Group BlueSignature℠ Prosano PPO

Base Benefit Book

Off Marketplace

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

azblue.com/MyBlue

Welcome!

Welcome to BlueSignature℠ Prosano, a health plan built around people and their communities. Thank you for making Blue Cross® Blue Shield® of Arizona (BCBSAZ) a part of your healthcare team. Making it easy for you to take your next step for health is what we're all about.

This is your Base Benefit Book. Together, this book, the Plan Attachment, and any applicable rider(s) are referred to collectively as your Benefit Book. Your Benefit Book is your complete guide to your health plan. It is also our contract with you.

Inside you'll find everything you need to know about getting care and managing your plan.

About Prosano Health

Prosano Health Solutions, Inc. ("Prosano Health") provides healthcare services through an integrated medical care program at Prosano Health Advanced Primary Care Centers. Prosano Health is contracted with BCBSAZ as an in-network provider and for care management services.

Tip! Your Benefit Book is available to you online at azblue.com/MyBlue.

QUICK START: USING YOUR HEALTH PLAN

In this section, we cover what you need to get started with your health coverage. Some of this information is also online at azblue.com/MyBlue. We put it in both places for your convenience.

Know the Lingo—Top Terms

Sometimes reading insurance information feels like learning a new language. The top most useful terms to know are defined here. You'll find an in-depth list of terms in Appendix A.

Allowed amount	The amount BCBSAZ has agreed to pay for a covered service. The allowed amount includes both the BCBSAZ payment and your cost share (see definition). Example: Let's say your doctor normally charges $150 for a particular service (that's the billed charge). For that service, BCBSAZ has set the allowed amount at $100. That is the amount the doctor will receive as payment for the service. Both you and the plan pay the allowed amount to the doctor. If your coinsurance is 20%, you pay $20 ($100 x 20%) at the time of your appointment, and your plan pays $80 ($100 - $20) when the claim is processed.
Coinsurance	The percentage of the allowed amount that you pay when you receive a covered healthcare service (after meeting your deductible). Example: If the allowed amount for a service is $120 and your coinsurance is 20%, you pay $24 ($120 x 20%) and your plan pays the other $96 ($120 - $24) if you've already met your annual deductible. If you haven't met your deductible, you pay the full allowed amount of $120 (except in the case of preventive services).
Copay **or** **Copayment**	The fixed or set dollar amount you pay for certain covered healthcare services. You pay your copay at the time you receive care. Prescriptions and network doctor visits are examples of covered services that often have copays. Usually, if a copay does not apply to a service, you can expect to pay any applicable deductible and coinsurance, and vice-versa.
Cost share **or** **Out-of-pocket costs**	What you pay for the covered healthcare services you use. Deductibles, coinsurance, access fees, and copays are all examples of cost share. Cost share does not include your monthly premiums or the cost of any noncovered services that you receive. Cost share may sometimes also be called out-of-pocket costs or out-of-pocket expenses. Learn more about cost share in your Plan Attachment.
Covered services	The medically necessary healthcare services or items that are benefits of your health plan.
Deductible **or** **Calendar-year deductible**	The amount you pay toward your covered healthcare services each calendar year before BCBSAZ begins to pay its share. Your deductible amount is listed in your Plan Attachment and in your Summary of Benefits and Coverage (SBC). Example: If your health plan has a $1,000 deductible, you pay the allowed amount for the services you use during the calendar year until you have paid a total of $1,000. After that, BCBSAZ begins paying its share. You will still pay any other cost-sharing amounts after meeting your deductible, such as copays or coinsurance. **Note:** Some plans allow you to get some services (such as emergency services) at the cost of your copay or coinsurance amount whether or not you've met the deductible. Copays or coinsurance amounts for these services do not count toward your deductible.
In-network provider	A doctor, hospital, outpatient surgery center, pharmacy, lab, or other professional or place that is contracted with the plan network to provide healthcare services to members in the plan.

Out-of-network provider	A doctor, clinic, hospital, or other provider or healthcare facility that is not in your plan network.
Out-of-pocket maximum	The amount you pay each calendar year before the plan begins paying 100% of the allowed amount (on most covered services) for the remainder of the calendar year.

Discover Your Care Choices

Who to see or call …	When you need …	How to use …
BCBSAZ plan in-network providers	Routine and specialty care	Log in to your MyBlue℠ account and click "Find a Doctor." You can search by name, type, or location.
BlueCare Anywhere℠	A visit with a board-certified doctor, counselor, or psychiatrist without going to an office. Have a video appointment by computer, tablet, or mobile device wherever you are.	Set up your account at BlueCare Anywhere to connect any day, any time, including weekends and holidays. You can also call **1-844-606-1612.**
Urgent care center	Non-life-threatening emergency care	Log in to MyBlue, click "Find a Doctor," and select "Doctors by name or specialty, hospitals, and clinics." Choose "Places by Type" and enter "urgent care" in the search bar.
Walk-in clinic (may be freestanding, or located inside a retail store)	Same-day care for a cold, flu, rashes, and other minor medical needs, as well as vaccinations and wellness screenings. You don't need an appointment, but calling ahead is a good idea.	Use our "Find a Doctor" tool in your MyBlue account. Click "Find a Doctor," and select "Doctors by name or specialty, hospitals, and clinics." Choose "Places by Type" and enter "Health Service Clinic/Center" to search for locations closest to you.
Nurse On Call	Advice from a registered nurse for illnesses like fevers and the flu, and minor injuries.	Call **1-866-422-2729** (open 24 hours a day, seven days a week).
Pediatric vision providers	Pediatric vision exams and eyewear	Use the "Find a Doctor" tool on azblue.com. Click "Find a Doctor" and then "I am a BCBSAZ Member who bought my own health plan." Under "Search a Network," choose the pediatric vision option that applies to your plan. This will take you to the BCBSAZ Vision Network where you can search by area, name, and more. You can also call **1-888-460-9539.**

Call 9-1-1 or go straight to the closest emergency room if you have a medical emergency.

Ask for Prior Authorization When Required

Some covered services and prescriptions need an "okay" from BCBSAZ before you get them. Getting an okay is called prior authorization. You don't need one for doctor visits, preventive care, urgent care, or emergency care.

You'll find more details about prior authorization in the Prior Authorization section. On the BCBSAZ website, you'll find prior authorization lists for:

- Medical services at azblue.com/individualsandfamilies/resources/forms
- Medications at azblue.com/pharmacy

Connect with Us!

When you have questions, we're here with answers.

Online	Your plan comes with a personalized online MyBlue account. Set up your account today so you can: • See an overview of what your health plan covers and how it works (this is your Summary of Benefits and Coverage, available under "Plan Benefits") • Check the status of a claim (under "Claims Search") • Find doctors, hospitals, or other healthcare providers in your plan's network using the "Find a Doctor" tool • Use the Drug Cost/Copay Calculator (under "Pharmacy"), and much more.
By phone	Our Customer Service team is here for you from 8 a.m. to 5 p.m. Arizona time, Monday through Friday. We're closed on holidays. • You'll find the phone number for Customer Service on the back of your ID card. • We also have special lines for: – TTY 1-800-770-8973 or 711 – A new ID card 1-855-776-7266 (1-855-PROSANO) – Pharmacy 1-866-325-1794 (open 24/7) – Chiropractic 1-800-678-9133 – Pediatric Vision 1-888-460-9539 – Fraud & Abuse Hotline 602-864-4875 or 1-800-232-2345, ext. 4875 – Telehealth Services (provided by BlueCare Anywhere) 1-844-606-1612
By mail	Blue Cross Blue Shield of Arizona P.O. Box 13466 Phoenix, AZ 85002-3466
Social media	Like us on **Facebook:** facebook.com/bcbsaz Follow us on **X:** twitter.com/bcbsaz Email complaints and concerns to socialcares@azblue.com

Tip!

Always carry your BCBSAZ ID card with you. Your card lists certain essential health plan details and tells you who to call for help. Show your ID card when you:

- Visit a doctor or other healthcare professional
- Go to a drugstore or pharmacy to get medication your doctor prescribes for you
- Visit an urgent care clinic, hospital, or emergency room

You'll also need your ID card when you call us, and when you sign up for your online MyBlue account.

YOUR HEALTH PLAN BENEFITS

This section tells you about the benefits that come with your BCBSAZ health plan. There is a general definition of covered services and a description of each benefit. Some covered benefits are limited to a certain number of visits or items, or dollar amount. These limits are stated within each individual benefit description.

You'll also find a list of services that are not covered in this section. Be sure to review this list before you see a doctor, have a lab test, fill a prescription, or use any other type of benefit. That's how you can make sure you use only covered benefits.

You'll find an in-depth list of terms in Appendix A. It's a good place to check if you come across a word that is not familiar.

What's Covered

Your BCBSAZ health plan covers a wide range of services and items to help you protect your health. The services and items covered include all those required by federal and state law.

A service or item is covered when it is *all* of these:

- A benefit of this plan;
- Approved when prior authorization is required (see Prior Authorization for more information);
- Given by an eligible provider acting within the scope of their practice as determined by BCBSAZ or BCBSAZ's contracted vendor(s);
- Medically or dentally necessary as determined by BCBSAZ or BCBSAZ's contracted vendor(s);
- Not excluded by this plan. (That is, the service or item is not listed in the What's Not Covered section of this Base Benefit Book, or noted in this section as "Not covered");
- Not experimental or investigational as determined by BCBSAZ (does not apply to covered services that are part of an approved clinical trial; see Clinical Trials in this section for more information); **and**
- Provided while this plan is in effect, and while you are eligible for benefits.

BCBSAZ decides if the service or item meets all factors for coverage.

Note about changes in level of care

Some covered benefits listed in this book will refer you to the following statement. When you see the statement it means that level of care changes apply to that specific benefit.

Some inpatient facilities provide different levels of care within the same facility. For example, a single hospital may offer acute inpatient, inpatient rehabilitation, and other inpatient care. If you are transferred to a different level of care, even within the same facility, prior authorization is required and your cost-share amount will change to match that level of care. See the Prior Authorization section to learn how this process works.

A. AMBULANCE SERVICES

Services covered:

- Ground ambulance transportation from the site of an emergency, accident, or sudden illness to the nearest facility that can give you the proper treatment.
- Air or water ambulance transportation to the nearest facility that can give you the proper treatment when:
  - The emergency, accident, or sudden illness occurs in an area that a ground vehicle can't get to; **or**
  - Transport by ground ambulance would be harmful to your medical condition.
- Ground, water, or air ambulance transfer from one facility to another when the transferring facility is unable to give you the level of service you need.

Not covered:

- Air ambulance transfers to a facility that is not an acute care facility. For example, a skilled nursing facility and an extended active rehabilitation facility are not acute care facilities. Therefore, air ambulance transfers to one of these types of facilities would not be covered.
- All other expenses for travel and transportation are not covered, except for the benefits described in the Transplant or Gene Therapy Travel and Lodging section.

B. BEHAVIORAL HEALTH SERVICES

Behavioral health services include treatment for mental health, chemical dependency, and substance use disorder. 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.

B.1 Inpatient Hospital Services

Services covered:

- Diagnostic testing
- Intensive care units and other special care units
- Medications, biologicals (medications that come from a living source, such as a vaccine or human insulin), 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

B.2 Sub-Acute Inpatient Behavioral Health Hospitalization (including residential treatment)

Services covered:

- 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
- Special care units
- Treatment and recovery rooms and equipment for covered services

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

- A doctor or registered nurse practitioner is present on the premises of the facility (in the building or on the campus) or on call at all times;
- The facility has 24/7 onsite RN coverage;
- The facility has enough behavioral health professional staff to provide the treatment you need;
- The facility is licensed to provide behavioral health services to patients who 1) must have 24-hour skilled care, **and** 2) are able to meet treatment goals in a reasonable period of time;
- The facility's clinical director is a behavioral health professional who directs the behavioral health services offered at the facility;
- The facility's medical director is a doctor or registered nurse practitioner who directs the physical health services offered at the facility; **and**
- The services meet BCBSAZ's Medical necessity definition, guidelines, and criteria.

➡ *See the Note about Changes in Level of Care for important information about this benefit.*

B.3 Behavioral Health Services (outpatient facility and professional services)

Your plan covers services in an individual, group, or structured group therapy program for these non-emergency outpatient behavioral health services: psychotherapy, outpatient therapy for chemical dependency or substance use disorder, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, intensive outpatient services, counseling for personal and family problems, electroconvulsive therapy (ECT), and partial hospitalization.

➡ *See the Note about Changes in Level of Care for important information about this benefit.*

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

There are some terms to know for this benefit:

- *Autism spectrum disorder* (ASD) means autistic disorder, Asperger's syndrome, or pervasive developmental disorder (not otherwise specified), as defined by current evidence-based criteria and referenced in the most current version of 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.

Your plan covers services for behavioral therapy services for the treatment of ASD for members who have been diagnosed with ASD. Covered behavioral therapy services must be delivered by a provider who is licensed or certified as required by law.

C. CATARACT SURGERY AND KERATOCONUS

Services covered:

- Removal of cataracts, including placement of a single intraocular lens at the time of the cataract removal
- First pair of external contact lenses after cataract surgery, and first pair of contact lenses for treatment of keratoconus

Not covered: Procedures associated with cataract surgery that are not included in this benefit description. These include replacement, piggyback, or secondary intraocular lenses, and any other treatments or devices for refractive correction.

D. CHIROPRACTIC SERVICES

Your plan covers services for chiropractic services. Physical medicine and rehabilitative services provided by a chiropractor do not count toward the 60-visit limit on physical therapy, occupational therapy, speech therapy, cognitive therapy, cardiac, and pulmonary habilitative and rehabilitative services.

Not covered: Maintenance or preventive treatment consisting of routine, long-term, or non-medically necessary care provided to prevent reoccurrences or to maintain the patient's status.

E. CHRONIC DISEASE EDUCATION AND TRAINING

Your plan covers services for chronic disease education and training (including nutritional counseling and training) for members diagnosed with one or more of the following conditions:

- Asthma
- Behavioral health
- Cardiovascular disease
- Coronary artery disease
- Eating disorders
- Food allergies
- Gastrointestinal disorders
- Heart failure
- High cholesterol/hyperlipidemia
- Hypertension
- Obesity
- Pre-diabetes and diabetes
- Renal disease/renal failure

Education and training must be from providers whose services are:

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

F. CLINICAL TRIALS

Your plan covers services related to an approved clinical trial. An approved clinical trial is defined by BCBSAZ as a Phase 1, 2, 3, or 4 clinical trial conducted for the prevention, detection, or treatment of cancer or other life-threatening disease or condition and approved or funded by at least one of the following:

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

Services covered:

- Benefits are available for covered services directly associated with an approved clinical trial meeting all requirements specified by applicable federal and Arizona law.
- Benefits are limited to those services covered under this plan that would be required if you received standard, non-investigational treatment.

- Services may include laboratory, radiology, physician services, medical diagnostic, and/or surgical procedures.

To have your plan cover services associated with an approved clinical trial, you or your provider must inform BCBSAZ that:

- You are enrolled in a clinical trial;
- The trial meets the requirements of applicable law; **and**
- The services to be rendered are directly associated with the trial.

Otherwise, BCBSAZ only covers services associated with 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.

Not covered:

- Any item, device, or service that is the subject of the clinical trial, or which is provided solely to meet the need for data collection and analysis
- Clinical trials not required by law to be covered
- Costs and services usually paid for by government, biotechnical, pharmaceutical, or device industry sources
- Costs of managing the research of the clinical trial
- Costs related to clinical trials that do not meet the applicable requirements
- Investigational drugs (except as stated under Medications for the Treatment of Cancer) or devices
- Non-health services that might be required in order for a person to receive treatment or intervention, such as travel and transportation and lodging expenses
- Services otherwise not covered under this plan

G. DENTAL SERVICES—MEDICAL

Be sure to use a dentist who is contracted with the plan network to provide medical-related dental services. Not all network dentists are contracted to provide this type of service.

G.1 Dental Accident Services

There are some terms to know for this benefit:

Accidental dental injury is an accidental injury to a sound natural tooth.

A *sound natural 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 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.

Benefits are available when provided to repair or replace a sound tooth that has been damaged or lost by an accidental dental injury.

Services covered:

- 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 and veneers
- Orthodontic services directly related to a covered accidental injury
- Treatment for a fractured jaw

Not covered:

- 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 and routine extractions

G.2 Dental Services Required for Medical Procedures

Benefits are available for dental services that are either: 1) part of a medical procedure, **or** 2) performed along with and made medically necessary solely because of a medical procedure.

Services covered:

- 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

Not covered:

- 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 and routine extractions

G.3 Medical Services Required for Dental Procedures

Your plan covers facility and professional anesthesiologist charges to perform dental services under anesthesia in an inpatient or outpatient facility for a member who:

- Is a child five years old or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office;
- Is likely to have an allergic reaction;
- Needs dental extractions due to cancer-related conditions; **or**
- Has any of the following:
  - A condition that could increase the danger of anesthesia
  - An unstable cardiovascular condition
  - Diabetes

- Heart problems
- Hemophilia
- Intellectual disability
- Malignant hypertension
- Senility or dementia
- Uncontrolled seizure disorder

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

H.1 Durable Medical Equipment (DME)

Your plan covers DME that meets *all* of the following criteria:

- It must be designed to offer medical use in the home setting;
- It must be specifically designed to improve or support the function of a body part (this must be its main purpose); **and**
- It cannot be primarily useful to a person in the absence of an illness or injury (the person must need the equipment because of an illness or injury).

Benefits are available for renting or buying DME (as determined by BCBSAZ), as well as for the repair or replacement of DME when BCBSAZ determines it is needed due to either: 1) normal wear and tear caused by proper use of the item (all manufacturer's instructions for use have been followed), **or** 2) the child has outgrown the DME.

Tip! Call us to find out what the base model is for the DME item you need before you rent or buy the item.

Coverage limits: See DME, Medical Supplies, and Prosthetic Appliances and Orthotics Limits and Exclusions.

Not covered:

- Charges for continued rental of a DME item after the purchase price is reached, if applicable
- Repair costs that are higher than the allowed amount for the DME item
- Repair or replacement of DME items lost or damaged due to neglect or use that does not follow the manufacturer's instructions or specifications

H.2 Medical Supplies

Services covered:

- Any device or supply recommended under current evidence-based criteria
- Insulin pumps (except when delivery through a pharmacy is required by the manufacturer) and insulin pump supplies
- Ostomy and urinary catheter supplies
- Peak flow meters
- Supplies associated with oxygen or respiratory equipment
- Volume nebulizers

Coverage limits: See DME, Medical Supplies, and Prosthetic Appliances and Orthotics Limits and Exclusions.

H.3 Prosthetic Appliances and Orthotics

Services covered:

- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- External and internal prosthetic appliances that are used as a replacement or substitute for a missing body part, and that 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 include artificial arms and legs, wigs, hairpieces, and terminal devices, such as a hand or hook.
- Orthopedic shoes that are:
  - Attached to a brace;
  - Depth-inlay or custom-molded (with inserts) for members with diabetes; **or**
  - Covered per BCBSAZ medical necessity criteria (see Medical necessity definition, guidelines, and criteria).
- Podiatric appliances, including foot orthotic devices and inserts, for prevention of complications associated with diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg
- Testicular implants following medically necessary removal of the testicles
- Therapeutic shoes for members diagnosed with diabetes mellitus who have any of the following complications of diabetes involving the foot:
  - Foot deformity;
  - History of pre-ulcerative calluses;
  - History of previous ulceration;
  - Peripheral neuropathy with evidence of callus formation;
  - Poor circulation; **or**
  - Previous amputation of the foot or part of the foot.

  Types of therapeutic shoes that are covered:
  - *Custom-molded shoes* are shoes built over a model of the member's foot. They are made from leather or other material of equal quality suitable to the shoe's purpose (dress, walking, work, etc.), have removable inserts that can be changed or replaced as the member's condition warrants, and have some sort of shoe closure. May include an internally seamless toe. (**Note:** Custom-molded shoes are covered only when the member has a foot deformity that cannot be accommodated by a depth shoe.)
  - *Depth shoes* are shoes that come with a full-length, heel-to-toe filler that, when removed, leaves at least of 3/16 of an inch of extra depth. The extra depth accommodates custom-molded or customized inserts. The shoes are made of leather or other material of equal quality suitable to the shoe's purpose (dress, walking, work, etc.); 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.
- Wigs and hairpieces for members diagnosed with:
  - A behavioral health condition; **or**
  - Alopecia (absence of hair) caused by chemotherapy, radiation therapy, or second- or third-degree burns.

Coverage limits and services not covered: See DME, Medical Supplies, and Prosthetic Appliances and Orthotics Limits and Exclusions.

H.4 DME, Medical Supplies, and Prosthetic Appliances and Orthotics Limits and Exclusions

Coverage limits:

- Certain equipment and medical supplies are covered under Pharmacy and Medications Benefits at BCBSAZ's sole discretion.
- Coverage is limited to one manual or electric (not hospital grade) breast pump with breast-pump supplies per member, per calendar year, per Health Resources and Services Administration guidelines (see Preventive Services). This limit does not apply to claims submitted with a primary behavioral health diagnosis.
- Coverage is limited to one set of new and four replacement sets of compression garments for the treatment of lymphedema per member, per calendar year. This limit does not apply to claims submitted with a primary behavioral health diagnosis.
- Coverage is limited to one wig and one hairpiece per member, per calendar year. This limit does not apply to claims submitted with a primary behavioral health diagnosis.
- Benefits are limited to the allowed amount for the DME item or medical supply **base model**. BCBSAZ determines what is covered as the base model. Deluxe or upgraded DME items or medical supplies may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Not covered:

- Biomechanical devices, which are any external devices operated through or in conjunction with nerve conduction or other electrical impulses
- Equipment and supplies you can buy over the counter or without a prescription or order from a medical provider, as determined by BCBSAZ. Examples include:

• Adjustable beds • Air cleaners • Air-fluidized beds • Air conditioners • Air purifier • Assistive eating devices • Atomizers • Bathroom equipment • Bed boards • Biofeedback devices • Braille teaching texts • Car seats • Corsets • Cushions • Dentures • Diathermy machines • Disposable hygienic items • Dressing aids and devices • Elastic/support/compression stockings (except for treating lymphedema) • Elevators • Exercise equipment	• Foot stools • Garter belts • Grab bars • Hair transplants • Health spas • Hearing aid batteries, except for cochlear implants • Heating and cooling units • Helmets • Hospital-grade breast pumps and related supplies • Humidifiers • Incontinence devices/alarms • Items used mainly for help in daily living, socialization, personal comfort, convenience, or other nonmedical reasons • Language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools • Massage equipment • Mineral baths • Myoelectric limbs	• Portable and permanent spa and whirlpool equipment and units • Reaching and grabbing devices • Reclining chairs • Replacement of external prosthetic devices due to loss or theft • Saunas • Strollers of any kind • Supplies used by a doctor or other healthcare provider during office treatments • Tilt or inversion tables or suspension devices • Vehicle or home modifications • Wigs and hair pieces for alopecia caused by anything other than chemotherapy, radiation therapy, second- or third-degree burns, a diagnosed behavioral health condition

I. EMERGENCY SERVICES

Your plan covers services needed to treat an emergency medical condition, whether the providers of these services are in or out of network. An emergency medical or behavioral health condition is an illness, injury, symptom, or condition so serious that you need care right away to avoid harm.

J. EOSINOPHILIC GASTROINTESTINAL DISORDER

Your plan covers formula (amino acid-based) for Eosinophilic Gastrointestinal Disorder (EGID) that is covered for members who are:

- At risk of mental or physical impairment if deprived of the formula;
- Diagnosed with EGID; **and**
- Under the continuous supervision of a doctor or a registered nurse practitioner.

K. FAMILY PLANNING—CONTRACEPTIVES AND STERILIZATION

Your plan covers contraceptive methods and devices, including sterilization procedures, approved by the U.S. Food and Drug Administration (the FDA) and prescribed by your doctor. At least one contraceptive in each of the methods approved by the FDA is covered without cost share when obtained from an in-network provider.

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

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

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

Not covered: All prescription and over-the-counter contraceptive medications and devices for male plan members.

L. HEARING AIDS AND SERVICES

Services covered:

- Batteries for cochlear implants
- Cleaning and repair of hearing devices
- Cochlear implants
- Dispensing fees for hearing devices
- New or replacement hearing devices no longer under warranty
- Routine hearing exams, except hearing screenings performed as part of a routine well exam

Your plan covers the allowed amount for a prescribed hearing aid meeting the specifications for your needs. BCBSAZ determines the covered model.

Coverage limits:

- Limited to one hearing exam per member, per calendar year
- Limited to one hearing device per member, per ear, per calendar year

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

Not covered:

- Additional warranties for hearing aids
- Assistive listening devices, including, but not limited to, hearing aids that sync wirelessly with MP3 players, laptops, televisions, and/or wireless devices
- Batteries or battery replacement for hearing aids other than cochlear implants
- Direct audio input, Bluetooth capability, or other additional features
- Disposable hearing aids
- Earmolds
- Replacement of lost, stolen, or damaged hearing aids when the member has already met the coverage limit of one hearing aid per member, per ear, per calendar year
- Replacement or repair of hearing devices still under warranty

M. HOME HEALTH SERVICES

Services covered:

- 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, that are not covered under the Pharmacy benefit (see Pharmacy and Medications Benefits)
  - Total parenteral nutrition services
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition (tube feeding), and other services that require skilled nursing care

The above services must meet all of the following criteria:

- A healthcare provider must order the service as part of a specific plan of home treatment;
- A licensed home health agency must provide the service in the member's home;
- The healthcare provider must review the appropriateness of the service at least once every 30 days, or more frequently, if appropriate under the treatment plan; **and**
- The service must be provided by a licensed practical nurse (LPN), registered nurse (RN), or other eligible provider.

Coverage limits: Benefits are limited to any combination of skilled nursing services needed in order to provide home infusion medication administration, enteral nutrition, and/or other services requiring skilled nursing care, up to a maximum of 42 home health visits per member, per calendar year. One visit is any period of time up to four hours. Any time exceeding a four-hour increment is considered another visit. The 42 home health visit limit does not apply to home health services provided instead of hospitalization or hospital outpatient services, or to claims for home health services submitted with a primary behavioral health diagnosis.

PT, OT, and ST visits provided in the home count toward the PT, OT, and ST habilitative or rehabilitative visit limit. If both PT, OT, or ST Services and home health services are provided during the same home visit, the home health services will apply toward the home health visit limit, and the PT, OT, and ST services will apply toward the PT, OT, and ST habilitative or rehabilitative visit limit.

Not covered:

- 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 and the Medical Foods for Inherited Metabolic Disorders sections of this book
- Services beyond the 42-visit calendar year maximum, except as stated in the coverage limits

N. HOSPICE SERVICES

Hospice services provide comfort and support for people in the last stages of a terminal illness, and to their families. Once hospice begins, treatment to cure the illness stops. The hospice benefit is provided in place of other medical benefits available under this plan, except for care not related to either the terminal illness or any complications associated with the terminal illness.

Your doctor must certify that you are in the later stages of a terminal illness and prescribe hospice care. Hospice care must be provided by a state-licensed hospice agency, and you must meet the requirements of the hospice.

The hospice agency determines the required level of care, which BCBSAZ reviews for medical necessity. Once you select the hospice benefit, the hospice agency coordinates all of your healthcare needs related to the terminal illness.

Services covered:

- 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 in-home services
- 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 that cannot be provided in the home setting
- Outpatient services
- Routine care—Intermittent visits provided by a member of the hospice team

➡ *See the Note about Changes in Level of Care for important information about this benefit.*

O. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

Your plan covers medical observation and detoxification services needed to stabilize a person who has developed substance intoxication due to the ingestion, inhalation, or exposure to one or more substances. Covered services include the initial medical treatment and support provided to a chemically dependent or addicted person during acute withdrawal from a drug or substance.

P. INPATIENT HOSPITAL

Services covered:

- Adjustments to previous bariatric surgery that was performed while the member was covered by a different health plan
- Blood transfusions, whole blood, blood components, and blood derivatives
- Covered cellular immunotherapies and gene therapies at in-network cost share only when administered in a contracted Blue Distinction® Center
- Diagnostic testing, including radiology, laboratory services, and biomarker testing
- Gender-affirming care

- General, spinal, and caudal anesthetic provided in connection with a covered service
- Intensive care units and other special care units
- Medications, biologicals, and solutions
- Operating, recovery, and treatment rooms and equipment for covered services
- Radiation therapy or chemotherapy
- 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
- Surgery and other invasive procedures
- Bariatric surgery performed using the following procedures:
  - Laparoscopic adjustable gastric banding (LAGB)
  - Laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS)
  - Laparoscopic roux-en-y gastric bypass (RYGBP)
  - Laparoscopic sleeve gastrectomy (LSG)
  - Open biliopancreatic diversion with duodenal switch (BPD/DS)
  - Open roux-en-y gastric bypass (RYGBP)

  Members must meet the following criteria to be eligible for bariatric surgery:
  - Be at least 18 years old, or have reached full skeletal growth;
  - Be previously unsuccessful with medical treatment for obesity;
  - Have a body-mass index (BMI) of at least 35; **and**
  - Have at least one co-morbidity related to obesity.

  The following medical information must be documented in the patient's medical record:
  - Active participation within the last two years in one physician-supervised weight-management program for a minimum of six months without significant gaps
  - Weight-management program must include monthly documentation of all of the following components:
    - Current dietary program
    - Physical activity (e.g., exercise program)
    - Weight

➡ *See the Note about Changes in Level of Care for important information about this benefit.*

Q. INPATIENT REHABILITATION—EXTENDED ACTIVE REHABILITATION AND SKILLED NURSING FACILITY SERVICES

Your plan covers inpatient services in a facility licensed to provide extended active rehabilitation (EAR) or licensed as a skilled nursing facility (SNF) that meets *all* of the following criteria:

- A doctor or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- For EAR services, the patient must require 24-hour rehabilitation nursing and have the ability to meet rehabilitation goals;
- For SNF services, the patient must require 24-hour skilled care and have the ability to meet treatment goals. 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;

- 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;
- The facility has 24/7 onsite RN coverage;
- The facility has enough professional staff to provide the needed treatment;
- The facility's designated medical director is a doctor 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 (see Medical necessity definition, guidelines, and criteria).

Coverage limits: Benefits are limited to 90 combined days of EAR and SNF services per member, per calendar year. This limit does not apply to claims for EAR or SNF services submitted with a primary behavioral health diagnosis.

➡ *See the Note about Changes in Level of Care for important information about this benefit.*

R. LONG-TERM ACUTE CARE—INPATIENT

Your plan covers specialized acute, medically complex care for patients who require extended hospitalization and treatment. Care must be provided in a licensed long-term acute care facility that offers specialized treatment programs and aggressive clinical and therapeutic interventions.

Room and board is covered for a semi-private room. A standard private room (not deluxe) will be covered if: 1) the hospital has only private rooms; **or** 2) a private room is medically necessary.

➡ *See the Note about Changes in Level of Care for important information about this benefit.*

S. MATERNITY

Your plan covers maternity benefits for 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 tests, may not be covered. For a complete listing of covered prenatal screening, please call Customer Service at the number on your ID card. Professional services provided in the member's home must be rendered by an eligible provider.

Maternity benefits are available for birth mothers, including surrogates, who are not members when they are giving birth to a child who is being legally adopted by a member. For benefits to apply, the member must:

- Adopt the child within one year of birth;
- Be legally obligated to pay the costs of birth; **and**
- Notify BCBSAZ within 60 days of their 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 request an adoption packet.

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

Under federal law, health insurers 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 insurer may pay for a shorter stay if the attending provider (for example, the member's doctor, nurse midwife, or physician assistant), after speaking with the mother, sends the mother or newborn home early.

Also, under federal law, insurers 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 (this means your cost share will not increase if you need to stay in the hospital longer than the 48 or 96 hours described above).

In addition, under federal law, a plan or insurer may not require that a doctor or other healthcare provider obtain prior 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, prior authorization may be required. You will find additional details in the Prior Authorization section.

T. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Your plan covers medical foods for inherited metabolic disorders. Inherited metabolic disorder is 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 for under the newborn screening program required under Arizona law (A.R.S. § 36-694);
- The disorder requires the patient to consume medical foods throughout his or her 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 are modified low-protein foods and metabolic formulas that are *all* of the following:

- 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;
- Prescribed 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;
- Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs (metabolic formula only); **and**
- Processed or formulated to contain less than 1 gram of protein per unit of serving (modified low-protein foods only).

Not covered:

- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available to buy 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 foods and formulas for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of galactosemia
- Nutrition for a diagnosis of anorexia
- Nutrition for nausea associated with mood disorder, end-stage disease, etc.
- Spices and flavorings
- Standard oral infant formula

Claims for reimbursement: Members eligible for this benefit may buy medical foods from any source. If you buy medical foods from an out-of-network provider, you will need to submit a claim form that includes *all* of the following information:

- A dated receipt or other proof of purchase;
- Amount paid for the medical foods;
- Member's name, identification number, group number, and birth date;
- Name of the prescribing or ordering doctor or registered nurse practitioner;
- Name, telephone number, and address of the medical food supplier; **and**
- The diagnosis for which the medical foods were prescribed or ordered.

Claim forms for medical foods are available from BCBSAZ. See the Medical Claims section for details and the address to submit claims.

Tip! Medical foods may also be covered under the Home Health Services benefit. Medical foods are not covered under Pharmacy and Medications Benefits.

U. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Your plan covers testing for decreased mental function or developmental delay.

V. OUTPATIENT SERVICES

Your plan covers the following outpatient services. They include, but are not limited to, any services that would be covered if they were performed as an inpatient service:

- Adjustments to previous bariatric surgery that was performed while the member was covered by a different health plan
- Allergy testing, antigen administration, and desensitization treatment
- Blood transfusions, whole blood, blood components, and blood derivatives
- Covered cellular immunotherapies and gene therapies at in-network cost share only when administered in a contracted Blue Distinction Center
- Diagnostic radiology services, including:
  - CAT/CT imagery
  - Mammograms and other modalities for breast cancer screening and diagnosis, as recommended by the National Comprehensive Care Network
  - Outpatient and ambulatory magnetic resonance imaging (MRI/MRA), PET scans, ECT, BEAM (Brain Electrical Activity Mapping)
  - X-rays
- Diagnostic testing, including, but not limited to, laboratory services and biomarker testing
- Dialysis
- End-stage renal disease services
- Epidural and facet injections, radio frequency ablation, and biofeedback for pain management
- Gender-affirming care
- Infusion/IV therapy in an outpatient setting
- Maternity services provided in outpatient birthing centers
- Medications, and the administration of medications, in an outpatient setting

- Orthognathic treatment and surgery, including, but not limited to, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)
- Outpatient and ambulatory cardiac testing, angiography, and video EEG
- Pre-operative testing
- Radiation therapy or chemotherapy
- Respiratory therapy
- Sleep studies
- Surgery and other invasive procedures
- Treatment of temporomandibular joint (TMJ) disorders
- Bariatric surgery performed using the following procedures:
  - Laparoscopic adjustable gastric banding (LAGB)
  - Laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS)
  - Laparoscopic roux-en-y gastric bypass (RYGBP)
  - Laparoscopic sleeve gastrectomy (LSG)
  - Open biliopancreatic diversion with duodenal switch (BPD/DS)
  - Open roux-en-y gastric bypass (RYGBP)

  Members must meet the following criteria to be eligible for bariatric surgery:
  - Be at least 18 years old, or have reached full skeletal growth;
  - Be previously unsuccessful with medical treatment for obesity;
  - Have a body-mass index (BMI) of at least 35; **and**
  - Have at least one co-morbidity related to obesity.

  The following medical information must be documented in the patient's medical record:
  - Active participation within the last two years in one physician-supervised weight-management program for a minimum of six months without significant gaps
  - Weight-management program must include monthly documentation of all of the following components:
    - Current dietary program
    - Physical activity (e.g., exercise program)
    - Weight

W. PHARMACY AND MEDICATIONS BENEFITS

W.1 Pharmacy Benefit

Your plan covers prescription medications that:

- Are 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;
- Are not excluded by a different provision in this plan;
- Are on the formulary or are a non-formulary medication that BCBSAZ and/or the PBM has authorized a formulary exception; **and**

- Except as otherwise required by applicable law, have been approved by the FDA for the diagnosis for which the medication has been prescribed.

Benefits are available for specialty medications obtained from a specialty pharmacy contracted with BCBSAZ. Coverage of specialty medications and limitations on these medications are determined by current evidence-based criteria and may change at any time without prior notice.

Call the Pharmacy Benefit Customer Service number on your ID card to request:

- A list of covered medications that require prior authorization
- A list of covered specialty medications (medications that treat chronic or complex conditions)
- A list of covered vaccines
- A list of formulary medications
- A formulary exception
- An exception to BCBSAZ prescription medication limitations
- Information on the assigned cost-share tier of a covered medication
- Information regarding non-formulary medications
- Information regarding maintenance medications (medications taken on an extended and continual basis for treatment of a chronic or ongoing health condition)
- Other information about your Pharmacy benefit

Certain vaccines are covered when you get them from in-network retail pharmacies and they are given by a certified, licensed pharmacist. The following supplies and devices are also covered under this benefit:

- Blood glucose monitors, including those designed for the legally blind and visually impaired
- Continuous glucose monitors
- Diabetic lancets, including automatic lancing devices
- Diabetic syringes/needles for insulin, including drawing up devices for the visually impaired
- Diabetic test strips, including visual reading and urine test strips
- Insulin cartridges, including insulin cartridges for the legally blind
- Insulin preparations and glucagon
- Insulin pumps when delivery through a pharmacy is required by the manufacturer
- Prescribed oral agents (drugs) for controlling blood sugar that are included on the plan formulary
- Spacer devices for asthma medications

Coverage limits: Covered medications are subject to limitations, including, but not limited to, quantity, age, gender, dosage, and frequency of refills. BCBSAZ and/or its independent, contracted Pharmacy Benefit Manager (PBM) determines which medications are subject to limitations. Medication limitations are subject to change at any time without prior notice.

Certain medications are subject to step therapy (see definition in Appendix A). You'll find information on how to request an exception for step therapy at azblue.com/pharmacy.

Prenatal vitamins are covered when prescribed. Growth hormones require prior authorization.

For medications subject to added controls under a government 340B program, you may be required to obtain prescriptions from designated providers and to obtain those medications from designated pharmacies, or those medications will not be covered.

You'll find additional Pharmacy benefit information in Using Your Pharmacy Benefits.

Tip! You can find cost estimates for your prescription drugs at MyBlue. After you log in, select "Pharmacy."

Not covered:

- Abortifacient (abortion-causing) medications
- All prescription and over-the-counter contraceptive medications and devices for male plan members
- Biologic serums
- Compounded medications obtained from a mail order pharmacy
- Designated medications prescribed by an ineligible provider or dispensed by an unapproved pharmacy or provider to members who are enrolled in the Designated Prescription Network program
- 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 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 well as 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 your Benefit Book. Go to azblue.com/pharmacy for a list of these specific exclusion details.
- Medications given to a member who is an inpatient in any facility, except those covered under Inpatient Hospital
- Medications labeled "Caution—Limited by federal law to investigational use," or words to that effect, and any experimental medications as determined by BCBSAZ and/or the PBM
- Medications obtained from an out-of-network mail order or specialty pharmacy
- Medications packaged with more than one medication or supply (including an over-the-counter medication, vitamin, or other excluded product) and billed as a single medication
- Medications that exceed BCBSAZ and/or the PBM's limitations, including, but not limited to, quantity, age, gender, and refill limits
- Medications to improve or achieve fertility or treat infertility
- Medications used for any cosmetic purpose, including, but not limited to, Tretinoin for members age 25 and older (Tretinoin is covered for individuals through age 24)
- Medications used to treat a condition not covered under this plan
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging, or name
- Non-formulary medications, unless BCBSAZ and/or the PBM authorizes a formulary exception
- 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

W.2 Medications for the Treatment of Cancer

Your plan covers, to the extent required by applicable state law, off-label use of medications for the treatment of cancer, and services directly associated with the administration of such medications.

Off-label refers to a medication that is FDA approved for treatment of a diagnosis or condition other than the cancer diagnosis or condition for which it is being prescribed, and which meets all requirements of Arizona law for mandated coverage of off-label use. These requirements include, but are not limited to, scientific evidence that the drug has been recognized as safe and effective for the specific type of cancer for which it is being prescribed.

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 it.

- 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 doctor using his or her independent medical judgment.
- If the medication is subject to prior authorization, your doctor must specifically notify BCBSAZ that they are requesting approval for this off-label use. After receiving your provider's request, BCBSAZ will review the criteria and eligibility for benefits.

All other applicable benefit limitations and exclusions will apply to this benefit.

X. PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, COGNITIVE THERAPY, CARDIAC, AND PULMONARY SERVICES

This benefit includes both habilitative and rehabilitative services and includes coverage for members diagnosed with autism spectrum disorder. There are some terms to know for this benefit:

- *Physical therapy (PT)* 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.
- *Occupational therapy (OT)* 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.
- *Speech therapy (ST)* is treatment of communication impairment and swallowing disorders.
- *Cognitive therapy (CT)* is treatment that focuses on present thinking, behavior, and communication, rather than on past experiences, and is oriented toward problem solving.
- Cardiac and pulmonary habilitative and rehabilitative services are supervised programs that include exercise, education, counseling, and other lifestyle changes designed to regain strength and prevent or reverse the progression of cardiac and pulmonary diseases.

X.1 Habilitative Services

Your plan covers PT, OT, ST, CT, cardiac, and pulmonary habilitative services.

Coverage limits: Benefits are limited to a maximum of 60 combined PT, OT, ST, CT, cardiac, and pulmonary habilitative visits per member, per calendar year. Evaluations count toward the 60 habilitative visit limit. Visits provided in the home count toward the 60 habilitative visit limit. The 60-visit limit does not apply to claims for habilitative services submitted with a primary behavioral health diagnosis.

Not covered:

- Activity therapy and milieu therapy, including community immersion or integration and home independence, unless related to an illness, injury, disability, or chronic disease
- All services in excess of the 60-visit limit, except for claims for habilitative services submitted with a primary behavioral health diagnosis
- OT for any purpose other than training the member to perform the activities of daily living
- Services to maintain posture, unless related to an illness, injury, disability, or chronic disease

X.2 Rehabilitative Services

Your plan covers PT, OT, ST, CT, cardiac, and pulmonary rehabilitative services.

Coverage limits: Benefits are limited to a maximum of 60 combined PT, OT, ST, CT, cardiac, and pulmonary rehabilitative visits per member, per calendar year. Evaluations count toward the 60 rehabilitative visit limit. Visits provided in the home count toward the 60 rehabilitative visit limit. The 60-visit limit does not apply to claims for rehabilitative services submitted with a primary behavioral health diagnosis.

Not covered:

- All services in excess of the 60-visit limit, except for claims for rehabilitative services submitted with a primary behavioral health diagnosis
- OT for any purpose other than training the member to perform the activities of daily living

Y. PHYSICIAN SERVICES

Physician services are services provided by a doctor.

Services covered:

- Allergy testing, antigen administration, and desensitization treatment
- Foot care, including trimming of nails or treatment of corns or calluses, when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg
- Gender-affirming care
- Inpatient medical visits
- Medications and the administration of medications in a doctor’s office
- Office, home, or walk-in clinic visits for the diagnosis and treatment of a sickness or injury (**Note:** Urgent care facilities are not walk-in clinics)
- Orthognathic treatment and surgery
- Second diagnostic surgical opinions
- Services for FDA-approved implanted contraceptive devices
- Services for FDA-approved patches, rings, and contraceptive injections; FDA-approved diaphragms, cervical caps, cervical shields, condoms, sponges, and spermicides; and FDA-approved emergency contraception (see the Guidance Regarding Preventive Medications for a list of contraceptive methods covered as preventive services under the Pharmacy benefit)
- Services for FDA-approved sterilization procedures
- Services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices
- Sleep studies
- Surgical procedures (including assistance at surgery)

- Only certain surgical assistants are eligible providers.
- Call Customer Service at the number on your member ID card to verify that the surgical assistant chosen by your doctor is eligible and to determine whether the surgical assistant and anesthesiologist selected by your doctor are in-network providers.

- Treatment of temporomandibular joint (TMJ) disorders

About your cost share for physician services:

- If multiple surgical procedures are performed during a single operative session, the secondary procedures are usually reimbursed at reduced amounts. Noncontracted providers may balance bill you for secondary, incidental, or mutually exclusive procedures, in addition to the primary surgical procedure.
- You may receive services in a doctor's office that incorporate services or supplies from a provider other than your doctor. A few examples:
  - You see your doctor to pick up DME that came from a medical supply company
  - Your doctor explains test results to you that came from a tissue sample analysis done by a pathologist
  - Your doctor explains your X-ray results based on a reading that was done by a radiologist
- If another provider submits a separate claim for those services or supplies, you will pay the cost share for that provider plus your office visit cost share.

Z. POST-MASTECTOMY SERVICES

Federal and state laws require certain breast reconstruction services following a medically necessary mastectomy. Your plan covers these legally required services, and 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 members receiving the mastectomy-related benefits described in this section, BCBSAZ will provide coverage in a manner determined in consultation between the attending physician and the member being treated. These benefits are subject to the same cost share generally applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Customer Service at the number on your ID card.

AA. PREVENTIVE SERVICES

Preventive services are those performed for screening purposes when you do not have active signs or symptoms of a condition. Your plan covers preventive services at no charge when obtained from an in-network provider. Coverage is provided when recommended by your provider and as appropriate for your age and gender, and as recommended by:

- Advisory Committee on Immunization Practices (ACIP) routine immunization recommendations at cdc.gov/vaccines/hcp/acip-recs/index.html
- Health Resources and Services Administration (HRSA) guidelines for pediatric and adolescent preventive care and screening at mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html
- HRSA guidelines for women's healthcare services at hrsa.gov/womens-guidelines/index.html

- U.S. Preventive Services Task Force (USPSTF) A or B rated services at uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

Your plan also specifically covers the following services at no charge when obtained from an in-network provider:

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

For a list of covered preventive medications, see Guidance Regarding Preventive Medications, or call Pharmacy Benefit Customer Service.

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

If you have been denied coverage of a preventive service due to your gender on file with BCBSAZ, and you are undergoing or have undergone gender transition, please contact Customer Service at the number on your ID card for assistance. BCBSAZ covers all gender-specific preventive services that are deemed medically necessary for a member, as determined by the member's attending provider, without regard to the member's gender identity, gender assigned at birth, or gender that is on file with BCBSAZ.

Coverage limits:

- Coverage is limited to one preventive physical exam per member, per calendar year, unless additional visits are necessary for the member to obtain all covered preventive services. This limit does not apply to claims submitted with a primary behavioral health diagnosis.
- Preventive services do not include diagnostic tests performed because you have a condition or an active symptom of a condition. Active symptoms and conditions are determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.
- If you have a service or test that falls under this benefit, but the service or test is being done because of a specific diagnosis or because you are experiencing signs or symptoms of a condition or disease, the service or test may be covered through another benefit section of this plan. Certain maternity services covered under this benefit also are available through the Maternity benefit.

Not covered:

- Abortifacient medications
- All prescription and over-the-counter contraceptive medications and devices for male plan members

BB. RECONSTRUCTIVE SURGERY AND SERVICES

Your plan covers services 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

Not covered: Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations, and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy to the extent required by federal and state law (see Post-Mastectomy Services) or medically necessary breast implant removal.

CC. SERVICES TO DIAGNOSE INFERTILITY

Your plan covers services to diagnose infertility.

Not covered: Services, medications, treatments, or procedures to achieve fertility or treat infertility.

DD. TELEHEALTH SERVICES—BLUECARE ANYWHERE

Your plan covers remote medical and behavioral health consultations between a provider and a patient offered by the telehealth services administrator (TSA) through BlueCare Anywhere, including:

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

To use BlueCare Anywhere telehealth services:

Log in to your MyBlue account and click the “BlueCare Anywhere” link. Or, download the app directly from the Google Play store or the Apple App Store. Learn more about BlueCare Anywhere telehealth services.

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 see a doctor in person.

Not covered:

- Services that are not provided through the TSA, including emergency services and preventive services
- Services covered under the Telehealth Services—In-Network Providers benefit described below

EE. TELEHEALTH SERVICES—IN-NETWORK PROVIDERS

Your plan covers 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.

Not covered:

- 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 (fax) machine, instant messages, or electronic mail, unless otherwise required by law
- Services covered under the Telehealth Services—BlueCare Anywhere benefit described above

FF. TRANSPLANT OR GENE THERAPY TRAVEL AND LODGING

For this benefit, the *caregiver* is the person primarily responsible for providing daily care, basic assistance, and support to a member who is eligible for transport, lodging, and reimbursement. Caregivers may perform a wide variety of tasks to assist the member in his or her daily life, such as preparing meals, assisting with doctors' appointments, giving medications, or assisting with personal care and emotional needs.

Your plan covers reimbursement for transplant travel and lodging expenses during evaluation, candidacy, transplant, and post-transplant care, and for complications directly related to the transplant. Reimbursement is available for transplant or gene therapy travel and lodging expenses when *all* of the following criteria are met:

- BCBSAZ has given prior authorization for the service or, if BCBSAZ did not give prior authorization for the service, upon review we determine the service meets the requirements of this benefit plan;
- The expenses are incurred by the member or the member's caregiver; **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; or bus, train, or air fare; **or**
  - Room charges from hotels, motels, and hostels or apartment rental.

Coverage limits: $10,000 per member, per transplant or gene therapy treatment. Covered expenses incurred by a caregiver count toward the member's limit.

Not covered:

- 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 coverage limits
- All travel and lodging expenses incurred by a donor or the donor's caregiver
- 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 are not covered under this benefit plan

- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- 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. See the Medical Claims section for details on how and where to submit a claim.

GG. TRANSPLANTS—ORGAN, TISSUE, AND BONE MARROW AND STEM CELL PROCEDURES

For this benefit, a bone marrow transplant is a medical or surgical procedure that has several stages, including:

- Administration of high-dose chemotherapy and high-dose radiotherapy as prescribed by the treating doctor;
- 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.

In-network benefits are available for covered transplant services from: 1) providers contracted with the plan network, 2) providers contracted with host Blue plans, **and** 3) Blue Distinction Centers for Transplants. Your plan covers the following types of transplants when 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 and single- and double-lung), pancreas, small bowel, small bowel-multivisceral

Your plan covers 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 48 contiguous United States to obtain tissue that is later 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
- 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

Not covered:

- 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

HH. URGENT CARE

Your plan includes services for urgent care. For this benefit, urgent care means treatment for conditions that require prompt medical attention, but which are not emergencies.

Providers contracted with the plan network as urgent care centers are listed in your MyBlue account under "Urgent Care Centers."

Please be aware that the plan network includes some providers, such as hospitals, that offer urgent care services, but which are not specifically contracted with the plan network 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.

II. PEDIATRIC DENTAL SERVICES

Pediatric dental services are covered under your plan for eligible members until the end of the plan year in which the member turns 19. Here are some terms to know for this benefit:

- *Abutment* is an anchor or support for a crown.
- *Bitewing x-ray* is a dental x-ray that shows the crowns of your upper and lower teeth (cavity-detecting x-ray).
- *Fixed bridge* is a false tooth (*pontic*) that is held in place by crowns placed on the teeth on either side of the missing tooth and is one piece.
- *Crown* is a covering (cap) placed over a tooth.
- *Denture* is a removable replacement for missing teeth.
- *Endodontic services* are dental treatments addressing the inside of the tooth root.
- *Full mouth x-ray* is a complete set of x-rays (including four bitewings) that shows all of the teeth in the mouth.
- *Implant* is an anchor placed in the gums or jawbone to replace the root portion of a tooth to support an artificial tooth, bridge, or denture.
- *Inlay* is a custom molded filling that is bonded to the biting surface of a tooth.
- *Interceptive orthodontic treatment* is early recognition and treatment of developing malocclusions in order to prevent more complicated treatment in the future.
- *Onlay* is a custom-molded filling that is bonded to the biting surface of a tooth and includes the cusp(s) of the tooth.
- *Oral surgery* is procedures to treat diseases, injuries, or defects in the mouth that may involve tooth extractions, removal of lesions, or removal or repair of soft or bony tissue.
- *Panoramic x-ray* means a type of x-ray taken with a special machine that rotates around the head to capture the jaws and teeth in one shot.
- *Periapical x-rays* are x-rays of the root and crown of the teeth.
- *Periodontic services* are dental treatments addressing the gums and supporting structures of the teeth.
- *Pontic* is a replacement tooth on a fixed bridge.
- *Prophylaxis* is preventive cleaning of the teeth.

- *Prosthodontic services* are services dealing with construction of artificial appliances for the mouth when there are missing or deficient teeth.
- *Restorative services* are services to repair or replace damaged teeth and treat oral diseases.
- *Sealants* are a protective coating applied to the biting surface of the teeth to help prevent cavities.
- *Space maintainer* is a device that helps prevent shifting of teeth when one or more teeth are missing.
- *Veneer* is a thin layer of material placed over a tooth, either to improve the aesthetics of a tooth or to protect existing damage to a tooth's surface.

II.1 Type I Services

Services covered:

- Oral examinations—Limited to two examinations per calendar year in any combination of periodic, limited, or comprehensive exams.
- Prophylaxis cleaning—Limited to two treatments per calendar year. If you receive any prophylaxis treatments, they will count toward the calendar-year limit for periodontal maintenance treatments.
- Sealants—Limited to one application in any three calendar years. Sealants applied to permanent molars with no decay or restoration.
- Space maintainers—Temporary appliances that replace prematurely lost teeth until permanent teeth erupt.
- Topical fluoride treatment—Limited to two topical fluoride treatments per calendar year. Direct application of fluoride solution to the teeth to prevent tooth decay in the dental office.
- X-rays:
  - Bitewing—Limited to two sets per calendar year. Any combination of x-rays billed on the same date of treatment are limited to the allowed amount for a full-mouth x-ray.
  - Full-mouth x-rays—Limited to one set in any five calendar years. Any combination of x-rays billed on the same date of treatment are limited to the allowed amount for a full-mouth x-ray.
  - Panoramic x-rays—Limited to one per five calendar years. A panoramic x-ray, when accompanied by bitewing x-rays, is considered the same as a set of full-mouth x-rays, and is subject to the benefit limit for full-mouth x-rays.
  - Periapical—Any combination of x-rays billed on the same date of treatment are limited to the allowed amount for a full-mouth x-ray.

Coverage limits and services not covered: See Pediatric Dental Limits and Exclusions.

II.2 Type II Services

Services covered:

- Emergency palliative treatment—Treatment of pain or discomfort in emergency situations.
- Endodontic pulpal therapy—Limited to one treatment per tooth, per member, per lifetime. Pulpal therapy for primary incisors is covered through age 5, and pulpal therapy for primary molars and cuspids is covered through age 10.
- Occlusal guards—Limited to one guard, per member, per calendar year, only for members age 13 and older. Occlusion analysis and adjustment of occlusal guards are also covered.
- Periodontal non-surgical services—Non-surgical procedures to treat diseases of the gums and bones, such as gingivitis or periodontitis. Periodontal scaling and root planing are limited to one procedure, per quadrant, every two calendar years. Full mouth debridement is limited to one procedure per member, per lifetime. Periodontal maintenance procedures are limited to

four procedures per calendar year. If you receive any prophylaxis/cleanings, they will count toward the calendar-year limit for periodontal maintenance procedures.

- Restorative fillings—Restoration of fractured, chipped or decayed teeth, including amalgam and composite resin. Placement of infiltrating resin restorations for strengthening, stabilizing and/or limiting the progression of a smooth surface lesion is limited to one restoration per tooth, per member, per three calendar-year period.
- Simple extractions—Extraction of an erupted tooth, an exposed root, or parts of a crown (coronal remnants) that is falling off a tooth.

Coverage limits and services not covered: See Pediatric Dental Limits and Exclusions.

II.3 Type III Services

Services covered:

- Anesthesia—Deep sedation or general anesthesia only when performed in conjunction with complex surgical extraction of an erupted or impacted tooth, or residual tooth roots, as defined in current evidence-based criteria.
- Bone grafts—Covered in connection with the following procedures:
  - Implants
  - Periodontal surgery
  - Surgery involving a tooth root
- Crowns, inlays, and onlays—Limited to once per tooth in any five calendar years, except for metallic surface inlays and repairs of inlays or onlays necessary due to restorative material failure. Available only when the tooth cannot be restored to full form and function with a routine filling.
- Endodontic root canal services
- Implants—Limited to one implant per tooth location in any five calendar years
- Intravenous conscious sedation and analgesia
- Oral surgery—Surgical tooth extractions (including removal of an impacted tooth or residual tooth roots), removal of lesions, and removal or repair of soft or bony tissue
- Periodontal surgical services:
  - Surgical procedures to treat diseases of the gums and bones, such as gingivitis or periodontitis. Limited to one procedure in any three calendar years, including gingivectomy or gingiovoplasty to allow access for a restorative procedure.
  - The limit of one procedure per three calendar-year period does not apply to gingivectomy or gingiovoplasty (one to three contiguous teeth or tooth bounded spaces per quadrant) not associated with a restorative procedure, clinical crown lengthening (hard tissue), pedicle soft tissue graft procedure, free soft tissue graft procedures, or subepithelial connective tissue graft procedures.
- Prosthodontic services:
  - Bridge and denture repair to original condition, if necessary to restore function of bridge or dentures
  - Denture relining or rebasing, if necessary to restore function of denture. Limited to one procedure in any three calendar years
  - Existing complete or partial dentures obtained under this benefit plan can be replaced only if:
    - The dentures are at least five years old and cannot be repaired; **or**
    - The denture is damaged beyond repair while in the oral cavity due to an injury received while the member is covered under this benefit plan

- Original placement of bridges, partial dentures, and complete dentures
- Replacement of dentures or bridgework once every five years, under the following circumstances:
  - Bridgework obtained under this benefit plan can be replaced only if:
    - Damage or disease to the teeth abutting or supporting the bridge has occurred to such an extent that the bridge must be replaced; **or**
    - The bridge is at least five years old and cannot be repaired; **or**
    - The bridge is damaged beyond repair while in the oral cavity due to injury the member received while covered under this benefit plan
  - Replacement of bridgework done before the member had coverage under this benefit plan is covered if the bridgework cannot be repaired.
- Replacement of removable dentures obtained before the member had coverage under this benefit plan is covered if the dentures cannot be repaired.

- Veneers—Limited to the following circumstances:
  - Repair of an existing veneer is necessary due to restorative material failure.
  - The surface of the tooth is not restorable by an alternate, dentally appropriate means.
  - The surface of the tooth is not structurally sound to hold a filling or to be repaired using an alternate, dentally appropriate means.

Coverage limits and services not covered: See Pediatric Dental Limits and Exclusions.

II.4 Type IV Services

Orthodontic benefits are available for the following medically necessary services, as defined in current evidence-based criteria:

- Pre-orthodontic treatment
- Limited, interceptive, and comprehensive orthodontic treatment
- Removable and fixed appliance therapy
- Orthodontic retention (removal of appliances, construction, and placement of retainer(s))
- Surgical repositioning of teeth

Coverage limits and services not covered: See Pediatric Dental Limits and Exclusions.

II.5 Pediatric Dental Type I-IV Services Limits and Exclusions

Coverage limits:

- Pediatric dental benefits apply only to specific dental codes associated with the services listed above. For a complete list of codes, see Pediatric Dental Codes.
- Benefits are only available for eligible members until the end of the plan year in which the member turns 19.

Not covered: Notwithstanding any other provision in this benefit plan, no pediatric dental benefits will be paid for expenses associated with the following services. Some services excluded from pediatric dental benefit coverage may be covered under your medical benefits. These exclusions do not apply to services that must be covered according to federal or state law.

- **Additional procedures to construct a new crown under existing partial denture framework**
- **Alternative dentistry**—Non-traditional or alternative dental therapies, interventions, services and procedures; naturopathic and homeopathic dentistry; diet therapies; nutritional or lifestyle therapies

- **Adjustment of a denture or bridgework that is made within six months after installation by the same dentist who installed it**
- **Appliances, procedures, devices, and services necessary to alter vertical dimension and/or restore an occlusion**
- **Athletic mouth guards**, including, but not limited to, any procedures and services necessary to fabricate or create such mouth guards
- **Benefit-specific exclusions and services in excess of limitations listed in this book under particular benefits**
- **Biologic materials to aid in tissue regeneration**
- **Biopsies,** including, but not limited to, biopsies of hard or soft oral tissue; and brush biopsies/transepithelial sample collection
- **Bleaching of any kind, both internal and external**
- **Bone grafts when done in connection with extractions, apicoectomies, or noncovered implants**
- **Bundled services**—When two or more services are submitted and the services are considered part of the same service to one another, BCBSAZ will pay the most comprehensive service (the service that includes the other non-benefited service), as determined by BCBSAZ
- **Closed or open reduction of maxilla or mandible, malar or zygomatic arch, or alveolus**
- **Collection and preparation of saliva sample** for laboratory diagnostic testing
- **Collection of microorganisms** for culture and sensitivity
- **Complicated reduction of facial bones with fixation and multiple surgical approaches**
- **Complicated sutures**
- **Cone beam imaging**, including magnetic resonance imaging (MRI) and CT procedures
- **Coping**, used as a definitive restoration when coping is an integral part of a fixed prosthesis or as a thin covering of the remaining portion of a tooth, usually fabricated of metal and devoid of anatomic contour
- **Correction of congenital malformations**, except as required by Arizona law for newborns, adopted children, and children placed for adoption
- **Coronoidectomy**—Surgical removal of the coronoid process of the mandible
- **Cosmetic services and any related complications**—Surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes; charges for personalization or characterization of prosthetic appliances
- **Court-ordered services**—Court-ordered testing, treatment, and therapy, unless such services are otherwise covered under this plan as determined by BCBSAZ
- **Dental office visit for observation, during which no services are provided**
- **Dental services and supplies not provided by a dentist**—except dental prophylaxis and root planing performed by a licensed dental hygienist under the supervision and direction of a dentist, and other covered services provided by dental hygienist outside Arizona, if the hygienist is providing services within the scope of his or her license and applicable state law
- **Dental topical medicament center**
- **Dental treatment or services for injuries resulting from the maintenance or use of a motor vehicle**, if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan
- **Duplicate, provisional and temporary devices, appliances, and services**, including provisional crowns; provisional replacement tooth on a fixed bridge; interim complete and partial dentures; temporary crowns for fractured teeth; and provisional retainer crowns

- **Emergency tracheotomy**
- **Enamel microabrasion**
- **Endodontic surgical services**, including but not limited to intentional reimplantation, including necessary splinting, for the intentional removal, inspection and treatment of a root and replacement of a tooth into its own socket; endodontic surgical procedure for isolation of a tooth with a rubber dam; endodontic hemisection (including any root removal), not including root canal therapy; and endodontic canal preparation and fitting of preformed dowels or posts
- **Excision of hyperplastic tissue**
- **Exfoliative cytological sample collection**
- **Expenses for services that exceed benefit limitations**
- **Experimental or investigational services or items**
- **Fees** that are a) for unspecified adjunctive procedures, including specialized procedures or techniques, by report; b) for implants, endodontic, oral surgery, periodontal, diagnostic, removal or fixed prosthodontic, restorative, adjunctive, or orthodontic services, when the claim does not specify the procedure performed; c) other than for dentally appropriate, in-person, direct member services, including any charges for failure to keep a scheduled appointment; d) for services submitted by a dentist who is compensated by a facility for the same services; **or** e) for services submitted by a dentist, which are for the same services performed on the same date for the same member by another dentist
- **Frenuloplasty**
- **Genetic tests** for susceptibility to oral diseases
- **Gold foil restorations**
- **Inpatient or outpatient facility services**—any facility charges associated with covered professional services provided in an inpatient or outpatient facility; any additional fees charged by a dentist for services provided in a facility
- **Laboratory and pathology services**
- **Local, regional block, and trigeminal division block anesthesia; nitrous oxide; oral sedation; and oral, intravenous or intramuscular analgesics or anxiolytics**
- **Locally administered antibiotics**
- **Major restorative and prosthodontics services** performed on other than a permanent tooth
- **Maxillary sinusotomy** for removal of tooth fragment or foreign body
- **Maxillofacial prosthetics** and any related services
- **Medications dispensed in a dentist's office**—prescription medications and over-the-counter medications, including pharmaceutical manufacturers' samples, oral antibiotics, oral analgesics, and topical fluoride, dispensed to the patient in a dentist's office by any mode of administration. This does not include eligible injectable medications or topical fluoride administered in the dentist's office.
- **Mutually exclusive services**—When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service); BCBSAZ will pay for the service that represents the final treatment as determined by BCBSAZ
- **Non-dentally necessary services**, as determined by BCBSAZ (**Note:** BCBSAZ may not be able to determine dental necessity until after services are rendered.)
- **Occlusal adjustments** (limited and complete)
- **Office infection control charges**
- **Oroantral fistula closure**
- **Partial ostectomy or sequestrectomy for removal of dead bone**

- **Posterior-anterior or lateral skull and facial bone survey radiographic image**
- **Primary closure of a sinus perforation**
- **Procedures related to salivary glands**—including surgical removal of a stone from a salivary gland or duct, excision of a salivary gland, surgical repair of a defect or restoration of a portion of a salivary gland duct, surgical closure of a salivary fistula, or radiography of a salivary gland
- **Removal of appliances, fixed space maintainers, or posts**
- **Removal of foreign bodies**—including removal of foreign bodies from mucosa, skin or subcutaneous alveolar tissue and removal of reaction-producing foreign bodies from the musculoskeletal system
- **Removal of torus palatinus or mandibularis**
- **Repair of damaged orthodontic appliances**
- **Replacement**—including replacement of dentures that have been lost, stolen, or misplaced, and replacement of lost or missing appliances
- **Sealants for teeth other than permanent molars**
- **Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion, or insurrection**
- **Services related to precision attachments**, including precision attachments, personalization, precious metal bases and other specialized techniques; removable prosthetic precision attachments; replacement of replaceable parts of semi-precision or precision attachments; precision attachments, connector bars or stress breakers for fixed partial dentures
- **Services related to tumors and cysts**, including but not limited to excision of benign or malignant lesions or tumors, removal of benign nonodontogenic cysts or tumors, and removal of benign odontogenic cysts or tumors
- **Services resulting from your failure to comply with professionally prescribed treatment**
- **Sinus augmentation**
- **Skin grafts; synthetic graft, mandible, or facial bones**
- **Specialized dental procedures and techniques**
- **State or territorial taxes on dental services performed**
- **Surgical reduction of fibrous tuberosity**
- **Telephonic and electronic consultations**, except for interactive telehealth services from an in-network dentist using audio and visual equipment to treat dental trauma, burns, or infection
- **Temporary dental services or supplies**, including provisional retainer crowns placed when additional treatment or diagnosis is needed prior to final impression
- **Tomographic surveys**
- **Tooth transplant**
- **Transseptal fiberotomy or supra crestal fiberotomy**
- **Transportation** services and travel expenses
- **Treatment or services for injuries resulting from war or an act of war, whether declared or undeclared**
- **Unscheduled dressing change by someone other than the treating dentist**

JJ. PEDIATRIC VISION BENEFITS

Pediatric vision benefits are covered under your plan for eligible members until the end of the plan year in which the member turns 19.

JJ.1 Pediatric Vision Exams (Routine)

Your plan covers pediatric routine vision exams. For this benefit, a *routine vision exam* is an exam generally performed to determine the need for corrective lenses. Routine vision exams can be performed on new or established patients, and may include routine ophthalmologic exams with refractions.

Coverage limits:

- Coverage is limited to one routine vision exam per member, per calendar year. In-network benefits are available only from providers contracted with the Pediatric Vision Benefits Administrator.
- Benefits are only available for eligible members until the end of the plan year in which the member turns 19.

Not covered:

- Eyeglasses, contact lenses, and other eyewear services (may be covered through another benefit of this plan)
- Medical eye exams (may be covered through another benefit of this plan)
- Office infection control charges
- Services not meeting accepted standards of optometric practice
- State or territorial taxes on vision services performed

JJ.2 Pediatric Contact Lens Fit and Follow Up

There are a few terms to know for this benefit:

- *Premium fit and follow-up* are more complex applications, including, but not limited to, toric, multifocal/monovision, post-surgical, and gas permeable, and includes extended/overnight wear for any prescription.
- *Standard fit and follow-up* are applications of clear, soft, spherical, daily-wear contact lenses for single-vision prescriptions, and does not include extended/overnight wear

Your plan covers standard and premium fit and follow-up services, for contact lenses covered under this benefit plan. Benefits are available only through the Pediatric Vision Benefits Administrator.

Coverage limits: Benefits are only available for eligible members until the end of the plan year in which the member turns 19.

Not covered:

- Office infection control charges
- Services not meeting accepted standards of optometric practice
- Services not provided through the Pediatric Vision Benefits Administrator
- State or territorial taxes on vision services performed

JJ.3 Pediatric Eyewear (Eyeglasses or Contact Lenses)

Here are some terms to know for this benefit:

- *Bifocal lenses* are lenses with two focal lengths: one for distance and one for near vision.

- *Conventional contacts* are lenses intended for ongoing, daily use.
- *Frequently replaced contacts* are lenses that are discarded after a prescribed usage period, typically ranging from one day to one month.
- *Lenticular lenses* are lenses composed of a thin carrier that has an area of high plus power molded to the front surface. This area of power is usually located in the center of the lens and takes on the appearance of a bubble.
- *Medically necessary contact lenses* are contact lenses that are necessary and appropriate for the treatment of certain conditions, as determined by current evidence-based criteria.
- *Progressive lenses* are lenses with no lines and gradient of increasing lens power. Lenses are designated as standard or premium depending on the date the design was introduced to the market, the lens' technology and design features, and the wholesale list price from the manufacturer's laboratory.
- *Single vision lenses* are lenses with one power.
- *Trifocal lenses* are lenses with three areas of viewing, each with its own focusing power.

Your plan covers prescription glasses for single vision, bifocal, trifocal, lenticular, or progressive lenses, and for the following optional lenses and treatments:

- Blended segment lenses
- High-index lenses
- Photochromic glass lenses
- Polarized lenses
- Polycarbonate lenses
- Standard, premium, or ultra anti reflective coating
- Ultraviolet protective coating

Coverage limits:

- Limited to one pair of prescription glasses and frames, or one set of conventional or frequently replaced contact lenses, or one set of medically necessary contact lenses per calendar year through the Pediatric Vision Benefits Administrator.
  - If you choose prescription glasses and you obtain the glasses from a provider contracted with the Pediatric Vision Benefits Administrator, coverage for frames will be limited to frames designated as "pediatric frames" by the provider.
  - If you choose contact lenses, coverage is limited to lenses designated as "pediatric contact lenses" by the Pediatric Vision Benefits Administrator.
  - Coverage is available for hard or soft conventional single or bifocal lenses, or for frequently replaced contact lenses. Coverage is available for medically necessary contact lenses in accordance with applicable evidence-based criteria.
- Benefits are only available for eligible members until the end of the plan year in which the member turns 19.

Not covered:

- Eyewear not provided through the Pediatric Vision Benefits Administrator
- Lens designs or coatings that are not listed in the benefit description
- Non-prescription (plano) lenses or contact lenses
- Non-prescription sunglasses
- Prosthetic devices and services

- Replacement of lost, broken, or stolen eyewear, when the member has exhausted the eyewear benefit quantity limit for the year
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion, or insurrection
- Services or materials resulting from your failure to comply with professionally prescribed treatment
- Services provided after the member's coverage termination date, except when eyewear ordered before coverage ended is delivered, and services are rendered to the former member within 31 days of the date of such order
- Two pairs of glasses in lieu of bifocals

JJ.4 Pediatric Low Vision Evaluation and Follow Up

Your plan covers services for pediatric low vision evaluation and follow-up. For this benefit, low vision is a significant loss of vision but not total blindness.

Coverage limits:

- Coverage is limited to one comprehensive low vision evaluation per member every five years, and for up to four follow-up visits per member in any five-year period from a provider contracted with the Pediatric Vision Benefits Administrator.
- Benefits are only available for eligible members until the end of the plan year in which the member turns 19.

Not covered: Services not provided through the Pediatric Vision Benefits Administrator.

JJ.5 Pediatric Low Vision Hardware

Your plan covers pediatric low vision hardware.

Coverage limits:

- Coverage is limited to one low vision hardware aid, including, but not limited to, high-power spectacles, magnifiers, and telescopes through the Pediatric Vision Benefits Administrator.
- Benefits are only available for eligible members until the end of the plan year in which the member turns 19.

Not covered: Hardware not provided through the Pediatric Vision Benefits Administrator.

What's Not Covered

The following services and/or expenses are not covered by your plan unless we've noted otherwise in this Benefit Book. That means that no benefits will be paid for any expenses for these services.

These exclusions do not apply to services that must be covered according to federal or state law.

Activity therapy and milieu therapy—Any care intended to assist a person with the activities of daily living; including community immersion, integration, home independence, and work re-entry therapy services and programs, as well as any care for comfort and convenience, except for limited hospice benefits

Acupuncture

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

Bariatric surgeries, except as stated in the Inpatient Hospital and the Outpatient Services sections of this book

Benefit-specific exclusions and limitations listed in this book as "Not covered" following the description of each benefit

Biofeedback, except for pain management

Blood administration for the purpose of general improvement in physical condition

Body art, piercing, and tattooing—Services related to body piercing, cosmetic implants, body art, tattooing, and any related complications

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

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

Certain types of facility charges—Inpatient and outpatient facility charges for treatment provided by the following facilities are not covered: group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes

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

Cognitive and vocational therapy—Services related to improving cognitive functioning (i.e., higher brain functions), reinforcing or re-establishing previously learned thought processes, compensatory training, sensory integrative activities, and services related to employability, except as stated in the Neuropsychological and Cognitive Testing and the Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy, Cardiac, and Pulmonary Services sections of this book

Consumable medical supplies, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as stated in the Durable Medical Equipment, Medical Supplies, and Prosthetic Appliances and Orthotics section of this book

Cosmetic services and any related complications—Surgery and any related complications, procedures, treatment, office visits, consultations, and other services for cosmetic purposes

Note: this exclusion does not apply to breast reconstruction following a medically necessary mastectomy, medically necessary breast implant removal, surgery to correct a congenital defect, or to medically necessary surgery to improve or restore the impaired function of a body part or organ.

Cosmetics and health and beauty aids

Counseling—Counseling and behavioral modification services, except as stated in the Behavioral Health Services, the Chronic Disease Education and Training, the Hospice Services, the Preventive Services, the Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy, Cardiac, and Pulmonary 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 and the Pediatric Dental Services sections 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 these listed services, including, but not limited to, procedures associated with dental implants and fitting of dentures

Development of a learning plan, and treatment and education for learning disabilities (such as reading and arithmetic disorders)

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, the Medical Foods for Inherited Metabolic Disorders, and the Pharmacy and Medications Benefits sections of this book

Domiciliary care

Expenses for services that exceed benefit limitations

Experimental or investigational services or items

Fees that are a) associated with the collection or donation of blood or blood products; b) other than for medically necessary, in-person, direct member services; c) for concierge medicine services; **or** d) for direct primary care

Fertility and infertility services—Services to improve or achieve fertility (ability to conceive) or to treat infertility (inability to conceive)

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

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

Foot orthotics, corrective orthopedic shoes, and arch supports for treatment of conditions other than diabetes mellitus and any of the following complications of diabetes involving the foot: peripheral neuropathy with evidence of callus formation; history of pre-ulcerative calluses; history of previous ulceration; foot deformity; previous amputation of the foot or part of the foot; or poor circulation

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 to treat idiopathic short stature (ISS)

Hearing services and devices, except as stated in the Hearing Aids and Services section of this book

Hypnotherapy

Inpatient or outpatient non-acute long-term care

IQ testing

Laboratory services provided without an order from an eligible provider

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

Lodging and meals, except as stated in 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 (as determined by BCBSAZ) is reasonably expected; services to prevent backtracking to a lower level of function; services to prevent future injury; and services to improve or maintain posture

Manipulation of the spine under anesthesia

Manipulation under anesthesia, except for reductions of fractures and/or dislocations done 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, Craigslist, or Amazon; or at garage sales, swap meets, and flea markets

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

Medications that are:

- Not FDA approved
- Not on the formulary or are a non-formulary medication that BCBSAZ and/or the PBM have not authorized a formulary exception
- 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 and Medications Benefits section of this book
- Used to treat a condition not covered by BCBSAZ

Membership costs or fees associated with health clubs and weight loss programs

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

Non-medically necessary services—Services that BCBSAZ determines are not medically necessary

Note: BCBSAZ may not be able to determine medical necessity until after services are rendered. See Medical necessity definition, guidelines, and criteria for more information on how we determine medical necessity.

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

Payments for exclusions imposed by any certification requirement

Payments for services that are unlawful in the location where the member resides at the time the expenses are incurred

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 with daily living, socialization, personal comfort and convenience; homemaker services; services primarily for rest, domiciliary or convalescent care; costs for television or telephone service; newborn infant photographs; meals other

than those provided to a member by an inpatient facility while the member is a patient in the inpatient facility; birth announcements; and other services and items for other non-medical reasons

Phase 3 cardiac rehabilitation

Private-duty nursing

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

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

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

Respite care

Reversal of surgical procedures, except as allowed for under current evidence-based criteria and other criteria, as determined by BCBSAZ

Screening tests—Any testing done on a person who does not have a specific diagnosis or acute signs or symptoms of a condition or disease for which the test is being run, regardless of whether the person 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, LOVAAS therapy, 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 Chronic Disease Education and Training, the Inpatient Hospital and the Outpatient Services sections of this book related to bariatric surgeries, and the Preventive Services 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 performed by ineligible providers (see eligible providers)

Services provided after the member's coverage termination date, except a) covered pediatric eyewear ordered before coverage ended that is delivered, and services are rendered to the former member within 31 days of the date of such order, and b) continuing coverage for 31 days for certain covered pediatric dental benefits if a dentist made a dental impression (such as a mold of the teeth)

before coverage terminated; a dentist opened a pulp chamber before coverage terminated, and a device is installed or treatment is finished within 31 days after coverage terminated; a dentist prepared a tooth for cast restoration before coverage terminated; or a dentist prepared abutment teeth for the completion of installation of prosthetic devices before coverage terminated

Services provided prior to member's coverage effective date

Services related to or associated with developmental delays, except as stated in the Behavioral Health Services, the Neuropsychological and Cognitive Testing, and the Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy, Cardiac, and Pulmonary Services sections 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 which are not prescribed by a doctor or other provider licensed to prescribe

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

Spinal decompression or vertebral axial decompression therapy (VAX-D)

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

Surgical treatment of hyperhidrosis

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 benefit plan

Therapy to improve general physical condition, including, but not limited to, inpatient and outpatient routine long-term care

Training and education, except as stated in the Behavioral Health Services, the Chronic Disease Education and Training, the Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy, Cardiac, and Pulmonary Services, 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; eye exercises; all types of refractive keratoplasties, including, but not limited to, radial keratotomy and/or LASIK surgery; any other procedures, treatments, and devices for refractive correction; eyeglass frames and lenses, contact lenses, and other eyewear; and vision examinations for fitting of eyeglasses and contact lenses, except as stated in the Cataract Surgery and Keratoconus and the Pediatric Vision Benefits sections of this book

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

Voluntary abortions

Wigs and hairpieces, except as stated in the Durable Medical Equipment, Medical Supplies, and Prosthetic Appliances and Orthotics section of this book

Workers' compensation—Services to treat illnesses and injuries that are:

- Covered by workers' compensation; **and**

- Expressly identified as workers' compensation claims when submitted to BCBSAZ.

This exclusion does not apply if the member has opted out of and/or is exempt from workers' compensation.

USING YOUR PHARMACY BENEFITS

Your BCBSAZ health plan includes benefits for prescription drugs. What's covered is detailed in the Pharmacy and Medications benefit description.

This section tells you how to get your prescriptions. You'll also learn about specialty medications, how your cost share is determined, and other details.

You'll find an in-depth list of terms in Appendix A. It's a good place to check if you come across a word that is not familiar.

Covered Medications — the Formulary

A formulary is a list of drugs that are covered by your health plan. It also helps you figure out how much you can expect to pay when you have a prescription filled at a pharmacy in your plan network.

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 made up of licensed pharmacists and doctors from within the community. In making decisions regarding formulary coverage, the P&T committee takes into consideration safety, effectiveness, and information about how the medication is currently being used.

Getting Your Prescriptions

You may fill prescription medications at either a retail pharmacy, the in-network mail order pharmacy, or an in-network specialty pharmacy. If you currently get a specialty medication from a specialty pharmacy and need to get that medication from a retail pharmacy instead, contact BCBSAZ. We will need to determine if you are eligible to receive the specialty medication from a retail pharmacy. Compounded medications must be filled by in-network retail pharmacies that have been credentialed (approved) by BCBSAZ to fill prescriptions for compounded medications. For a list of these pharmacies, contact Customer Service at the number on your ID card.

If your pharmacy is not able to process a prescription, you or your doctor may ask for an exception by calling the Pharmacy Benefit Customer Service number on your ID card (available 24 hours a day, seven days a week, 365 days a year). There is no guarantee that BCBSAZ/PBM will authorize an exception. Reasons for requesting an exception include, but are not limited to: quantity, age, gender, dosage and/or frequency of refill limitations, requests for a formulary exception, and requests for waiver of cost share for medications or devices taken or used for a preventive purpose.

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 any of these things happen, you can either:

- 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.

Medication Synchronization Program

If you are taking two or more prescription medications for a chronic (ongoing) condition, you may request early or short refills of eligible covered medications by calling the Pharmacy Benefit Customer Service number on your ID card and asking to be enrolled 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.

Specialty Medications

If you get a specialty medication from an in-network pharmacy that is not contracted with BCBSAZ specifically for the Specialty Medications benefit, the medication will not be covered under this Pharmacy benefit, but may be covered under another benefit. In that case, it will be subject to the cost-sharing provisions and prior authorization requirements of that benefit.

Visit the Pharmacy section of MyBlue for lists of contracted specialty pharmacies in your area and covered specialty medications. The Pharmacy Benefit Customer Service team (at the number on your ID card) can answer any questions about whether or not a certain specialty medication is covered.

Prescription Cost Share

Your cost share is based on the tier to which BCBSAZ has assigned the medication at the time the prescription is filled. No exceptions will be made regarding the assigned tier of a medication. BCBSAZ may change the tier of a medication at any time without notice. Go to azblue.com to view the lists of prescription drug tiers. To confirm the tier of a particular medication, you may also call Pharmacy Benefit Customer Service at the number on your ID card.

Other than as explained in Preventive Services within the Your Health Plan Benefits section and in your Plan Attachment, no exceptions will be made concerning the cost share you will pay for any medication, regardless of the medical reasons for which you need it. This means if you are taking a brand-name or compounded medication, you pay the applicable cost share for brand-name medications even when there is no equivalent generic medication, or if you are unable to take a generic medication for any reason.

You'll find specifics about any applicable copay or coinsurance amounts and deductibles in your Plan Attachment.

Requests for Formulary Exceptions

BCBSAZ will respond to a formulary exception request to cover a prescription medication not included in the formulary within 72 hours of receiving the request. BCBSAZ will respond to formulary exception requests within 24 hours of receipt, if the request includes documentation from the provider that either:

- The member is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function; **or**
- The member is taking a non-formulary medication as part of a current course of treatment.

Submission of Claims and Cost Adjustments

If you submit a claim for a medication 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 Explanation of Benefits (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 submitting a claim, and will not result in an EOB.

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 call the Pharmacy Benefit Customer Service number on your ID card.

Members, providers, and pharmacies occasionally use coupons, patient assistance programs, and other discount programs to reduce out-of-pocket member costs for prescription medications. When you use a coupon, patient assistance program, or other discount program to get a prescription under your BCBSAZ Pharmacy benefit, the amount of the discount (the dollar value) will be applied to your deductible and out-of-pocket maximum if the medication is:

- A covered medication without a generic equivalent; **or**
- A covered medication with a generic equivalent that has been approved for BCBSAZ coverage through any of the following:
  - Prior authorization;
  - Step therapy; **or**
  - The BCBSAZ formulary exception and appeal process.

FINDING & WORKING WITH HEALTHCARE PROVIDERS

Your health plan is a PPO. That means you have a choice to see a provider in the BCBSAZ network that comes with your plan. Or, you can choose to go outside of the network. You typically pay less when you see an in-network provider. This section explains eligible providers, how to save when you need covered services, and how to find in-network providers.

There is also important information about what to do if you need urgent or emergency care or when you're out of the area.

A few quick tips:

Consider choosing a primary doctor

With your plan, you don't need to select a primary care provider (PCP). However, we recommend that you establish a relationship with a primary doctor. A doctor who knows your medical history is better able to help you spot potential health problems early, while they are small and easier to change.

Before you receive non-emergency or non-urgent services:

- Check the provider's network status and know whether or not they are a contracted plan network provider with BCBSAZ
- Read your benefit materials
- Know your coverage
- Know the limits and exclusions on your coverage (what is not covered)
- Know how much cost share you will have to pay

After you receive services:

- Read your Explanation of Benefits (EOB) and/or monthly health statements
- Tell BCBSAZ if you see any differences between the member cost share listed on your claims documents and what you actually paid.

You'll find an in-depth list of terms in Appendix A. It's a good place to check if you come across a word that is not familiar.

About Covered Services and Choosing Providers

A service that is covered under your plan must also meet two requirements to be covered by BCBSAZ:

- Performed by an eligible individual provider acting within his or her scope of practice; **and**
- Performed at an eligible facility that is licensed or certified for that specific type of service (when applicable).

Scope of practice is determined by the regulatory oversight agency for each health profession. It refers to the procedures, actions, and processes that a licensed or certified medical professional is legally allowed to perform based on their specific education and experience, and demonstrated competency. For example, neurosurgery would not be within the scope of practice for a dentist.

The fact that a service is performed by an eligible and/or in-network provider does not mean that the service will be covered. That's because:

- Not all eligible providers are contracted to participate in the plan network.
- Services may be offered by in-network providers that are not covered by your plan.

Provider contracts allow providers to charge you up to billed charges for noncovered services. We encourage you to discuss costs with your provider before getting noncovered services.

Eligible providers

BCBSAZ defines eligible providers as the properly licensed, certified, or registered providers listed here, when acting within the scope of their practice and license.

Professional Providers	Facility/Ancillary Providers
• Board Certified Applied Behavioral Analyst (BCABA) • Certified registered nurse first assist (CRNFA) • Certified nurse midwife • Certified registered nurse anesthetist (CRNA) • 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 optician • 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 facility

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.

Acupuncturists and doctors of naturopathy and homeopathy are examples of ineligible (not eligible) providers, as defined by BCBSAZ. Other provider types may also be ineligible.

Eligible providers for pediatric services

Eligible providers for pediatric dental services include the following properly licensed providers, when acting within the scope of their practice:

- Doctor of dental surgery (DDS)
- Doctor of medical dentistry (DMD)

Eligible providers for pediatric vision services include the following properly licensed providers, when acting within the scope of their practice:

- Doctor of medicine (MD)
- Doctor of optometry (OD)
- Doctor of osteopathy (DO)
- Licensed optician

Benefits may also be available from other dental or vision professionals whose services are mandated by federal or Arizona law, or who are accepted as eligible by BCBSAZ, or the pediatric benefits administrators. If you need to check on a provider's eligibility or network participation status, use our "Find a Doctor" tool in your MyBlue account. You can also call Customer Service at the number on your ID card.

Balance billing

In most cases, the provider's contract does not allow the provider to charge you 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 this other source (a third-party insurer), or from proceeds received from the other source, for covered services. BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan pays in-network providers for our portion of the allowed amount of a claim.

Except in emergencies, any covered service you receive from an in-network provider must be provided to you within the United States for the services to be considered in-network and subject to in-network member cost share.

In-network Providers

BCBSAZ works with a network of healthcare providers that are licensed in the United States, and that all have a plan-network contract with BCBSAZ, or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ PPO members. These are your in-network providers. When you are traveling outside of Arizona, healthcare providers that are licensed in the United States and have a PPO contract with a Blue Cross and/or Blue Shield plan other than BCBSAZ, as part of the BlueCard® network, are also considered to be in-network providers. In-network providers will file your claims with BCBSAZ or the applicable out-of-state Blue Cross and/or Blue Shield plan.

Save money by staying in-network

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.

The following example shows how your out-of-pocket costs can change depending on whether or not your provider is in- or out-of-network. In this example, the member has already met their calendar-year deductible, and has 20% coinsurance for in-network services and 40% coinsurance for out-of-network services.

<table>
<tr><th>Billed Charges</th><th>Allowed Amount</th><th colspan="2">Costs with In-Network Providers</th><th colspan="2">Costs with Out-of-Network Providers</th></tr>
<tr><td rowspan="2">$1,000</td><td rowspan="2">$400</td><td>You pay:</td><td>20% of the allowed amount:

$80 (20% x $400)</td><td>You pay:</td><td>40% of the allowed amount, plus any amount not covered by BCBSAZ:
$160 (40% x $400)
+$600 balance bill
$760</td></tr>
<tr><td>BCBSAZ pays:</td><td>Remainder of allowed amount:
$320 ($400 – $80)</td><td>BCBSAZ pays:</td><td>$240 ($400 – $160)</td></tr>
</table>

Except for emergency services, if the provider submitting a laboratory, DME/medical supply, air ambulance, and/or specialty pharmacy claim does not have either 1) a plan network contract with BCBSAZ at the time the claim is submitted to BCBSAZ, **or** 2) a PPO contract with the out-of-state Blue Cross and/or Blue Shield plan at the time the claim is submitted, the claim will be processed as an out-of-network claim.

Finding an in-network provider in and outside of Arizona

You can find a list of in-network providers online using the "Find a Doctor" tool in your MyBlue account. If you do not have Internet access and would like to ask for a paper copy of the directory, or have questions about a provider's plan network participation, please call Customer Service before you make an appointment or receive services.

If you cannot find an in-network provider, or are unable to make an appointment with one, you can either:

- Call BCBSAZ Customer Service at the number on the back of your ID card, or
- Ask your regular doctor to send us a request for prior authorization for you to see an out-of-network provider. Keep in mind that we will not issue a prior authorization if we find an available in-network provider who can treat you. You'll find more details about prior authorization in the Prior Authorization section.

Provider treatment decisions and disclaimer of liability

While treating you, in-network providers are acting as 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 in deciding what services to provide you, and how to provide them. 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.

Out-of-network Providers (contracted and noncontracted)

Within this plan, BCBSAZ considers the following to be out-of-network providers:

- Providers who are contracted with BCBSAZ or a host Blue plan as participating-only providers, but do not have a plan network contract;
- Eligible providers who have no contract with BCBSAZ or a host Blue plan (noncontracted providers);
- Providers who are contracted with the Blue Cross Blue Shield Global® Core program; **and**
- Providers who submit a laboratory, DME/medical supply, air ambulance, or specialty pharmacy claim to a host Blue plan and do not have a PPO contract with that plan.

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 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 a balance bill.

Providers contracted with BCBSAZ who are not in the plan network

Some BCBSAZ providers are contracted with BCBSAZ for certain networks, but are not contracted as plan network providers. For purposes of this benefit plan, they are considered noncontracted, and will be treated like any other noncontracted provider described in this Benefit Book. For example, BCBSAZ participating-only providers are noncontracted providers. They may submit your claims to BCBSAZ, although they are not required to. Except for emergency services, and ancillary services provided in an in-network facility, if you receive covered services from a provider who is contracted with BCBSAZ, but not contracted as a plan network provider, you will pay your out-of-network deductible and coinsurance. Because these providers are considered noncontracted, they may balance bill you like any other noncontracted provider.

Noncontracted providers

Eligible providers who have no provider participation agreement with BCBSAZ or any host Blue plan are noncontracted 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 their billed charges and what this plan will pay can be very large. Before you receive services from a noncontracted provider, ask them about the amount of your financial responsibility.

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. A noncontracted provider will not receive a copy of your EOB and will not know the amount this benefit plan paid you for the claim.

Providers contracted with the Blue Cross Blue Shield Global® Core Program

Providers who are contracted with Blue Cross Blue Shield Global Core are out-of-network providers. For covered services from these providers, you will pay your out-of-network deductible, coinsurance, and access fees (except for emergency services), plus the balance bill. See the Out-of-area Services section below for more information about the Blue Cross Blue Shield Global Core program.

Eligible Provider Status & Payment Summary Subject to all terms and conditions noted in this section				
Provider Contract Status	**Provider Network Status and Applicable Cost Share**	**Provider Required to File Claim on Member's Behalf?**	**Provider Accepts BCBSAZ Allowed Amount and Does Not Balance Bill?**	**Who Receives Payment?**
Providers contracted with BCBSAZ as plan network providers*	In-network*	**Yes***	**Yes***	**The provider** BCBSAZ pays the provider the allowed amount, minus your cost share.
Providers contracted with another Blue Cross or Blue Shield plan ("host Blue") as PPO providers*	In-network*	**Yes***	**Yes***	**The provider** The host Blue, on behalf of BCBSAZ, pays the provider the allowed amount, minus your cost share.*
Providers contracted with host Blue as participating-only providers*	Out-of-network	**Yes**	**Yes**	**The provider** The host Blue, on behalf of BCBSAZ, pays the provider the allowed amount, minus your cost share.
Providers contracted with Blue Cross Blue Shield Global Core	Out-of-network	**Yes**	**No**	**The provider** Blue Cross Blue Shield Global Core pays the provider the allowed amount, minus your cost share.
Noncontracted providers for non-emergency or non-ancillary services rendered in an in-network facility—in and outside Arizona, including providers who are contracted with BCBSAZ but not for your plan network (must be eligible providers)*	Out-of-network	**No** (although the provider may choose to file the claim for you as a courtesy)	**No** You may be responsible for the provider's full billed charges. There may be a large difference between billed charges and what you can get back from BCBSAZ. Ask about billed charges before you receive services.	**You or the provider** BCBSAZ pays you or the provider the allowed amount, minus your cost share.
Noncontracted emergency service providers—in and outside Arizona (must be eligible providers)	Out-of-network	**No** (although provider may choose to file the claim for you as a courtesy)	**Yes** If the provider disputes the allowed amount, the provider must resolve the dispute with BCBSAZ directly.	**The provider** BCBSAZ pays the provider the allowed amount, minus your cost share.

**Except as noted elsewhere in this Benefit Book*

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:

1. 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**

2. 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.

1. 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.

2. 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.

Network Status (Pediatric Services Only)

In-network and out-of-network providers for pediatric dental services

- In-network providers are the following: (1) dentists in Arizona who are contracted with BCBSAZ, and (2) dentists outside Arizona who participate in the BCBSAZ network through an arrangement between BCBSAZ and the pediatric dental benefits administrator. The pediatric dental benefits administrator is responsible for contractual arrangements with non-Arizona dentists. Coverage for pediatric dental services is not available through the BlueCard program.

- Out-of-network providers are Arizona dentists who are not contracted with BCBSAZ, and dentists outside Arizona who do not have a contractual arrangement with the pediatric dental benefits administrator to provide pediatric dental services to BCBSAZ members outside Arizona.

In-network and out-of-network providers for pediatric vision services

- In-network providers are the following: (1) for exams and evaluations provided in Arizona, physicians or optometrists who are contracted with the Pediatric Vision Benefits Administrator, (2) for exams and evaluations provided outside Arizona, physicians or optometrists contracted with the Pediatric Vision Benefits Administrator, and (3) for eyewear provided in Arizona or outside Arizona, optometrists or opticians contracted with the Pediatric Vision Benefits Administrator. Coverage for pediatric vision services is not available through the BlueCard program.
- Out-of-network providers are: (1) Arizona providers who are not contracted with the Pediatric Vision Benefits Administrator to provide pediatric vision exams and evaluations to BCBSAZ members in Arizona, and (2) providers outside Arizona who are not contracted with the Pediatric Vision Benefits Administrator to provide exams, evaluations and/or eyewear to BCBSAZ members outside Arizona.

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. Inter-plan arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Anytime you obtain healthcare services outside of BCBSAZ's geographic service area, the claims for these services may be processed through one of these inter-plan arrangements.

When you receive care outside of BCBSAZ's service area, you will receive it from one of two kinds of providers. Most providers (known as participating providers) contract with the local Blue Cross and/or Blue Shield plan in that geographic area (we call them a host Blue plan). Some providers do not contract with the host Blue plan (these are nonparticipating providers). We explain below how BCBSAZ pays each kind of provider.

Inter-plan arrangements eligibility—claim types

All claim types may be processed through inter-plan arrangements as described above, except for all dental care benefits (except when paid as medical claims/benefits), and any prescription drug benefits or vision care benefits that may be provided by a third party that is 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 plan, BCBSAZ will remain responsible for doing what we agreed to in the contract. However, the host Blue plan is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive out-of-area covered services and the claim is processed through the BlueCard program, the amount you pay for the covered services is calculated based on the lower of:

- The billed charges for your out-of-area covered services; **or**
- The negotiated price that the host Blue plan makes available to us.

Often, this negotiated price will be a simple discount that reflects an actual price that the host Blue plan 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 we have used for your claim because they will not be applied after a claim has already been paid.

Special cases—value-based programs (including the BlueCard program)

If you receive covered services under a value-based program inside a host Blue plan's service area, you will not be responsible for paying the provider for any of the provider incentives, risk-sharing fees, and/or care-coordinator fees that are part of such an arrangement, except when a host Blue plan passes these fees on to BCBSAZ through average pricing or fee schedule adjustments. 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, we will include any such surcharge, tax, or other fee as part of the claim charge passed on to you.

Nonparticipating providers outside BCBSAZ's service area

What you pay:

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 plan'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 1) billed charges for covered services, 2) the payment we would make if the healthcare services had been obtained within our service area, **or** 3) a special negotiated payment to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be responsible for paying 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 (what we call the BlueCard service area), you may be able to take advantage of the Blue Cross Blue Shield Global Core program when you receive covered services. The Blue Cross Blue Shield Global Core program is different from the BlueCard program in certain ways. For instance, although the Blue Cross Blue Shield Global Core program connects you with a network of inpatient, outpatient, and professional providers, the network is not served by a host Blue plan. So, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers at the time of service, and submit the claims to BCBSAZ 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 **1-800-810-BLUE (2583),** or call collect at **804-673-1177.** The Service Center is available 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will set up a doctor 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 also contact BCBSAZ to obtain prior authorization for non-emergency inpatient services.

- **Outpatient services:** Doctors, urgent care centers, and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services.
- **Submitting a Blue Cross Blue Shield Global Core claim:** When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. The claim form is available from BCBSAZ Customer Service, from the Service Center, or online at bcbsglobalcore.com. If you need help with your claim submission, call the Service Center at **1-800-810-BLUE (2583)**. You can also call collect at **804-673-1177**, anytime, 24 hours a day, seven days a week.

Services received on cruise ships

If you receive healthcare services while on a cruise ship, you will pay your 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 department at the phone number listed on your ID card for more information, or mail copies of your receipts to the BCBSAZ address for cruise ship claims.

PRIOR AUTHORIZATION

Some services that are covered by your plan need our OK before you get them. These services may include procedures, treatments, and medications. The BCBSAZ review process is called prior authorization. Your doctor may also call it precertification, or preapproval.

When prior authorization is required, your doctor or other treating provider sends BCBSAZ a request for prior authorization along with any other information we need. The most important thing for you to remember is prior authorization must be done before you receive the service or fill the medication.

You'll find an in-depth list of terms in Appendix A. It's a good place to check if you come across a word that is not familiar.

When to Get a Prior Authorization

Not all services or medications require prior authorization. Prior authorization is not needed for emergency services or urgent care services. If it is required for a service you need, your doctor or treating provider must get the prior authorization on your behalf before rendering services. Sometimes, prior authorization is required for services only when they are provided in certain settings. If prior authorization is not obtained for medications that require it, the medications will not be covered.

On the BCBSAZ website, you'll find a list of services that need prior authorization at azblue.com/individualsandfamilies/resources/forms and medications that need prior authorization at azblue.com/pharmacy. You can also call Customer Service at the number on your ID card to request a prior authorization list.

Important: We update our prior authorization requirements from time to time. We post the new information online when we do. So, it's a good idea to review the prior authorization requirements found at the links above before you have a new type of service or fill a new medication.

How to Get a Prior Authorization

Ask your treating provider (the provider you are seeing) to contact BCBSAZ for prior authorization before you receive services and medications that require it. Your provider is the one who must contact BCBSAZ because they have the information and medical records we need to make a benefit determination. BCBSAZ will rely on the information we get from your provider. If that information is not correct, or if something is missing, that may affect our decision on your request or claim.

BCBSAZ will make a decision about your prior authorization request within a reasonable time period, considering your medical circumstances, but not later than 10 business days from the day we get your request. If we need more time to make a decision, BCBSAZ may extend the prior authorization time by an additional 15 days. If this happens, we will tell you before the end of the original 10-day period, and give you an expected decision date. We will also let you know if there is any additional information we may need in order to make our decision. You or your provider will then have at least 45 days to send us this information.

Factors we consider in evaluating a prior authorization request for services or medications:

- If the service will be performed in the appropriate care setting
- If the treating provider or location of services is in-network
- Whether the service is medically necessary (based on your medical and treatment history) or investigational
- Whether you have reached your coverage limit
- Whether your coverage is active or not (has lapsed)
- Your plan's limitations and exclusions

If you don't ask for prior authorization

If you have a service or fill a prescription that needs prior authorization, but we did not get a request for prior authorization, we will most likely not cover the service, and you will have to pay the billed charges in full.

In addition, if your out-of-network provider does not get a prior authorization from BCBSAZ for a service that requires it, you may be required to pay a prior authorization charge as listed in your Plan Attachment, or the claim may be denied. You'll find a list of services that need prior authorization at azblue.com/individualsandfamilies/resources/forms and medications that need prior authorization at azblue.com/pharmacy. If you have to pay a prior authorization charge, it does not count toward your calendar-year deductible or out-of-pocket maximum.

Prescription medication exception

If a covered medication requires prior authorization, but you must get the medication outside of BCBSAZ's prior authorization hours, you may have to pay the entire cost of the medication when you pick it up. In such cases, you can:

- Have your treating provider request prior authorization on the next business day, then
- File a reimbursement claim with BCBSAZ.

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 who offers the covered services you need, your treating provider may contact BCBSAZ and ask for prior authorization for the in-network cost share for services you will receive from an out-of-network provider. BCBSAZ will first look for an in-network alternative. If we determine that an in-network provider is available to treat you, BCBSAZ will not provide prior authorization for services from an out-of-network provider.

The process of prior authorization for in-network cost share for services from an out-of-network provider is separate from the process of prior authorization for services. If your service needs prior authorization, and the provider you are planning to see is out-of-network, and you want to be eligible for the in-network cost share, your treating provider will need to make **two separate prior authorization requests—**one for the service itself, and one for use of the out-of-network provider. If BCBSAZ provides 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.

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 and/or services over a certain period of time. You may request prior authorization for additional visits and/or services. If your request involves urgent care and is made at least 24 hours prior to the expiration of your plan of care, BCBSAZ will make a decision as soon as possible considering the urgency of your medical condition, but no later than 24 hours after we get the request. If your request isn't made at least 24 hours prior to the expiration of your plan of care, BCBSAZ will make a determination as soon as possible in accordance with medical exigencies, but no later than 72 hours after we receive the request. If prior authorization is denied, you may appeal the denial in the same way you appeal any other coverage denial.

When BCBSAZ Provides Prior Authorization for Your Service

You and your provider will receive a letter from BCBSAZ explaining exactly what has been approved under the prior authorization. Payment will be made for the service that has received prior authorization in accordance with plan benefits.

If BCBSAZ denies your prior authorization request

If BCBSAZ does not approve your request for prior authorization, you can file an appeal. We will send you a notice explaining the reason for the denial and how you can appeal the decision. You'll find the information on where and how to file an appeal on MyBlue.

If your request for prior authorization for a service is denied because BCBSAZ decides that the service is not medically necessary, remember that this denial is a benefits determination made according to the provisions (terms) of this plan. Your provider may sometimes recommend services or treatment not covered under this plan. If BCBSAZ denies prior authorization, you and your provider should decide whether to proceed with the service or procedure based on what is best for you and your health.

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 one that falls under one of these scenarios:

- Not responding to the request within 72 hours could seriously jeopardize the member's life, health, or ability to regain maximum function; **or**
- In the opinion of a doctor with knowledge of the member's medical condition, not responding to the request within 72 hours would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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.

MEDICAL CLAIMS

This section tells you when, how, and where to submit medical claims. A claim is a request for payment. In most cases, in-network providers will file claims for you. Noncontracted providers may file your claims for you, but have no obligation to do so.

It's important that you or your providers file all your claims. That is how BCBSAZ can track your covered expenses and properly credit your applicable deductibles, coinsurance, out-of-pocket maximums, and coverage limits.

If you choose to pay a provider directly and submit a receipt and claim form to BCBSAZ, BCBSAZ will credit your deductibles and out-of-pocket maximums as required by applicable law and the provisions of this policy. The receipt you send with your claim form must include:

- The amount paid;
- The procedure and diagnosis codes for the services you received; **and**
- A notation showing that you paid the provider directly.

Under your plan, if you choose to pay a contracted provider directly for a covered service, the provider will not submit the claim to BCBSAZ for processing. You will need to submit the claim to BCBSAZ.

You'll find an in-depth list of terms in Appendix A. It's a good place to check if you come across a word that is not familiar.

Claim Forms

BCBSAZ claim forms are available under "Manage My Plan/Forms" within MyBlue. You can also call the Customer Service number on your ID card to have one mailed to you.

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

- Billed charges
- Date of service
- Diagnosis code
- Group number
- Member ID number
- Member name
- Name of provider
- Patient name
- Patient's birth date
- Procedure code
- Provider ID number
- Area of oral cavity or tooth treated, as applicable (dental claims only)
- Description of service (dental claims only)

Time limit for claim filing

A complete claim, as described above, must be filed **within one year from the date of service.** Any claim not filed with all required content within the one-year period is considered 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 in the following situations:

- When 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
- When 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 them from filing the claim
- Other similar situations outside the member's reasonable control

Other information needed to process a claim

Even when you send in a claim with all information listed above, BCBSAZ may need to request medical or dental records or coordination of benefits information (explained in the section Coordination of Benefits) to make a coverage determination. If BCBSAZ has requested medical records or other information from a third party, BCBSAZ will stop processing the claim while the request is pending. BCBSAZ may deny a claim if the requested records are not provided by the requested deadline.

Where to Send Claims

Claims for medical services:	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
Claims for pediatric vision services:	Vision Claims P.O. Box 8504 Mason, OH 45040-7111

Claims for services provided by independent clinical laboratory, DME/medical supply, specialty pharmacy, and air ambulance providers are required to be filed by providers as follows:

- **Independent clinical laboratory and specialty pharmacy:** Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the referring provider is located.
- **DME/medical supplies:** Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the member resides.
- **Air ambulance:** Claims must be filed with the Blue Cross and/or Blue Shield plan in the state of the member pickup location.

Explanation of Benefits and Monthly Member Health Statement

After your claim is processed, BCBSAZ will send you an Explanation of Benefits (EOB). Most EOBs are consolidated and sent to you in a monthly Member Health Statement rather than as single EOBs. You can see all of your BCBSAZ EOBs at MyBlue.

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 to make sure it shows the same amounts your provider actually bills to or collects from you. If you paid a larger cost share than you should have for a covered service, the provider will be responsible for refunding you. BCBSAZ will also send your in-network provider the information that appears on your EOB.

Note: Save your EOBs and receipts for any medical services you receive in case you need to refer back to one of these documents in the future. BCBSAZ or any contracted vendor may charge a fee to send you copies of claims records.

Notice of determination

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

- Describe additional material or information we need in order to process the claim, if any, and the reasons we need the material or information;
- Explain the specific reason(s) for the denial (for example, it might say that a service is not covered because the provider is ineligible, or because the services are not covered under your plan);
- Explain any business rule, guideline, or protocol that we relied on in making the adverse determination (or explain that this information is available free of charge upon request);
- Explain the scientific or clinical judgment for the determination (or explain that the information is available free of charge upon request), if the denial is based on medical necessity, experimental treatment, or similar limit;
- Let you know the specific plan provision that we referenced in making the determination; **and**
- Describe applicable grievance/appeal procedures.

Time period for claim decisions

Within 30 days of receiving your claim for a service that was already rendered, BCBSAZ will send you either an EOB explaining how the claim was processed and what was paid (or not), or a notice that BCBSAZ has asked your provider for records that we need in order to make a decision on your claim. Except for claims covered by the No Surprises Act, if BCBSAZ cannot make a decision on your claim within 30 days, BCBSAZ may extend the 30-day processing time by up to 15 days. If this happens, we will tell you before the end of the 30-day period, and give you an expected decision date. We will also let you know if there is any other information we need in order to process the claim. You or your provider will then have at least 45 days to send us this information.

ELIGIBILITY FOR BENEFITS

This eligibility section explains who is covered, when, and what to do if something changes. We suggest starting with the Eligibility Overview and Changes to Your Information. Then, you can use this section table of contents to go straight to the information you need when you need it.

You'll find an in-depth list of terms in Appendix A. It's a good place to check if you come across a word that is not familiar.

Eligibility Overview

Effective date of coverage

Contract holder	A contract holder's effective date of coverage will be either the date the contract holder becomes eligible to enroll or the first billing date after the contract holder becomes eligible to enroll as determined by the group, as long as the contract holder completes the application process within 31 days of becoming eligible.
Dependent	Dependent coverage is available only if an eligible contract holder has enrolled for coverage. Eligible dependents will have the same effective date as the contract holder if they are included on the application at the time the contract holder first enrolls. If the contract holder and/or dependents do not enroll when first eligible, the contract holder and/or dependents may only apply for coverage at the group's annual open enrollment period, except as stated under Special Enrollment Period in this section of the Base Benefit Book, or if court-ordered.
Spouse	The effective date of coverage for a new spouse is the date of marriage, if the contract holder completes an application within 31 days of that date. Otherwise, the spouse may not enroll until the next open enrollment period, unless he or she qualifies under a special enrollment period (see Special Enrollment Period later in this section).
Newborn, adopted child, or 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 automatically add the child to the plan 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 a special enrollment period (see Special Enrollment Period later in this section).

Eligibility requirements

Children—Children are eligible for dependent coverage until their 26th birthday.

Contract holder—A contract holder becomes eligible to enroll for coverage after meeting the group's eligibility requirements outlined in the Group Master Contract.

Disabled dependent child—A child who has reached age 26 may continue coverage as a dependent under this plan if the child is otherwise eligible for the plan and meets *all* of the following criteria:

- Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;
- Is totally disabled due to a continuous physical or intellectual disability or condition, as defined by 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.

Benefit-specific eligibility for non-members

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

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

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

Pediatric dental and vision benefit eligibility

Pediatric dental and vision benefits are only available for eligible members until the end of the plan year in which the member turns age 19. All other members are not eligible for pediatric dental or vision benefits.

Loss of eligibility effective dates

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 payment from the group
- The date on which an approved leave of absence expires, if the contract holder fails to return to active employment
- The date on which the contract holder's death occurs
- The date on which the group and/or contract holder fails to pay amounts due and any grace period available under applicable law is exhausted

Dependent eligibility ends on the following days:

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

Some groups have up to 31 days to notify BCBSAZ that a contract holder or dependent has become ineligible. Until BCBSAZ receives this notice and removes the ineligible member or dependent from the plan, BCBSAZ may quote benefits, give prior authorization, or pay claims that ultimately will need to be paid back by the member or their provider, if it is later determined the member was already ineligible when they received services. Benefit quotes or prior authorizations like this become invalid, regardless of whether or not the group has notified the member/contract holder that they are no longer eligible.

Changes to Your Information

It is important that you let us know as quickly as possible when something related to your personal or health information changes, such as a dependent becoming ineligible, a marriage or divorce, or a change of address. If BCBSAZ pays any claims based on old information, you may have to reimburse those payments if you or your dependents became ineligible and then incurred the 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.

Let BCBSAZ Customer Service know right away about changes to *any* of the following:

- A disabled dependent age 26 or older who is no longer disabled;
- Eligibility of you or your dependents for the Arizona Health Care Cost Containment System (AHCCCS) or other Medicaid coverage during the term of this contract;
- Eligibility of you or your dependents for Basic Health Program (BHP) coverage during the term of this contract;
- Eligibility of you or your dependents for individual coverage through the Marketplace;
- 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 changes in benefits; **or**
- Your mailing address or phone number.

Conversion Coverage

If your coverage under this benefit plan ends for any reason other than the group changing carriers or administrators, and you keep your permanent residence in Arizona, you may apply for an individual conversion contract (an individual health insurance policy) offered by BCBSAZ. BCBSAZ must receive your written application for a conversion contract within 31 days of the date your group coverage ends.

You may also apply for conversion coverage when your COBRA coverage expires, as long as your employer is still under the same group benefit plan.

Coordination of Benefits

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 Coordination of Benefits (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 the Pharmacy benefit, BCBSAZ will pay as the primary insurer, without regard to the member's other coverage.

Non-Duplication of Benefits

If services are covered under this benefit plan and under 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 decide which coverage pays first. Payment of the claim will be subject to all applicable deductibles, coinsurance, and copays. The combined benefit payments cannot be more than the amount that BCBSAZ would have paid if you had no other coverage.

If services are covered under this group 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 be more than 100% of the amount BCBSAZ would have paid if you had no other coverage. BCBSAZ does not coordinate benefits with non-group coverage from insurance plans other than BCBSAZ.

BCBSAZ does not coordinate benefits for services covered by the Pharmacy benefit. For the Pharmacy benefit, BCBSAZ will pay as the primary insurer, without regard to the member's other coverage.

Special Enrollment Period

There are certain qualifying events that make you eligible for a special enrollment period. That's a time you can enroll in a health plan outside of the normal open enrollment period. You must send in your completed application within 30 days of a qualifying event to be covered under this benefit plan. The following events qualify for a special enrollment period:

- A person loses minimum essential coverage, as that term is defined in applicable law. Loss of minimum essential coverage includes, but is not limited to, the following:
  - Person enrolled in non-COBRA coverage: A person loses coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing:
    - In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, a person loses coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual)
    - In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, a person loses coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual
    - A person loses coverage because the person incurs a claim that would meet or exceed a lifetime limit on all benefits
    - A person loses coverage because a plan no longer offers any benefits to a class of similarly situated individuals
    - A person loses coverage at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.
  - Person enrolled in COBRA coverage: An employee or dependent who has COBRA continuation coverage exhausts COBRA continuation coverage
- A person gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement of a foster child, or through a child support order or other court order
- A person loses a dependent or is no longer considered a dependent through divorce or legal separation
- A contract holder and/or his/her dependent dies
- A person loses coverage because of the death of the covered employee
- A person loses coverage because the person has coverage through his or her spouse and the spouse dies

- A person loses coverage because the person has coverage through his or her spouse or parent and a divorce or legal separation occurs
- A dependent child ceases to be a dependent child under the generally applicable requirement of the plan
- The covered employee is employed by an employer that offers multiple health benefit plans and the covered employee elects a different plan during open enrollment
- A person no longer lives, resides or works in the other plan's service area and no other benefit plan is available to that person;
- A person loses coverage because an eligible employer-sponsored plan will no longer be affordable or provide minimum value, as those terms are defined in applicable law.

You also qualify for a special enrollment period if you experience one of the events listed below. The difference in these cases is that we must receive your completed application within 60 days of the loss of your other coverage:

- A person loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- A person is notified that they are eligible for a Medicaid or CHIP premium assistance subsidy
- Any other special enrollment rights available under applicable federal or state law

Termination of Coverage

Reasons for termination of coverage

The contract holder and/or any dependents' coverage under this benefit plan may end coverage (terminate) for the following reasons, including, but not limited to:

- Coverage for the contract holder and/or dependents is rescinded (the contract holder and/or one or more dependents is no longer eligible for coverage)
- Nonpayment of amounts due by the group and/or contract holder, after expiration of any applicable grace period available under applicable law
- The contract holder and/or any dependent(s) die
- The contract holder and/or dependent(s) ask to terminate coverage
- The contract holder and/or dependents obtain other coverage that qualifies as minimum essential coverage

Termination date of coverage

BCBSAZ will notify the group and/or the contract holder of the date that coverage will end (the termination dates of coverage) for the contract holder and/or any dependents. The contract holder and/or dependents' coverage ends no later than the date the Group Master Contract terminates. When the contract holder's coverage ends, coverage for all dependents also ends on the same day.

Benefits after termination

Except as described below, you have no coverage on and after the date coverage ends, regardless of the reason for termination. This applies even if the expense was incurred because of an accident, injury, or illness that occurred or existed while this coverage was in effect (except as described under the Disability extension of benefits section).

Continuation of coverage

Under applicable law, it is the group's responsibility to tell employees and dependents of the availability, terms, and conditions of continuation of coverage available under COBRA. COBRA requires 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.

Continuation of coverage is available when an employee is absent from employment by reason of service in the uniformed services, as defined by applicable federal law. You must check with your 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 share with you, upon request, the evidence-based criteria we used to make this decision. 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 ends its coverage through BCBSAZ, your medical expense benefits will continue for the disabling condition only, for a period not more than 12 months from the date of termination of coverage. To ensure an orderly extension of benefits and timely processing of your claims, it is important to provide BCBSAZ with written notice of your disabling condition no later than 31 days after the coverage end date. You do not give up your right to extended benefits if you do not notify BCBSAZ; however, BCBSAZ cannot pay claims until we have received your written notice.

When you provide notice, you will also be required to provide reports satisfactory to BCBSAZ that show the date the group policy was terminated, 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 ends its coverage through BCBSAZ.

Individual termination

If you are totally disabled on the date your coverage terminates under this plan, medical expense benefits will continue for the disabling condition only, for a period of not more than 12 months from the date of termination. You do not give up your right to extended benefits if you do not notify BCBSAZ; however, BCBSAZ cannot pay claims until we have received written notice.

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 will run at the same time (concurrently) as your continuation coverage under COBRA, until the 12-month extension of benefits period runs out. Because these provisions run concurrently, please contact your employer before making any changes to or terminating your COBRA continuation coverage. If you cancel your COBRA coverage, you will also cancel your disability extension.

A disability extension of benefits ends when you are no longer totally disabled, or when you become eligible for or covered under any other group benefit plan with similar benefits.

Continuation of coverage for pediatric dental benefits

For members who are eligible for pediatric dental benefits, BCBSAZ will continue to cover certain services for 31 days after coverage terminates under the following circumstances:

- Your dentist made a dental impression (such as a mold of your teeth) before your coverage terminated;
- Your dentist opened a pulp chamber before your coverage terminated, and a device is installed or treatment is finished within 31 days after your coverage terminated;

- Your dentist prepared a tooth for cast restoration before your coverage terminated; **or**
- Your dentist prepared abutment teeth for the completion of installation of prosthetic devices before your coverage terminated.

Third-party beneficiaries

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

YOUR RIGHTS

Statement of ERISA Rights

ERISA stands for the Employment Retirement Income Security Act of 1974. It is a federal law. ERISA rights do 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 are entitled to:

- Receive information about your plan and benefits—Examine, without charge, at the plan administrator's office and other locations, such as worksites and union halls, all documents governing the plan that are available from the plan administrator, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Upon written request to the plan administrator, you may obtain copies of the plan documents, including insurance contracts and collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and an updated summary plan description. The plan administrator may charge you for the copies.
- Continue your group health plan coverage under COBRA—COBRA refers to the set of federal and state laws that regulate continuation of healthcare coverage for you, your spouse, and/or dependents if you lose 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 your interest as well as the interest of 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 that 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.

If you have questions about ERISA . . .

If you have any questions about your plan, you should contact your plan administrator. If you have any questions about the above statement or about your rights under ERISA, or if you need assistance in getting 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 ask for certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Your Right to Information; Availability of Notice of Privacy Practices

You have the right to inspect and copy your information and records maintained by BCBSAZ, with some limited exceptions required by law. If you choose to review your medical records in person, BCBSAZ will require a reasonable amount of time to research and retrieve the records before scheduling a time with you to review the records.

The BCBSAZ "Notice of Privacy Practices" describes how BCBSAZ may use and disclose your information to administer your health plan. It also describes some of your individual rights and BCBSAZ's responsibilities under federal privacy regulations. BCBSAZ mails a copy of this Notice of Privacy Practices to your address shortly after you enroll for coverage with BCBSAZ. Please keep this notice with your other health plan documents. You can also view the "Notice of Privacy Practices" by visiting the BCBSAZ website, 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 **1-800-232-2345** 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 1-877-475-4799 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 hólǫ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

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

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

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

Tagalog: Kung ikaw, o ang iyong tinutulungan, 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:
[illegible] Blue Cross Blue Shield of Arizona، [illegible] 877-475-4799.

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

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

APPENDIX A: TERMS TO KNOW

Access fee	A fixed fee you pay to a provider for certain covered services, usually at the time of service. If an access fee applies to a particular service, you must pay the access fee plus any other applicable cost share for the service. Access fees do not count toward meeting your deductible.
Allowed amount	The amount a provider receives as payment for a covered service. The allowed amount includes both the BCBSAZ payment and your cost share (see definition). BCBSAZ calculates your coinsurance amount and how much applies toward your deductible based on the allowed amount, less any access fees or prior authorization charges. The allowed amount does not include any balance bills from noncontracted providers. The allowed amount isn't tied to the amounts providers in a given area usually charge for their services. If the allowed amount is based on a fee schedule (see table below), a change to the fee schedule may result in a higher member cost share. Allowed Amount for Pediatric Dental Benefits: BCBSAZ or its contracted vendor bases the Allowed Amount on the lesser of the dental provider's billed charges or the applicable fee schedule, with adjustments for any negotiated contractual arrangements and certain operational guidelines.

The following table explains how BCBSAZ determines the allowed amount for medical services.

Type of Provider	Type of Claim	How We Determine the Allowed Amount
Providers contracted with BCBSAZ as plan network providers	Emergency and non-emergency	We compare the provider's billed charges to the applicable fee schedule, and generally use the lower of the two amounts. Then, we adjust the amount as needed to meet the contractual arrangements we have made with the provider, as well as to comply with certain operational guidelines.
Providers contracted with a third party (vendor)	Emergency and non-emergency	We compare the provider's billed charges to the vendor's fee schedule, and generally use the lower of the two amounts. Then, we adjust the amount as needed to meet our contractual arrangements with the vendor.
Providers contracted with another Blue Cross or Blue Shield plan ("host Blue")	Emergency and non-emergency	We compare the provider's billed charges to the price the host Blue plan has negotiated with the provider. The allowed amount will be the lower of the two amounts.
Noncontracted providers in Arizona, including providers contracted with another BCBSAZ network, but not contracted as a plan network provider for this benefit plan	Non-emergency	We compare the provider's billed charges to the applicable BCBSAZ fee schedule (with adjustments for certain operational guidelines). The allowed amount will be the lower of the two amounts.
Noncontracted providers outside Arizona	Non-emergency	We compare the provider's billed charges to the amount the host Blue normally pays for a local nonparticipating provider. The allowed amount will be the lower of these two amounts. If the host Blue has not set an amount it normally pays for a nonparticipating provider, we may then base the allowed amount on the applicable fee schedule with adjustments for certain operational 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	We compare the provider's billed charges to the applicable BCBSAZ fee schedule (with adjustments for certain operational guidelines). The allowed amount will be the lower of the two amounts. The member's cost share will be based on the lesser of the provider's billed charges or the Qualifying Payment Amount, as defined by federal law.
Noncontracted pediatric vision providers in and outside Arizona	Non-emergency	For claims for pediatric eyewear provided by out-of-network providers, the allowed amount means the amount of reimbursement by the Pediatric Vision Benefits Administrator to a member for out-of-network benefits that is allocated to a covered service. The allowed amount is calculated based on the average in-network provider reimbursement for each service item based on the Pediatric Vision Benefits Administrator's transactions. The Pediatric Vision Benefits Administrator calculates deductible and coinsurance for out-of-network benefits based on the allowed amount; the calculation is the sum of the paid claims and member out-of-pocket expenses divided by total claims where member out-of-pocket expenses include copays or fixed costs. The Pediatric Vision Benefits Administrator may periodically revise the allowed amount based on updated data.

Ancillary services	Ancillary services include emergency medicine, anesthesiology, pathology, radiology, neonatology, certain laboratory services, or as otherwise required by law.
Balance bill	The difference between a noncontracted provider's billed charges and the allowed amount. In-network providers will accept the allowed amount for covered services. 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 for paying a noncontracted provider's billed charges, even though BCBSAZ will reimburse you for approved claims based on the allowed amount. Depending on what billing arrangements you make with a noncontracted provider, they may charge you for full billed charges at the time of service, or send you a balance bill for the difference between billed charges and the amount that BCBSAZ reimburses you. Any amounts paid for balance bills do not count toward the deductible, coinsurance, or out-of-pocket maximum.
Bariatric surgery	A surgical procedure to promote weight loss for the treatment of morbid obesity. Bariatric surgery also includes any revisions to a prior bariatric surgical procedure.
Base Benefit Book	This document (see also Benefit Book and benefit plan).
BCBSAZ	Blue Cross Blue Shield of Arizona, when we are the issuer of the insurance coverage, as well as when we are the administrator of a group benefit plan. Within this book, BCBSAZ also may include contracted vendors, when a contracted vendor is performing functions on behalf of BCBSAZ. Blue Cross Blue Shield of Arizona is an independent licensee of the Blue Cross Blue Shield Association. BCBSAZ is a not-for-profit corporation organized under the laws of the state of Arizona as a hospital, medical, dental, and optometric services corporation, and is authorized to operate a healthcare services organization as a line of business.
Behavioral health benefits	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	Your Base Benefit Book plus your Plan Attachment and any rider(s).
Benefit plan or plan	The documents 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 and any Plan Attachment; • The Summary of Benefits and Coverage (SBC); • Your application for coverage; • Any plan that is issued to replace this plan, **and** • Any rider, amendment, or modification to this plan, including, but not limited to, any changes in deductible, coinsurance, or copay amounts. 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 (the group or entity through which you receive your plan benefits) must keep a summary plan description and give a copy to you when you ask for one in writing. While your plan sponsor may include this Base Benefit Book as part of this summary plan description, the Base Benefit Book is not by itself a summary plan description.

Billed charges	For a provider that has a participation agreement governing the amount of reimbursement, the term billed charges refers to the amount the provider normally charges for a service. For a provider that does not have a participation agreement governing the amount of reimbursement, billed charges refers to the lowest amount that the provider is willing to accept as payment for a service.
Blue Distinction	A national designation awarded by Blue Cross Blue Shield (BCBS) plans to recognize providers that demonstrate expertise in delivering quality specialty care that is safe, effective, and cost-efficient.
Cancer treatment medication	Prescription drugs and biologicals that are used to kill, slow, or prevent the growth of cancerous cells.
Cardiac and pulmonary services	Cardiac and pulmonary habilitative and rehabilitative services are supervised programs that include exercise, education, counseling, and other lifestyle changes designed to regain strength and prevent or reverse the progression of cardiac and pulmonary diseases.
Caregiver	The person primarily responsible for providing daily care, basic assistance, and support to a member who is eligible for transport, lodging, and reimbursement.
Chiropractic Benefits Administrator (CBA)	The CBA is an independent company that 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. The CBA for BCBSAZ is a company called American Specialty Health Networks, Inc.
Cognitive therapy	Treatment that focuses on present thinking, behavior, and communication, rather than on past experiences, and is oriented toward problem solving.
Coinsurance	The percentage of the allowed amount that you pay when you receive a covered service (after meeting your deductible). BCBSAZ subtracts any applicable access fees and 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. While BCBSAZ normally uses the allowed amount to figure out your coinsurance amount, there is an exception: If a hospital provider's billed charges are less than the hospital's reimbursement, BCBSAZ will calculate your coinsurance based on the lesser billed charge.
Compounded medications	Medications that contain at least one FDA-approved component and that are custom-mixed by a pharmacist.
Contract holder	The person to whom a benefit plan is issued. Any other person approved for coverage under the plan along with the contract holder is a dependent. Under group coverage, the contract holder is the *member* (see definition) who is eligible for coverage because of his or her affiliation with a group.
Coordination of Benefits	A process to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim. See Coordination of Benefits for more details.
Copay or copayment	The amount you pay your healthcare provider when you receive certain covered services. Different services may have different copay amounts. The Plan Attachment we sent along with this Base Benefit Book tells you which services have a copay, and what the amount is. Usually, if a copay does not apply, you will have a deductible and/or coinsurance to pay.
Cosmetic	Surgeries, procedures, treatments, 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	The total amount you owe for a covered service. Depending on your plan type, your cost share may include one or more of the following: deductible, copay, coinsurance, access fee, or prior authorization charge.
Coverage limit	A limit that applies to a specific benefit. The limit may be based on the number of days or visits, a type of service, timeframe (calendar year), age, gender, or other factors. If you reach a coverage limit, depending on the specific benefit, no further services may be covered, and you may have to pay the provider's billed charges for those services. However, if you reach the coverage limit 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 coverage limits are described in Your Health Plan Benefits, along with the benefit they apply to.
Covered service	A medically necessary healthcare service or item that is a benefit of your health plan. Covered services are listed in the Your Health Plan Benefits section of this book.
Custodial care	Health services and other related services that: • 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 does not require continued administration by licensed skilled medical personnel, such as an LPN, RN, or licensed therapist; **or** • Do not seek to cure.
Deductible	The amount you pay toward covered healthcare services each calendar year before BCBSAZ begins to pay its share. The deductible applies to every covered service unless otherwise specified. The deductible is calculated based on the allowed amount. Amounts you pay for copays and access fees do not count toward the deductible. Your deductible amount is listed in the enclosed Plan Attachment, as well as in your SBC document.
Dentist	A properly licensed DDS or DMD.
Dependents	The contract holder's spouse, under a legally valid, existing marriage; **and** The contract holder's children or the children of the contract holder's spouse, including natural children, legally adopted children, stepchildren, children placed for adoption, children under legal guardianship substantiated by a court order, children who are entitled to coverage under a medical support order, and foster children.
Designated prescription network program	A program that requires certain members who take certain medications to get prescriptions for those covered medications from one designated eligible provider, and to get all medications designated by BCBSAZ or the PBM from one network pharmacy or provider. BCBSAZ or the PBM determines which members are required to participate in this program.
Disabled dependent child	A child who has reached age 26 and who meets criteria for coverage under this plan as described in the eligibility overview.
Doctor or physician	For purposes of classifying benefits and member cost shares in your plan, we use the terms doctor and physician to mean a properly licensed MD, DO, DPM, or DC.
Domiciliary care	A supervised living arrangement in a home-like environment for people who are unable to live on their own because they need assistance with the activities of daily living, such as bathing, dressing, and food preparation.

Emergency medical condition	A medical or behavioral health condition that appears suddenly with severe symptoms (such as severe pain, unconsciousness, or other serious symptom). The condition is one that would make the average person with a basic understanding of health and illness think that failing to get immediate medical attention would result in *any* of the following: • Harm to the member or others; • Permanent disability; • Serious impairment to a bodily function or part; **or** • Serious jeopardy to the patient's life, health, or ability to completely recover.
Employee	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 or member under this plan.
Evidence-based criteria	Medical, pharmaceutical, dental, and administrative criteria that 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 are 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. A BCBSAZ contracted vendor may establish evidence-based criteria for services they provide or administer as stated in the vendor's contract with BCBSAZ. You can get more information about the criteria by calling the Customer Service number on your ID card.
Fee schedule	A proprietary schedule of provider fees collected and put together by BCBSAZ. BCBSAZ develops its fee schedule 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 past claims experience • Other pricing information that may be available to BCBSAZ • Information and comments from providers • Negotiated contractual arrangements with providers BCBSAZ may change its fee schedule at any time without prior notice to members. If the allowed amount for a service is based on a fee schedule, a change to the fee schedule may result in higher member cost share for that service.
Formulary	A formulary is a list of drugs that are covered by your health plan. It also helps you figure out how much you can expect to pay when you have a prescription filled at a pharmacy in your plan network. BCBSAZ and/or the PBM decide which medications are on the formulary.
Formulary exception	When BCBSAZ and/or the PBM has authorized coverage of a non-formulary medication for a member. BCBSAZ and/or the PBM decide whether to authorize formulary exceptions for coverage of non-formulary medications.
Gender-affirming care	Treatment for gender dysphoria, including hormone replacement therapy and testing to monitor safety, psychotherapy, surgical treatment, and other medical services required by federal or state law.
Generic medications	Medications defined as generic by the national database system used by BCBSAZ to pay prescription claims.
Group	The association, employer, trust, or other entity that sponsors a group benefit plan on behalf of its employees or participants. The group is sometimes also called the plan sponsor.

Group master contract (sometimes referred to as the agreement)	The legal agreement between the group and BCBSAZ.
Habilitative services	Healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health Insurance Marketplace (the Marketplace)	The health insurance marketplace run by the federal government. It provides a service via HealthCare.gov to help individuals and small businesses shop for and enroll in health coverage. The term also refers to state exchanges, regional exchanges, subsidiary exchanges, as well as the federally-facilitated exchange.
In-network provider	A doctor, hospital, outpatient surgery center, pharmacy, lab, or other professional or place that belongs to the network that serves members of your health plan.
Maintenance medications	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 changes, all as determined by BCBSAZ or the PBM. BCBSAZ and/or the PBM ("BCBSAZ/PBM") may designate or use national databases to designate certain medications as maintenance medications.
Medical/surgical benefits	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	If you are taking two or more medications for a chronic condition, and the medications are being dispensed by a single network pharmacy, the pharmacy may synchronize them for you. This means they can put the refills for these medications on the same schedule, so that you always have them filled at the same time. In order to begin medication synchronization, the pharmacy may need to have BCBSAZ approve what is called a short refill.
Member	An individual, employee, participant, or dependent covered under a benefit plan.
Non-formulary medication	A medication that is not on the formulary. You can ask your prescribing provider to request that BCBSAZ make a formulary exception for a non-formulary medication. BCBSAZ and/or the PBM decide which medications are non-formulary medications and whether to authorize formulary exceptions for non-formulary medications.
Occupational therapy	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.
Open enrollment period	An annual period during which the contract holder and their dependents are eligible to enroll for coverage or change benefit plan options. Your group's plan administrator will notify you of the group's open enrollment period. Contract holders and/or any dependents can change benefit plans only during an open enrollment period, except as set forth in your Benefit Book or as allowed under applicable law. Individuals may also have limited open enrollment rights.
Out-of-network provider	A doctor, clinic, hospital, or other healthcare provider that is not a part of any BCBSAZ plan network.
Out-of-pocket maximum	The amount you pay each calendar year before the plan begins paying 100% of the allowed amount (on most covered services) for the remainder of the calendar year. BCBSAZ applies deductible, coinsurance, copays, and access fees toward any out-of-pocket maximum that applies to the member's benefit plan. You are still responsible for other types of cost-share payments, even after you have met your out-of-pocket maximum. You have separate out-of-pocket maximums for in-network and out-of-network providers.

	The following types of payments do not count toward the out-of-pocket maximum. Other than the deductible, which you have to meet before coinsurance applies, you must keep paying for the following even after you reach your out-of-pocket maximum: • Amounts above the maximum allowed for a specific benefit (coverage limits are included in Your Health Plan Benefits) • Any amounts for balance billing • Any amounts for noncovered services • Any charges for lack of prior authorization (see prior authorization below) If you have family coverage, there is an out-of-pocket maximum for each individual member as well as for your family. Amounts applied to each member's out-of-pocket maximum also apply to the family out-of-pocket maximum. The family maximum is applied in the same way as the individual maximum described above and is subject to the same rules. When the family has met its family out-of-pocket maximum, it also satisfies the out-of-pocket maximum requirements for all the individual members.
PBM	The independent Pharmacy Benefit Manager that contracts with BCBSAZ to administer the prescription medication benefits covered under this benefit plan.
Pediatric Vision Benefits Administrator	An independent company contracted with BCBSAZ to provide a network of participating vision services providers and customer service and claims administration services for pediatric vision benefits covered under this benefit plan. BCBSAZ uses Blue View Vision as our pediatric vision benefits administrator.
Pharmacy coverage guidelines	Pharmaceutical and administrative criteria that are developed from review of published peer-reviewed medical and pharmaceutical literature and other relevant information and are used to help 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 online at azblue.com/pharmacy. The guidelines are also available by calling the number for Pharmacy Benefit Customer Service number on your ID card.
Physical therapy	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.
Plan Attachment	A document sent with your Base Benefit Book that includes cost-sharing provisions (terms). See your ID card for the name of the plan network for this benefit plan.
Plan network	The network of providers contracted to provide services to members of this benefit plan. Plan network providers also are referred to as in-network providers. See your ID card for the name of your plan network.
PPACA	The Patient Protection and Affordable Care Act of 2010, as amended.
Preventive services	Services provided for screening purposes when a member does not have active signs or symptoms of a condition.
Primary Care Provider (PCP)	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 see a PCP for a referral before seeing a specialist.
Prior authorization	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 maximum.

Prosano Health Advanced Primary Care Center	A facility where services are received from a Prosano Health Advanced Primary Care Provider.
Prosano Health Advanced Primary Care Provider	Any properly licensed, certified, or registered person or facility furnishing Prosano Health Advanced Primary Care Services to you either virtually or in person at a Prosano Health Advanced Primary Care Center.
Prosano Health Advanced Primary Care Services	Services provided at or by Prosano Health at an Advanced Primary Care Center. Prosano Health may elect to offer additional services that are not explicitly described in this Benefit Book in its sole and absolute discretion.
Provider	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.
Qualified Health Plan (QHP)	A health plan that has, in effect, a certification that it meets the standards issued or recognized by the Marketplace through which such plan is offered.
Rehabilitative services	Services that help a person restore skills and functioning for daily living that have been lost due to injury or illness.
Respite care	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	A generic term referencing any type of healthcare treatment, test, procedure, supply, medication, technology, device, or equipment.
Short refill	A prescription refilled with less medication than usual.
Special enrollment period	A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Marketplace outside of the initial and annual open enrollment periods.
Specialist	A doctor or other healthcare professional who practices in a specific area other than those practiced in by PCPs, family doctors, and other general practitioners; or a properly licensed, certified, or registered individual healthcare provider whose practice is limited to rendering behavioral health services. For purposes of cost share, this definition of the term specialist does not apply to dentists. Your benefit plan does not require you to get a referral from a PCP before you see a specialist.
Specialty medications	Medications that treat chronic or complex conditions. BCBSAZ/PBM determine which medications are specialty medications.
Specialty pharmacy	A pharmacy contracted with BCBSAZ/PBM to fill member prescriptions for specialty medications.
Speech therapy	Treatment of communication impairment and swallowing disorders.
Step therapy	A program that requires members to first try the generic version of a certain medication before BCBSAZ or the PBM will consider covering the brand-name version of that medication. The step therapy program also requires members to take certain medications on the formulary before BCBSAZ or the PBM will consider approval of a formulary exception for a non-formulary medication. BCBSAZ/PBM determines which medications are part of the step therapy program. **Note:** Certain medications are not considered to be medically necessary (and therefore are not covered) unless you are participating in a step therapy program.
Summary of Benefits and Coverage (SBC)	A federally required document with information on access fees, coinsurance percentages, copays, deductible amounts, other cost-sharing amounts, benefits, exclusions, limitations, and other important information.
Telehealth Services Administrator (TSA)	Amwell, an independent company that is contracted with BCBSAZ to offer members the services of contracted healthcare providers over an interactive web platform or app. Amwell also provides technical support for the telehealth services (i.e., BlueCare Anywhere) covered under this plan.

Telehealth services from BlueCare Anywhere	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	Services delivered through interactive qualified electronic media.
Treating provider	A provider you are currently seeing for a particular health concern or condition.
Urgent care	Treatment for conditions that require prompt medical attention, but which are not emergencies.

APPENDIX B: OTHER HEALTH PLAN DETAILS

This section describes a variety of elements that are part of your BCBSAZ policy. It is for your reference. You may or may not need this information. We've included it so you have it if a topic or question comes up that isn't covered elsewhere in this Base Benefit Book.

Access to information about dependent children

BCBSAZ does not take part in 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 to information about their children, unless a court order denies such access. Without a copy of such order and subject to the confidentiality provisions described below, 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. You can find these guidelines in your MyBlue account. You can also call Customer Service at the number on your ID card to ask for a printed copy. You do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ.

Medical appeals and grievances (including for urgently needed services)	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 Benefits Administrator at the number on the back of your ID card, or call **1-800-678-9133.** Or write to: Appeals Coordinator, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001. **Fax:** 1-877-248-2746

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 as defined under Arizona law. This process is not available for all balance bills. Call Customer Service at the number on your ID card for information on any of the following:

- Initiating the dispute resolution process
- Appealing a denial of prior authorization for urgently needed services you have not yet received
- The types of balance bills that may be disputed.

Basis of operational guidelines

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

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. (Arizona Revised Statute) § 33-931. A.R.S. § 33-931 may give providers medical lien rights apart from this benefit plan or any contract with BCBSAZ. BCBSAZ will not be involved with any collection dispute that may arise under the provisions of A.R.S. § 33-931.

The terms 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.

Broker commissions

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

Blue Cross Blue Shield Association

As a member of BCBSAZ, you hereby acknowledge and agree to the following:

- This benefit plan constitutes a contract between the group and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross 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;
- BCBSAZ is not contracting as the agent of the Association;
- 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**
- You will not seek to hold the Association or any Blue Cross and/or Blue Shield plan other than BCBSAZ accountable or liable for BCBSAZ's obligations herein.

Confidentiality and release of information

We have processes and systems in place to safeguard sensitive or confidential information and to release such information only in accordance with federal and state law. If you wish to allow someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from your MyBlue account, or call Customer Service and request a printed copy of the CIRF form.

Cost of records

In order to process your claims, BCBSAZ may need to ask your provider for copies of your health records. In-network providers generally cannot charge you for providing BCBSAZ with health records. Noncontracted providers have no contractual obligation to provide records to BCBSAZ at no charge. If you receive services from a noncontracted provider who charges for record preparation or the cost of copies, you will need to arrange with this provider to send any needed records to BCBSAZ, and pay any fees they may charge for sending the records.

Court orders for health insurance coverage of 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, to the provider, or to a state agency, as applicable.

Dental necessity guidelines and criteria

BCBSAZ or its contracted vendor, in its sole and absolute discretion, decides whether a service is dentally necessary based on the following definition. A dentally necessary service is a service that meets *all* of the following requirements:

- It is consistent with the diagnosis or treatment of a symptom, illness, disease, or injury;
- It is not primarily for the convenience of a member or a provider;
- It is rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ or its contracted vendor; **and**
- It meets BCBSAZ's or its contracted vendor's dental necessity guidelines and criteria in effect when the service is rendered. If BCBSAZ or its contracted vendor does not have formal dental necessity guidelines or criteria for a dental service, BCBSAZ or its contracted vendor will base its decision on the judgment and expertise of a BCBSAZ healthcare professional or dental consultant retained by BCBSAZ or its contracted vendor.

BCBSAZ or its contracted vendor uses evidence-based criteria to make dental necessity decisions on selected coverage topics. For additional information on evidence-based criteria, call the Customer Service number on your ID card.

Decisions about dental necessity may differ from your provider's opinion. A provider may prescribe, order, recommend, or approve a service that BCBSAZ or its contracted vendor decides is not dentally 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 and Monthly Member Health Statement and the Appeal and grievance process sections.

Also, not all dentally necessary services will be covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A service may be dentally necessary and still not be covered.

Discretionary authority

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

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. If a service or item meets all of the following criteria, it is **not** considered experimental or investigational:

- It is possible for the service or item to result in improvement outside the investigational setting;
- The scientific evidence permits conclusions concerning the effect of the service or item on health outcomes;
- The service or item is as beneficial as any established alternative;
- The service or item has 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 improves the net health outcome.

BCBSAZ or its contracted vendor may classify a service or item as experimental or investigational if *any* one or more of the following applies:

- 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, or efficacy;
- The provider rendering the service or item keeps written notes showing 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.

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 we can often resolve issues when you give us 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 clearly explain the basis for the lawsuit, and must be sent by certified mail to:

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

Failure to follow these steps 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 (that is, for not using all of our available solutions). 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, and construed and enforced in accordance with, applicable federal law and the laws of the state of Arizona, without regard to conflict of laws principles.

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, based on the unique facts of the case, makes a good-faith decision as to whether or not 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), 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 also was a Medicaid beneficiary on the date of service, to the extent required by law.

Medical necessity definition, guidelines, and criteria

BCBSAZ, in its sole and absolute discretion, decides whether a service is medically necessary based on the following definition. A medically necessary service is a service that meets *all* of the following requirements:

- It is consistent with the diagnosis or treatment of a symptom, illness, disease, or injury;
- It is not primarily provided for the convenience of a member or a provider;
- It is the most appropriate site, supply, or service level that can safely be provided; **and**
- It 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.

BCBSAZ uses evidence-based criteria to make medical necessity decisions. For additional information on evidence-based criteria, call the Customer Service number on your ID card.

Biomarker testing services are covered in accordance with applicable law and not subject to this definition of medical necessity.

BCBSAZ contracts with vendors to administer some or all of the benefits covered under this plan. These contracted vendors make medical necessity determinations based on their own medical necessity criteria.

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 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 not be covered (see the What's Covered section).

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 amounts due.

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

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:

cms.gov/nosurprises

You can also call 1-800-985-3059.

To view a statement of Your Rights and Protections Against Surprise Medical Bills, go to 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.

Pediatric dental services predetermination of benefits

Your dentist may ask BCBSAZ or its contracted vendor to estimate the benefits that will be available to cover a proposed treatment plan. Upon request, BCBSAZ or its contracted vendor will send a predetermination of benefits to your dentist.

We only accept predetermination requests from dentists because of the detailed information, including the procedure codes for your proposed treatment, that is required.

BCBSAZ or its contracted vendor will provide a non-binding estimate of your benefits available under your plan, based on the information available to us at the time the request is submitted. Your claim may process differently from the predetermination of benefits for reasons that include, but are not limited to, whether BCBSAZ or its contracted vendor processes additional claims after the predetermination is issued, whether there are any changes to your eligibility status between the date of the predetermination of benefits and the date of service, whether your dentist submits a claim with different procedures or codes than were submitted with the predetermination request, and whether coordination of benefits applies.

You may want to ask your dentist to submit a predetermination request if you are considering an extensive course of treatment.

Predeterminations are not required for any services covered under this plan. A predetermination is not the same as prior authorization, which is required prior to receipt of certain covered medical services.

Your dentist may call BCBSAZ or its contracted vendor at the customer service number on your ID card for information on how to request a predetermination of benefits.

Plan amendments/changes

There is no guarantee that the benefits listed here will not change.

- Benefits may be added, deleted, or changed upon notice to the group and/or contract holder and/or participant or as required according to 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.

BCBSAZ will give you 60 days' advance written notice of major changes to this plan. Changes include retroactive changes that are permitted under federal or state laws. Please review and retain this book, replacement books, plan attachments, SBCs, 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 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 drug to fall below the amount you pay for that drug 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 in-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 in-network provider you choose because not all providers have the same negotiated reimbursement rate for the same service.

To get an idea of your estimated cost share for a particular service, please call Customer Service at the number on your ID card. To get an estimated cost share, you will need to know the name of the provider, as well as the diagnosis and procedure codes related to the service. The estimated cost share is only an estimate, and the actual cost share may be different from the estimated cost share based on factors such as the services actually performed, and the type and location of the facility where you receive the services.

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. If you haven't released all of the records we need in order to process a claim, we may deny 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, the coverage will be treated as never having been in effect.

Premiums paid for the coverage for the ineligible person will be refunded, minus any claims that BCBSAZ paid for that person. BCBSAZ is entitled to recover claim payments that exceed the amount of premium paid (if the ineligible person received more in claim benefits than the dollar value of their premium payments, BCBSAZ is entitled to keep all premium payments, and collect from the ineligible person the difference between the premium payments and the dollar value of all paid claims). 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 provided 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.

APPENDIX C: PEDIATRIC DENTAL CODES

The service codes listed below match the covered services detailed in the Pediatric Dental Services benefit section. We are including them here so that members using pediatric dental services can share them with their child's dentist.

All listed codes are subject to limitations and exclusions listed in this Benefit Book, including calendar year and coverage limits, and frequency and age limitations.

Type I

Procedure Code	Procedure Description
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT
D0170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT
D0191	ASSESSMENT OF A PATIENT
D0210	INTRAORAL - COMPLETE SERIES (RADIOGRAPHIC IMAGE)
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE
D0250	EXTRAORAL - 2D PROJECTION RADIOGRAPHIC IMAGE CREATED USING A STATIONARY RADIATION SOURCE, AND DETECTOR
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES
D0330	PANORAMIC RADIOGRAPHIC IMAGE – 1 IMAGE EVERY 60 (SIXTY) MONTHS
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS
D0372	INTRAORAL TOMOSYNTHESIS COMP SERIES OF RADIOGRAPHIC IMAGES
D0373	INTRAORAL TOMOSYNTHESIS BITEWING RADIOGRAPHIC IMAGE
D0374	INTRAORAL TOMOSYNTHESIS PERIAPICAL RADIOGRAPHIC IMAGE
D0387	INTRAORAL TOMOSYNTHESIS COMP SERIES RADIOGRAPHIC IMAGES CAPTURE ONLY
D0388	INTRAORAL TOMOSYNTHESIS BITEWING RADIOGRAPHIC IMAGE CAPTURE ONLY
D0389	INTRAORAL TOMOSYNTHESIS PERIAPICAL RADIOGRAPHIC IMAGE CAPTURE ONLY
D0414	LAB PROCESSING OF SPECIMEN
D0419	ASSESSMENT OF SALIVARY FLOW BY MEASUREMENT
D0460	PULP VITALITY TESTS
D0470	DIAGNOSTIC CASTS
D0600	DIAGNOSTIC PROCEDURE
D0705	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY
D0706	INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY
D0707	INTRAORAL – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY
D0708	INTRAORAL – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY
D0709	INTRAORAL – COMPLETE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CAPTURE ONLY
D0801	3D DENTAL SURFACE SCAN DIRECT
D0802	3D DENTAL SURFACE SCAN INDIRECT
D0803	3D FACIAL SURFACE SCAN DIRECT

D0804	3D FACIAL SURFACE SCAN INDIRECT
D1110	PROPHYLAXIS - ADULT
D1120	PROPHYLAXIS - CHILD
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH
D1351	SEALANT - PER TOOTH
D1352	PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT-PERMANENT TOOTH
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION
D1355	CARIES PREVENTIVE MEDICAMENT APPLICATION – PER TOOTH
D1510	SPACE MAINTAINER-FIXED UNILATERAL
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR
D1520	SPACE MAINTAINER-REMOVABLE UNILATERAL
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MAXILLARY
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MANDIBULAR
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER – PER QUADRANT
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER – PER QUADRANT
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MAXILLARY
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MANDIBULAR
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN
D9311	CONSULTATION WITH A MEDICAL HEALTH CARE PROFESSIONAL
D9912	PRE-VISIT DENTAL PATIENT SCREENING
D9994	DENTAL CASE MANAGEMENT - PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL-TIME ENCOUNTER
D9997	DENTAL CASE MANAGEMENT – PATIENTS WITH SPECIAL HEALTH CARE NEEDS

Type II

Procedure Code	Procedure Description
D2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT
D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT
D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT
D2161	AMALGAM - FOUR OR MORE SURFACES PRIMARY OR PERMANENT
D2330	RESIN, ONE SURFACE, ANTERIOR
D2331	RESIN, TWO SURFACES, ANTERIOR
D2332	RESIN, THREE SURFACES, ANTERIOR
D2335	RESIN- FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR
D3110	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)
D3120	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT
D3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)
D3240	PULPAL THERAPY (RESORBABLE FILLING)- POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)
D3355	PULPAL REGENERATION - INITIAL VISIT

D3356	PULPAL REGENERATION - INTERIM MEDICATION REPLACEMENT
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT
D4346	SCALING IN PRESENCE OF MODERATE OR SEVERE GINGIVAL INFLAMMATION
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS
D4910	PERIODONTAL MAINTENANCE
D7111	EXTRACTION, CORONAL REMNANTS - DECIDUOUS TOOTH
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)
D7880	OCCLUSAL ORTHOTIC APPLIANCE
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURES
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION
D9612	THERAPEUTIC PARENTERAL DRUGS, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS
D9613	INFILTRATION OF SUSTAINED RELEASE THERAPEUTIC DRUG - SINGLE OR MULTIPLE SITES
D9910	APPLICATION OF DESENSITIZING MEDICAMENT
D9911	APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH
D9940	OCCLUSAL GUARDS, BY REPORT
D9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH
D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH

Type III

Procedure Code	Procedure Description
D2510	INLAY-METALLIC-ONE SURFACE
D2520	INLAY-METALLIC-TWO SURFACES
D2530	INLAY-METALLIC-THREE OR MORE SURFACES
D2542	ONLAY-METALLIC-TWO SURFACES
D2543	ONLAY - METALLIC - THREE SURFACES
D2544	ONLAY - METALLIC - FOUR OR MORE SURFACES
D2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE
D2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACES
D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES
D2642	ONLAY- PORCELAIN/CERAMIC - TWO SURFACES
D2643	ONLAY- PORCELAIN/CERAMIC - THREE SURFACES
D2644	ONLAY- PORCELAIN/CERAMIC - FOUR OR MORE SURFACES
D2650	INLAY - RESIN-BASED COMPOSITE - ONE SURFACE
D2651	INLAY - RESIN-BASED COMPOSITE -TWO SURFACES
D2652	INLAY - RESIN-BASED COMPOSITE - THREE OR MORE SURFACES
D2663	ONLAY - RESIN-BASED COMPOSITE - THREE SURFACES
D2664	ONLAY - RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES
D2710	CROWN - RESIN-BASED COMPOSITE (INDIRECT)
D2712	CROWN - 3/4 RESIN-BASED COMPOSITE (INDIRECT)
D2720	CROWN-RESIN WITH HIGH NOBLE METAL
D2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL
D2722	CROWN-RESIN WITH NOBLE METAL
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL
D2751	CROWN-PROCELAIN FUSED TO PREDOMINANTLY BASE METAL
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL
D2753	CROWN PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS

D2780	CROWN - 3/4 CAST HIGH NOBLE METAL
D2781	CROWN - 3/4 CAST PREDOMINATELY BASE METAL
D2782	CROWN - 3/4 CAST NOBLE METAL
D2783	CROWN - 3/4 PORCELAIN/CERAMIC
D2790	CROWN - FULL CAST HIGH NOBLE METAL
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL
D2792	CROWN-FULL CAST NOBLE METAL
D2794	CROWN-TITANIUM
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED CAST OR PREFABRICATED POST AND CORE
D2920	RE-CEMENT OR RE-BOND CROWN
D2928	PREFABRICATED PORCELAIN/CERAMIC CROWN – PERMANENT TOOTH
D2929	PREFABRICATED PORCELAIN/CERAMIC CROWN - PRIMARY TOOTH
D2930	PREFABRICATED STAINLESS STEEL CROWN -PRIMARY TOOTH
D2931	PREFABRICATED STAINLESS STEEL CROWN -PERMANENT TOOTH
D2932	PREFABRICATED RESIN CROWN
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH
D2940	PROTECTIVE RESTORATION
D2941	INTERIM THERAPEUTIC RESTORATION - PRIMARY DENTITION
D2949	RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION
D2950	CORE BUILD-UP, INCLUDING ANY PINS WHEN REQUIRED
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN
D2980	CROWN REPAIR, NECESSITATED BY RESTORATIVE MATERIAL FAILURE
D2981	INLAY REPAIR
D2982	ONLAY REPAIR
D2983	VENEER REPAIR
D2990	RESIN INFILTRATION/SMOOTH SURFACE - LIMITED TO 1 IN 36 MONTHS
D3310	ENDODONTIC THERAPY, ANTERIOR (EXCLUDING FINAL RESTORATION)
D3320	ENDODONTIC THERAPY BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)
D3330	ENDODONTIC THERAPY MOLAR (EXCLUDING FINAL RESTORATION)
D3331	TREATMENT OF ROOT CANAL OBSTRUCTION; NON SURGICAL ACCESS
D3332	INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR
D3351	APEXIFICATION/RECALCIFICATION- INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)
D3352	APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.)
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)
D3410	APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR
D3421	APICOECTOMY - BICUSPID (FIRST ROOT)
D3425	APICOECTOMY - MOLAR (FIRST ROOT)
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY
D3428	BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY - PER TOOTH, SINGLE SITE
D3430	RETROGRADE FILLING-PER ROOT
D3432	GUIDED TISSUE REGENERATION RESORBABLE BARRIER, PER SITE IN CONJUNCTION WITH PERIRADICULAR SURGERY
D3450	ROOT AMPUTATION-PER ROOT

D3471	SURGICAL REPAIR OF ROOT RESORPTION – ANTERIOR
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR
D3501	SURG EXPOSURE OF ROOT SURFACE W/O APICOECTOMY OR REPAIR OF ROOT RESORPTION – ANTERIOR
D3502	SURG EXPOSURE OF ROOT SURFACE W/O APICOECTOMY OR REPAIR OF ROOT RESORPTION – PREMOLAR
D3503	SURG EXPOSURE OF ROOT SURFACE W/O APICOECTOMY OR REPAIR OF ROOT RESORPTION – MOLAR
D3911	INTRAORVICE BARRIER
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL) - NOT INCLUDING ROOT CANAL THERAPY
D3921	DECORONATION OR SUBMERGENCE OF ERUPTED TOOTH
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGIOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4212	GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4245	APICALLY POSITIONED FLAP
D4249	CLINICAL CROWN LENGTHENING-HARD TISSUE
D4260	OSSEOUS SURGERGY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4261	OSSEOUS SURGERGY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)- ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4263	BONE REPLACEMENT GRAFT -FIRST SITE IN QUADRANT
D4264	BONE REPLACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT
D4266	GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE
D4267	GUIDED TISSUE REGENERATION - NON-RESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL)
D4268	SURGICAL REVISION PROCEDURE, PER TOOTH
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES), FIRST TOOTH OR EDENTULOUS TOOTH, IMPLANT, POSITION IN SAME GRAFT SITE
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES), EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE
D4286	REMOVAL OF NON-RESORBABLE BARRIER
D4322	SPLINT INTRA-CORONAL; NATURAL TEETH OR PROSTH CROWNS
D4323	SPLINT EXTRA-CORONAL; NATURAL TEETH OR PROSTH CROWNS
D5110	COMPLETE DENTURE - MAXILLARY
D5120	COMPLETE DENTURE - MANDIBULAR
D5130	IMMEDIATE DENTURE -MAXILLARY
D5140	IMMEDIATE DENTURE - MANDIBULAR
D5211	UPPER PARTIAL - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5212	LOWER PARTIAL - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5214	MANDIBULAR PARTIAL DENTURE, CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5225	MAXILLARY PARTIAL DENTURE-FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)
D5226	MANDIBULAR PARTIAL DENTURE-FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)
D5228	IMMEDIATE MANDIBULAR PARTIAL DENTURE FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE, ONE PIECE CAST METAL, MAXILLARY
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE, ONE PIECE CAST METAL, MANDIBULAR
D5410	ADJUST COMPLETE DENTURE, MAXILLARY
D5411	ADJUST COMPLETE DENTURE, MANDIBULAR
D5421	ADJUST PARTIAL DENTURE-MAXILLARY
D5422	ADJUST PARTIAL DENTURE-MANDIBULAR
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH)
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH
D5640	REPLACE BROKEN TEETH-PER TOOTH
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE - PER TOOTH
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)
D5671	REPLACE TEETH AND ACRYLIC ON METAL FRAMEWORK (MANDIBULAR)
D5710	REBASE COMPLETE MAXILLARY DENTURE
D5711	REBASE COMPLETE MANDIBULAR DENTURE
D5720	REBASE MAXILLARY PARTIAL DENTURE
D5721	REBASE MANDIBULAR PARTIAL DENTURE
D5725	REBASE HYBRID PROSTHESIS
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)
D5731	RELINE LOWER COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)
D5765	SOFT LINER FOR COMPLETE OR PARTIAL REMOVABLE DENTURE INDIRECT
D5850	TISSUE CONDITIONING, MAXILLARY
D5851	TISSUE CONDITIONING, MANDIBULAR
D5863	OVERDENTURE - COMPLETE MAXILLARY
D5865	OVERDENTURE - COMPLETE MANDIBULAR
D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH)
D6010	SURGICAL PLACEMENT OF IMPLANT BODY; ENDOSTEAL IMPLANT
D6011	SECOND STAGE IMPLANT SURGERY
D6012	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY - 1 EVERY 60 MONTHS
D6013	SURGICAL PLACEMENT OF MINI IMPLANT
D6040	SURGICAL PLACEMENT: EPOSTEAL IMPLANT
D6050	SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT
D6051	INTERIM ABUTMENT - INCLUDES PLACEMENT AND REMOVAL
D6055	CONNECTING BAR -IMPLANT SUPPORTED OR ABUTMENT SUPPORTED
D6056	PREFABRICATED ABUTMENT - INCLUDES MODIFICATION AND PLACEMENT

D6057	CUSTOM ABUTMENT - 1 EVERY 60 MONTHS
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN
D6066	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)
D6067	IMPLANT SUPPORTED METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FIXED PARTIAL DENTURE - 1 EVERY 60 MONTHS
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO HIGH NOBLE METAL FIXED PARTIAL DENTURE - 1 EVERY 60 MONTHS
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO PREDOMINATELY BASE METAL FIXED PARTIAL DENTURE - 1 EVERY 60 MONTHS
D6071	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO NOBLE METAL FIXED PARTIAL DENTURE - 1 EVERY 60 MONTHS
D6072	ABUTMENT SUPPORTED RETAINER FOR CAST HIGH NOBLE METAL FIXED PARTIAL DENTURE 1 EVERY 60 MONTHS
D6073	ABUTMENT SUPPORTED RETAINER FOR PREDOMINATELY BASE METAL FIXED PARTIAL DENTURE - 1 EVERY 60 MONTHS
D6074	ABUTMENT SUPPORTED RETAINER FOR CAST NOBLE METAL FIXED PARTIAL DENTURE - 1 EVERY 60 MONTHS
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD
D6076	IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)
D6077	IMPLANT SUPPORTED RETAINER FOR CAST METAL FIXED PARTIAL DENTURE - 1 EVERY 60 MONTHS
D6080	IMPLANT MAINTENANCE PROCEDUDRES WHEN PROSTHESES ARE REMOVED & REINSERTED, INCLUDING CLEANSING OF PROSTHESES AND ABUTMENTS
D6081	SCALING AND DEBRIDEMENT IN PRESENCE OF INFLAMMATION OF SINGLE IMPLANT
D6082	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS
D6083	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS
D6084	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM OR TITANIUM ALLOYS
D6085	PROVISIONAL CROWN
D6086	IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS
D6087	IMPLANT SUPPORTED CROWN - NOBLE ALLOYS
D6088	IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS
D6089	ACCESSING AND RETORQUING LOOSE IMPL SCREW - PER SCREW
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS BY REPORT
D6091	REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT
D6092	RE-CEMENT OR RE-BONDED IMPLANT/ABUTMENT SUPPORTED CROWN
D6093	RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE
D6095	REPAIR IMPLANT ABUTMENT - 1 EVERY 60 MONTHS
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW
D6097	ABUTMENT SUPPORTED CROWN – PORCELAIN FUSED TO TITANIUM OR TITANIUM ALLOYS
D6098	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS
D6099	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO NOBLE ALLOYS
D6100	IMPLANT REMOVAL, BY REPORT
D6101	DEBRIDEMENT OF A PERI-IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT, AND SURFACE CLEANING OF EXPOSED IMPLANT SURFACES, AND FLAP ENTRY AND CLOSURE
D6102	DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERI-IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT, AND INCLUDES SURFACE CLEANING OF THE EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE
D6103	BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT - DOES NOT INCLUDE FLAP ENTRY AND CLOSURE. PLACEMENT OF A BARRIER MEMBRANE OR BIOLOGIC MATERIALS TO AID IN OSSEOUS REGENERATION ARE REPORTED SEPARATELY

D6104	BONE GRAFT AT TIME OF IMPLANT PLACEMENT
D6110	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY
D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR
D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY
D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR
D6114	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY
D6115	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR
D6116	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY
D6117	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY
D6120	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS
D6121	IMPLANT SUPPORTED RETAINER FOR METAL FPD - PREDOMINANTLY BASE ALLOYS
D6122	IMPLANT SUPPORTED RETAINER FOR FPD METAL - NOBLE ALLOYS
D6123	IMPLANT SUPPORTED RETAINER FOR METAL FPD – TITANIUM AND TITANIUM ALLOYS
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT
D6191	SEMI-PRECISION ABUTMENT – PLACEMENT
D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT
D6195	ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS
D6198	REMOVE INTERIM IMPLANT COMPONENT
D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE
D6210	PONTIC-CAST HIGH NOBLE METAL
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL
D6212	PONTIC-CAST NOBLE METAL
D6214	PONTIC – TITANIUM – LIMITED TO 1 EVERY 60 MONTHS
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL
D6243	PONTIC – PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS
D6245	PONTIC-PORCELAIN/CERAMIC
D6250	PONTIC-RESIN WITH HIGH NOBLE METAL
D6251	PONTIC-RESIN WITH PREDOMINANTLY BASE METAL
D6252	PONTIC-RESIN WITH NOBLE METAL
D6253	PROVISIONAL PONTIC
D6519	INLAY/ONLAY – PORCELAIN/CERAMIC – LIMITED TO 1 EVERY 60 MONTHS
D6520	INLAY – METALLIC – TWO SURFACES – LIMITED TO 1 EVERY 60 MONTHS
D6530	INLAY – METALLIC – THREE OR MORE SURFACES - LIMITED TO 1 EVERY 60 MONTHS
D6543	ONLAY – METALLIC – THREE SURFACES - 1 EVERY 60 MONTHS
D6544	ONLAY – METALLIC – FOUR OR MORE SURFACES -1 EVERY 60 MONTHS
D6545	RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS
D6548	RETAINER - PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS
D6600	RETAINER INLAY-PORCELAIN/CERAMIC, TWO SURFACES
D6601	RETAINER INLAY-PORCELIAN/CERAMIC, THREE OR MORE SURFACES
D6602	RETAINER INLAY-CAST HIGH NOBLE METAL, TWO SURFACES
D6603	RETAINER INLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES
D6604	RETAINER INLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES
D6605	RETAINER INLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES
D6606	RETAINER INLAY - CAST NOBLE METAL, TWO SURFACES
D6607	RETAINER INLAY-CAST NOBLE METAL THREE OR MORE SURFACES
D6608	RETAINER ONLAY-PORCELAIN/CERAMIC, TWO SURFACES
D6609	RETAINER ONLAY-PORCELAIN/CERAMIC, THREE OR MORE SURFACES
D6610	RETAINER ONLAY - CAST HIGH NOBLE METAL, TWO SURFACES
D6611	RETAINER ONLAY-CAST HIGH NOBLE METAL, THREE OR MORE SURFACES

D6612	RETAINER ONLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES
D6613	RETAINER ONLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES
D6614	RETAINER ONLAY - CAST NOBLE METAL, TWO SURFACES
D6615	RETAINER ONLAY - CAST NOBLE METAL, THREE OR MORE SURFACES
D6624	RETAINER INLAY - TITANIUM
D6634	RETAINER ONLAY - TITANIUM
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE
D6720	RETAINER CROWN-RESIN WITH HIGH NOBLE METAL
D6721	RETAINER CROWN-RESIN WITH PREDOMINANTLY BASE METAL
D6722	RETAINER CROWN - RESIN WITH NOBLE METAL
D6740	RETAINER CROWN - PORCELAIN/CERAMIC
D6750	RETAINER CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL
D6751	RETAINER CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL
D6753	RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS
D6780	RETAINER CROWN-3/4 CAST HIGH NOBLE METAL
D6781	CROWN - 3/4 CAST PREDOMINATELY BASE METAL - 1 EVERY 60 MONTHS
D6782	CROWN - 3/4 CAST NOBLE METAL - 1 EVERY 60 MONTHS
D6783	RETAINER CROWN - 3/4 CAST PORCELAIN/CERAMIC
D6784	RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS
D6790	RETAINER CROWN-FULL CAST HIGH NOBLE METAL
D6791	RETAINER CROWN-FULL CAST PREDOMINANTLY BASE METAL
D6792	RETAINER CROWN-FULL CAST NOBLE METAL
D6794	RETAINER CROWN - TITANIUM
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE
D6980	BRIDGE REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTION OF TOOTH, AND ELEVATION OF MUCOPERIOSTEAL FLAP
D7220	REMOVAL OF IMPACTED TOOTH- SOFT TISSUE
D7230	REMOVAL OF IMPACTED TOOTH- PARTIALLY BONY
D7240	REMOVAL OF IMPACTED TOOTH- COMPLETELY BONY
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH
D7280	SURGICAL ACCESS OF UNERUPTED TOOTH
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION
D7297	CORTICOTOMY – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT
D7298	REMOVAL OF TEMPORARY ANCHORAGE DEVICE (SCREW RETAINED PLATE) REQ FLAP
D7299	REMOVAL OF TEMPORARY ANCHORAGE DEVICE REQ FLAP
D7300	REMOVAL OF TEMPORARY ANCHORAGE DEVICE WITHOUT FLAP
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS- ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY
D7510	INCISION AND DRAINAGE OF ABSCESS- INTRAORAL SOFT TISSUE
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)
D7520	INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE

D7521	INCISION AND DRAINAGE OF ABSCESS- EXTRAORAL SOFT TISSUE -COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)
D7720	MAXILLA-CLOSED REDUCTION
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM
D7921	COLLECT - APPLY AUTOLOGOUS PRODUCT - LIMITED TO 1 IN 36 MONTHS
D7922	PLACEMENT INTRA-SOCKET BIOLOG DRESSING TO AID HEMOSTASIS/CLOT STABILIZATION, PER SITE
D7953	BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION-PER SITE
D7960	FRENULECTOMY ALSO KNOWN AS FRENECTOMY OR FRENOTOMY-SEPARATE PROCEDURE NOT INCIDENTAL TO ANOTHER PROCEDURE
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)
D7971	EXCISION OF PERICORONAL GINGIVAL
D7979	NON-SURGICAL SILAOLITHOTOMY
D9120	FIXED PARTIAL DENTURE SECTIONING
D9222	DEEP SEDATION/GENERAL ANESTHESIA – FIRST 15 MINUTES
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT
D9930	TREATMENT OF COMPLICATIONS (POSTSURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT

Type IV

Procedure Code	Procedure Description
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE
D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION
D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION
D8040	LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION
D8210	REMOVABLE APPLIANCE THERAPY
D8220	FIXED APPLIANCE THERAPY
D8660	PRE-ORTHODONTIC EXAMINATION TO MONITOR GROWTH AND DEVELOPMENT
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S))
D8681	REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT
D8696	REPAIR OF ORTHODONTIC APPLIANCE – MANDIBULAR
D8697	REPAIR OF ORTHODONTIC APPLIANCE – MANDIBULAR
D8698	RE-CEMENT OR RE-BOND FIXED RETAINER – MAXILLARY
D8699	RE-CEMENT OR RE-BOND FIXED RETAINER – MANDIBULAR
D8701	REPAIR OF FIXED RETAINER, INCLUDES REATTACHMENT – MAXILLARY
D8702	REPAIR OF FIXED RETAINER, INCLUDES REATTACHMENT – MANDIBULAR
D8703	REPLACEMENT OF LOST OR BROKEN RETAINER – MAXILLARY
D8704	REPLACEMENT OF LOST OR BROKEN RETAINER – MANDIBULAR
D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCE(S) – OTHER THAN AT CONCLUSION OF TREATMENT