurred by a donor or Caregiver 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:

- The expenses are incurred by the Member, donor, or Caregiver;
- 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;
- For transplant coverage, the Member or donor must be receiving Medically Necessary pre- and post-operative treatments, including without limitation, treatment of complications related to the covered transplant or routine follow-up care for a covered transplant or a transplant that occurred while the Member was covered by another insurance plan; and
- The expenses are for any of the following:
  - 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
  - Other expenses required by federal or state law to be covered.

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
- 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 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

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

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: In-network benefits are available for covered transplant services from in-network Providers, including Blue Distinction Centers for Transplants. 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
- Other services required by federal or state law to be covered

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 Medically Necessary 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
- Other services required by federal or state law to be covered

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. URGENT CARE

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

Benefit-Specific Definition: **"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." Please be aware that the BCBSAZ network includes some Providers, such as hospitals, that offer Urgent Care services, but are not specifically contracted with BCBSAZ as Urgent Care Providers. No matter what the circumstances, if you obtain Urgent Care services at a hospital or a hospital's on-site Urgent Care department, you will be responsible for the applicable emergency room Cost Share.

LL. VISION EXAMS (ROUTINE)

Your Cost Share: You pay a Routine Vision Exam Copay per Member, per Provider, per day for an exam by an in-network vision care Provider. If you receive the exam from an out-of-network vision care Provider, you pay deductible and out-of-network Coinsurance. If you receive services from a noncontracted Provider, you also pay the Balance Bill. If a medical condition is identified during your Routine Vision Exam, you will be responsible for the applicable Cost Share, as described in the *"Physician Services"* section of this book.

Benefit-Specific Definition: A **"Routine Vision Exam"** is an exam generally performed to determine the need for corrective lenses.

Benefit Description: Benefits are available for Routine Vision Exams. Routine Vision Exam services do not have to meet the medical necessity requirement.

Benefit-Specific Exclusions:
- Medical eye exams (such exams may be covered through another benefit of this plan)
- Eyeglasses, contact lenses, and other eyewear services

WHAT IS NOT COVERED

Notwithstanding any other provision in this Benefit 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:

Abortions – Non-spontaneous, medically-induced abortions (by surgical or non-surgical means), except as stated in the *"Pregnancy, Termination"* section of this book

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

Acupuncture

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

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

Biofeedback

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

Certain Types of Facility Charges – Inpatient and outpatient facility charges for treatment provided by 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

Complications of Noncovered Services – Complications and consequences, whether immediate or delayed, arising from any condition or Service not covered under 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, or surgery to correct a congenital defect.

Cosmetics and health and beauty aids

Counseling – Counseling and behavioral modification services, except as stated in the *"Behavioral Health Services,"* the *"Education and Training,"* the *"Hospice Services,"* the *"Preventive Services,"* and the *"Telehealth Services – BlueCare Anywhere"* sections of this book

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

Custodial Care

Dental – Except as stated in the *"Dental Services – Medical"* section of this book, 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 the *"Eosinophilic Gastrointestinal Disorder (EGID)"* and the *"Medical Foods for Inherited Metabolic Disorders"* sections of this book

Domiciliary Care

Expenses for services that exceed benefit limitations

Experimental or Investigational Services or Items

Fees – a) other than for medically appropriate, in-person, direct member services; b) for concierge medicine services; or c) for direct primary care

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

Flat Feet – Services for treatment of flat feet, weak feet, and fallen arches. This exclusion does not apply to arch supports when Medically Necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg.

Foot Care – Services for foot care, including trimming of nails or treatment of corns and calluses. This exclusion does not apply when medically appropriate for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg.

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

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)

Habilitation Services, except for certain limited services to treat Autism Spectrum Disorder

Hearing Aids and Associated Services – Routine hearing exams, hearing aids, including external, semi-implantable middle ear, and implantable bone conduction hearing aids, and any associated services. Hearing screenings are covered as part of a preventive physical exam.

Hypnotherapy

Inpatient or Outpatient Non-acute Long-term Care

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

Lodging and Meals, except as stated in the *"Transplant or Gene Therapy Travel and Lodging"* section of this book

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

Manipulation of the spine under anesthesia

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

Massage Therapy

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
- Not used in accordance with current Evidence-based Criteria or Pharmacy Coverage Guidelines
- Off-label, unlabeled, and orphan medications, except as stated in the *"Pharmacy Benefit"* section of this book
- 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

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

Over-the-counter Items – Medications, devices, equipment, and supplies that are lawfully obtainable without a prescription, except as stated in the *"Durable Medical Equipment (DME), Medical Supplies, and Prosthetic Appliances and Orthotics,"* the *"Eosinophilic Gastrointestinal Disorder (EGID),"* the *"Medical Foods for Inherited Metabolic Disorders,"* and the *"Preventive Services"* sections of this book

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

Private Duty Nursing

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

Reversal of 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 the *"Preventive Services"* section of this book, 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 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 the administration of drugs that can be self-administered, except when medically necessary

Services for Weight Loss and Gain, except as stated in the *"Education and Training,"* the *"Inpatient Hospital"* and the *"Outpatient Services"* sections of this book related to bariatric surgeries, and the *"Preventive Services"* sections of this book

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 the *"Termination of Coverage"* section of this book

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 all medications for the treatment of sexual dysfunction

Smoking Cessation programs, medications, aids, and devices

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

Telephonic and Electronic Consultations – Telephonic and electronic consultations, except as stated in the *"Telehealth Services – BlueCare Anywhere"* and the *"Telehealth Services – In-Network Providers"* sections of this book

Therapy services, except as stated in this plan

Training and Education, except as stated in the *"Behavioral Health Services,"* the *"Education and Training,"* the *"Physical Therapy (PT) – Occupational Therapy (OT) – Speech Therapy (ST),"* and the *"Preventive Services"* sections of this book

Transportation – Transport services and travel expenses, except as stated in the *"Ambulance Services"* and the *"Transplant or Gene Therapy Travel and Lodging"* sections of this book

Vision – Vision therapy; all types of refractive keratoplasties; any other procedures, treatments, and devices for refractive correction; eyeglasses, contact lenses, and other eyewear; vision examinations for fitting of eyeglasses and contact lenses, except as stated in the *"Cataract Surgery"* and the *"Vision Exams (Routine)"* sections of this book

Vitamins – All vitamins, minerals, and trace elements that are lawfully obtainable without a prescription

Wigs and Hairpieces, except as stated in the *"Durable Medical Equipment (DME), Medical Supplies, and Prosthetic Appliances and Orthotics"* section of this book

Workers' Compensation – Services to treat illnesses and injuries that are (1) covered by workers' compensation; and (2) 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.

CLAIMS INFORMATION

Filing Claims

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

If you pay a Provider on a direct pay basis and submit a receipt to BCBSAZ, BCBSAZ will credit your deductibles and out-of-pocket coinsurance 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 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
- Signature of Provider who rendered services

Medical Records and Other Information Needed to Process a Claim

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

Explanation of Benefits (EOB) Form 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 in-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:

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

Pharmacy Prescriptions; Submission of Claims by Members

When you submit a prescription to 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 utilized by members, Providers, and pharmacies to reduce out-of-pocket Member costs associated with prescription medications. When coupons, patient assistance programs, or other discount programs are utilized to obtain a covered medication under your BCBSAZ *"Pharmacy Benefit,"* any cost sharing amounts paid by another person on behalf of the Member for a covered medication will be applied to the member's deductible and Out-of-pocket Coinsurance Maximum if the medication is:

- A covered medication without a generic equivalent, or
- A covered medication with a generic equivalent and Member has obtained access to the covered medication drug through:
  - Prior Authorization
  - Step Therapy
  - BCBSAZ Appeal Process

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 and the date by which a determination can be expected. If the extension is necessary to obtain additional information, the extension notice will describe the information needed. You or your Provider will have at least 45 days to submit the 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 and the date by which a determination can be expected. If the extension is necessary to obtain additional information, the

extension notice will describe the information needed. You and your Provider will have at least 45 days to submit the 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.

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 BCBSAZ 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) coverage during the term of this contract 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 noncustodial 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 percent of the amount BCBSAZ would have paid if you had no other coverage. BCBSAZ does not coordinate benefits with non-group coverage provided by an insurance plan other than BCBSAZ. BCBSAZ does not coordinate benefits for services covered by the *"Pharmacy Benefit."* For this benefit, BCBSAZ will pay primary, without regard to the member's other coverage.

Definitions Related to Eligibility and Administration

"Dependents" are the following individuals: (1) the contract holder's spouse under a legally valid existing marriage; and (2) the contract holder's children or the children of the contract holder's spouse, including natural children, legally adopted children, step-children, children placed for adoption, children under legal guardianship substantiated by a court order and children who are entitled to coverage under a medical support order. To qualify for coverage, a dependent must satisfy applicable eligibility rules, such as payment of any required premium.

"Disabled Dependent Child" is a child who has reached age 26 and who meets criteria for coverage under this plan described in *"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. The Plan Administrator will notify the Contract Holder if the Group has established such an Open Enrollment period. Contract holders and Dependents can change benefit plans only during an Open Enrollment period, except as set forth in this Benefit Book.

Eligibility Requirements

- 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 are eligible for dependent coverage until their 26th birthday.

- Disabled Dependent Children – A child who has reached age 26 may continue coverage as a dependent under this plan if the child is otherwise eligible for the plan and meets all of the following criteria:
  - Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;
  - Is 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.

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. See your SBC for Contract Holder effective date.

- Dependent – Dependent coverage is available only if an eligible Contract Holder has enrolled for coverage. Eligible Dependents will have the same effective date as the Contract Holder if they are included on the application at the time the Contract Holder first enrolls. If the Contract Holder and/or Dependents do not enroll when first eligible, the Contract Holder and/or Dependents may only apply for coverage at the group's annual Open Enrollment period, except as stated in *"Special Enrollment 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, as long as 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."*

- 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 and the Contract Holder will be responsible for any additional premium, unless the Contract Holder notifies BCBSAZ in writing to remove the newborn or adopted child from this Benefit Plan. Even if no additional premium is required (e.g., you already have family coverage), the Contract Holder must notify BCBSAZ in writing to remove the child from the Benefit Plan. Contact Customer Service at the number 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

The date eligibility ends is not necessarily the date coverage ends under the Benefit Plan. Coverage for contract holders and Dependents ends in accordance with the requirements of the Group Master Contract. 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.

Contract Holder eligibility ends on the following days:
- The last day for which the Contract Holder was entitled to receive compensation from the Group, regardless of the date such compensation is actually paid, and for which BCBSAZ has received premium, as set forth in the Group Master Contract.
- The date an approved Leave of Absence expires, if the Contract Holder fails to return to active employment.
- The date of death.

Dependent eligibility ends on the following days:
- For a dependent spouse and any children of that spouse who are not the natural or adopted children of the Contract Holder, the date of the final divorce decree.
- The birthday the child turns age 26, if the child is not a Disabled Dependent child.
- The date disability or dependency ceases for a Disabled Dependent child over age 26.
- The date a child covered by a medical support order is no longer eligible under the court order or administrative order.
- The date of the contract holder's death or as might otherwise be provided in the Group Master Contract.

Date of Termination of Coverage

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

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

Contract holders' and/or dependents' coverage ends no later than the date the Group Master Contract terminates. When a contract holder's coverage terminates, coverage for all Dependents also terminates. Members may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Members may also apply to BCBSAZ for an individual conversion contract.

Special Enrollment Periods

If a Contract Holder or dependent does not enroll when first eligible, the Contract Holder or dependent may enroll for coverage other than at Open Enrollment if he or she meets the following criteria:

- The person requests coverage under this Benefit Plan by completing an application within 60 days of either of the following:
  - The person loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP); or
  - The person receives notice that he or she is eligible for a CHIP premium assistance subsidy; or
- At the time of the initial enrollment period, the Employee or dependent: (1) was covered under a public or private health insurance policy or other health Benefit Plan; (2) lost coverage under the other policy or plan for one or more of the reasons listed below, as applicable to the individual seeking coverage; and (3) requests coverage under this Benefit Plan by completing an application within 31 days of the loss of other coverage:
  - Dependent's termination of employment
  - Employee or dependent's termination of eligibility
  - Employee or dependent's switch from full-time to part-time Employee status or vice versa
  - Termination of the other plan's coverage
  - The death of a spouse
  - Legal separation or divorce
  - Exhaustion of COBRA
  - Termination of the employer's contribution toward the coverage
  - The person is employed by an employer that offers multiple health benefit plans and the person elects a different plan during an Open Enrollment; or
- BCBSAZ receives an application from one of the following persons seeking coverage under this Benefit Plan, within 31 days of one of the following qualifying events, as applicable to the individual seeking coverage:
  - The person becomes a dependent of a Contract Holder or contract holder's spouse through marriage, birth, adoption or placement for adoption.
  - The person exhausts a lifetime maximum on all benefits under the other policy or plan (qualifying event is denial of a claim due to operation of a lifetime maximum).
  - The person no longer resides, lives or works in the other plan's service area and no other Group Benefit Plan is available to the person.
- Any other special enrollment rights available under applicable federal or state law

Leave of Absence

Please see your Group benefits administrator for information regarding coverage during a Leave of Absence.

Medical Support Orders

Coverage is available to a child of the Contract Holder in accordance with any court order or administrative order issued by a court of competent jurisdiction that requires the Contract Holder to provide health benefits coverage for such child. The order must clearly specify the name of the Contract Holder, the name and birth date of each child covered by the order and the time period to which the order applies.

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

Termination of Coverage

Benefits After Termination

Except as described below, you have no coverage on and after the date coverage ends, regardless of the reason for termination. 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 disability extension of benefits).

Continuation of Coverage

Under applicable law, it is the group's responsibility, to inform employees and Dependents of the availability, terms, and conditions of continuation of coverage available under COBRA. COBRA laws require most employers that sponsor a Group health plan to offer employees and their covered Dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at Group rates in certain instances where coverage under the plan would otherwise end. You must check with your Plan Administrator to determine if you qualify for continuation coverage.

Disability Extension of Benefits

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

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

  When you provide notice, you will be required to also provide reports satisfactory to BCBSAZ that show the date of your termination, the condition that resulted in you becoming totally disabled and that you have been totally disabled from that condition from the time of such termination. You are eligible for this extension of benefits whether covered as an active Employee, the dependent of an active Employee or a qualified COBRA beneficiary on the date the Group discontinues coverage through BCBSAZ.

- *Individual termination:* If you are totally disabled on the date your coverage as an active Employee (or as the dependent of an active Employee) terminates, medical expense benefits will continue, for the disabling condition only, for a period not to exceed 12 months from the date of termination. You do not waive your right to extended benefits if you do not notify BCBSAZ; however, BCBSAZ cannot pay claims until notice is received.

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

  If you are eligible for an extension of benefits because of an individual termination as described above and you elect continuation coverage under COBRA, the extension of benefits shall run concurrently with your continuation coverage under COBRA, until the 12-month extension of benefits period is exhausted. Because these provisions run concurrently, please contact your employer before making any changes to or terminating your COBRA continuation coverage. An extension of benefits ends when you are no longer totally disabled, or become eligible for, or covered under, any other Group plan with like benefits.

Conversion Coverage

If this Benefit Plan terminates because the Group changes its insurance plan, you are not eligible for a conversion contract. If your coverage under this Benefit Plan ends for any reason other than the Group changing insurance plans and you maintain your permanent residence in Arizona, you may apply for an individual conversion contract offered by BCBSAZ.

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

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 descriptions for *"Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures"* and *"Transplant or Gene Therapy Travel and Lodging"*).
- If a non-member is pregnant with a baby that is to be adopted by a BCBSAZ Member of this plan, the non-member may be eligible for Maternity benefits under the following circumstances:
  - The child is adopted by a BCBSAZ Member within 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.

GENERAL PROVISIONS

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 in the *"Confidentiality and Release of Information"* section of this book, BCBSAZ provides equal parental access to information.

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 do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ. 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.

If you receive a bill from an out-of-network Provider for services provided at an in-network facility and want to dispute the amount of the bill, you may be able to initiate a dispute resolution process defined under Arizona law. This process is not available for all balance bills. To initiate the dispute resolution process or to appeal a denial of Prior Authorization for urgently needed services you have not yet received, please call Customer Service at the number on your ID card.

Billing Limitations and Exceptions

When there is another source of payment such as a liability insurer, in-network Providers may be entitled to collect any difference between the Allowed Amount and the provider's Billed Charges from the other source or from proceeds received from the other source, pursuant to A.R.S. § 33-931. A.R.S. § 33-931 may give Providers medical lien rights independent of this Benefit Plan or any contract with BCBSAZ. BCBSAZ is not a party to any collection dispute that may arise under the provisions of A.R.S. § 33-931.

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

Blue Cross and Blue Shield Association

You hereby expressly acknowledge and agree to the following:

i. This Benefit Plan constitutes a contract between the Group and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("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 health and dental coverage products either directly or through independent licensed insurance brokers. Commission payments to brokers are one of the costs factored into premiums, but BCBSAZ's premium calculation is not based on whether a product is sold directly or by a broker. BCBSAZ generally pays a commission to the broker of record or legal assignee designated by the broker until the insurance contract is terminated, the Group terminates its relationship with the broker and notifies BCBSAZ or the broker becomes ineligible for receipt of commissions. Brokers are required under their agreement with BCBSAZ to provide information on commission rates with BCBSAZ.

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, claim 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 Customer Service and request a hard copy of the CIRF form.

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your Provider. In-network Providers generally cannot charge you for providing BCBSAZ with health records. 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 cost of copies, you will need to arrange with your Provider to obtain any records required by BCBSAZ and pay any applicable fees.

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.

Discretionary Authority

BCBSAZ has Discretionary Authority to determine extent of coverage under the terms of this Benefit Plan.

Identity Protection Services

Identity Protection Services are available to members of this plan. For more information, contact Customer Service at the number on your ID card.

Lawsuits against BCBSAZ

BCBSAZ has an Appeal Process for resolving certain types of disputes with members. BCBSAZ encourages you to use the Appeal Process before filing a lawsuit, as issues can often be resolved when you give BCBSAZ more information through the Appeal Process. Under Arizona's Health Care Insurer Liability Act, before suing BCBSAZ, a Member must first either complete all available levels of the BCBSAZ Appeal Process or give BCBSAZ written notice of intent to sue at least 30 days before filing the lawsuit. The written notice must set forth the basis for the lawsuit and must be sent by certified mail to the following address:

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

Failure to comply with these provisions may result in dismissal of the lawsuit. A Member must complete all applicable levels of appeal before bringing a lawsuit other than a suit filed pursuant to the Health Care Insurer Liability Act. Failure to complete the mandatory levels of the Appeal Process may result in dismissal of the lawsuit for failure to exhaust BCBSAZ's administrative remedies. By providing this notice BCBSAZ does not waive, but expressly reserves all applicable defenses available under 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.

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.

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: (1) on delivery, if hand-delivered; (2) 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 (3) if transmitted electronically, on the earlier of the day of actual receipt or 24 hours after electronic transmission to the member's email address of record.

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 right to 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 in-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 services at in-network facilities:* The same emergencies rule above applies if you receive services from out-of-network Providers while you are at an in-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.

Payments Made in Error

If BCBSAZ erroneously makes a payment or overpayment 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, any SBCs, all riders, amendments, and other communications concerning your coverage.

Prescription Medication Rebates

BCBSAZ receives rebate payments based on the volume and/or market share of pharmaceutical products used by BCBSAZ members. BCBSAZ participates in contracts with pharmaceutical manufacturers, pursuant to which BCBSAZ receives these rebate payments. These rebate contracts are subject to renegotiation and/or termination from time to time.

The rebates BCBSAZ receives on your prescription drug utilization are not reimbursable to you, including prescription costs applied to any Copay, deductible, Coinsurance calculation, or Out-of-pocket Coinsurance Maximum that may apply under your plan. You acknowledge and agree that BCBSAZ will keep all rebates.

Pharmacy rebates may cause the overall cost of a medication to fall below the amount you pay for that medication under 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, BCBSAZ network Providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate. This means that your in-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.

Provider Treatment Decisions and Disclaimer of Liability

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

that is not covered. BCBSAZ has no control over any diagnosis, treatment, care, or other services rendered by any Provider and disclaims any and all liability for any loss or injury to you caused by any Provider by reason of the provider's negligence, failure to provide treatment or otherwise.

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. A failure to provide records needed to adjudicate a claim can result in denial of the claim.

Rescission of Coverage

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

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

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

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.

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 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, collective bargaining agreements, the latest annual report (Form 5500 Series), and an 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

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.

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.

MULTI-LANGUAGE INTERPRETER 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 hóló̧ díí t’áá hazaadk’ehjí háká a’doowołgo bee haz’ą́ doo bą́ą́h ílínígóó. Ata’ halne’ígíí koj̨í’ bich’j̨’ 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 ܕܩܐ ܡܥܕܪܝܬܘܢ ܠܗ، ܐܝܬ ܠܘܟܘܢ ܫܘܐܠܐ ܒܘܕ Blue Cross Blue Shield of Arizona، ܐܢܬܘܢ ܐܝܬ ܠܘܟܘܢ ܙܕܩܐ ܕܡܩܒܠܝܬܘܢ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܐ ܕܝܘܟܘܢ ܡܓܢܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܝ ܩܐ ܡܢܝܢܐ ܕܝܠܗ 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: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีค่าถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799