BlueEssential

Benefit Book for Individuals

azblue.com/member

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact Blue Cross® Blue Shield® of Arizona (AZ Blue) at one of the phone numbers on the back of your ID card.

AZ Blue Portal Account

AZ Blue also makes information available at www.azblue.com, and you may wish to look there before calling. Your AZ Blue Portal Account allows you to manage your health insurance plan from anywhere you have Internet access. Go to www.azblue.com/member for more information and to register for an account. After you register, you can*:

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

*Access to AZ Blue Portal Account links and services will vary based on Benefit Plan type.

AZ Blue Customer Service

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

Hours:	Monday through Friday, 8:00 a.m. to 5:00 p.m. MST (except holidays)
ID card:	Members can access their ID card 24/7 in the Member portal. Prefer a physical card? Order one through your Member portal to be mailed to your home or call us. (602) 864-4115 (within the Phoenix Metro area) (800) 232-2345, ext. 4115 (outside of Phoenix Metro)
Hearing Impaired (TTY):	(800) 770-8973, TTY: 711
For assistance in Spanish (en Español):	(602) 864-4884
Mailing Address:	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466

Benefits Administrator Contact Information

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

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Claim Submissions

Mail New Claims to:	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix, AZ 85062-2924
Claims for Transplant Travel and Lodging:	Attention: Transplant Travel Claim Processor, Mail Stop: C803, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
Claims for Services Received on a Cruise Ship:	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
Claims for Chiropractic Services:	Claims Administration, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001

Disputes

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

Social Media

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

DEFINITIONS

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

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

Type of Provider	Type of Claim	Basis for Allowed Amount
Providers contracted with AZ Blue	Emergency and non-emergency	Generally, the lesser of the provider's Billed Charges or the applicable AZ Blue Fee Schedule, with adjustments for any negotiated contractual arrangements and certain *"Claims Editing Procedures and Pricing Guidelines."*
Providers contracted with a vendor	Emergency and non-emergency	Generally, the lesser of the provider's Billed Charges or the vendor's Fee Schedule, with adjustments for any negotiated contractual arrangements
Providers contracted with another Blue Cross or Blue Shield plan ("Host Blue")	Emergency and non-emergency	Lesser of the provider's Billed Charges or the price the Host Blue plan has negotiated with the Provider
Noncontracted Providers (in Arizona)	Non-emergency	Lesser of the provider's Billed Charges or the applicable Fee Schedule, with adjustments for certain *"Claims Editing Procedures and Pricing Guidelines."*
Noncontracted Providers (outside Arizona)	Non-emergency	Lesser of the provider's Billed Charges or the amount the Host Blue would pay the nonparticipating Provider. In the event that the Host Blue has not established an amount it would pay the nonparticipating Provider, the Allowed Amount is based on the applicable Fee Schedule, with adjustments for certain *"Claims Editing Procedures and Pricing Guidelines."*
Noncontracted ground ambulance Providers, including Providers contracted with another AZ Blue network, but not contracted as a plan network Provider for this Benefit Plan (in and outside Arizona)	Emergency	The Allowed Amount is based upon the ambulance provider's Billed Charges.
Noncontracted Providers in an in-network facility (in and outside Arizona)	Non-emergency and non-ancillary	The Qualifying Payment Amount, as defined by federal law, is the Allowed Amount. If you sign a consent for a noncontracted Provider to perform services at an in-network facility, you are responsible for the difference between the Qualifying Payment Amount and the provider's Billed Charges.
Noncontracted Providers, excluding air ambulance (in and outside Arizona)	Emergency	The Qualifying Payment Amount, as defined by federal law, is the Allowed Amount.
Noncontracted air ambulance Providers (in and outside Arizona)	Emergency and non-emergency	Lesser of the provider's Billed Charges or the applicable AZ Blue Fee Schedule, with adjustments for certain *"Claims Editing Procedures and Pricing Guidelines."* The member's Cost Share will be based on the lesser of the provider's Billed Charges or the Qualifying Payment Amount, as defined by federal law.

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

"AZ Blue" or "We" means Blue Cross Blue Shield of Arizona when acting as the issuer of insurance coverage or as the administrator of a group Benefit Plan. Within this Benefit Book, "AZ Blue" or "We" may also include contracted vendors, when a contracted vendor is performing functions on behalf of AZ Blue.

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

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

"Benefit Book" means this document.

"Benefit Plan" means the Contract of insurance between an individual Member and AZ Blue. Your AZ Blue Benefit Plan includes this book and any SBC, your application for coverage, any waivers issued in connection with your Benefit Plan, any Benefit Plan that is issued to replace this Benefit Plan, and any rider, amendment, or modification to this Benefit Plan.

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

"Blue Cross Blue Shield of Arizona" is an independent licensee of the Blue Cross and Blue Shield Association. AZ Blue is a not-for-profit corporation organized under the laws of the state of Arizona as a hospital, medical, dental, and optometric services corporation and is authorized to operate a healthcare services organization as a line of business.

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

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

"Chiropractic Benefits Administrator (CBA)" means American Specialty Health Networks, Inc., the independent company that administers chiropractic benefits for AZ Blue. The CBA develops and manages the AZ Blue network of chiropractic Providers, processes chiropractic claims, determines medical necessity and handles utilization management, grievances, and appeals related to Chiropractic Services.

"Complications of Pregnancy" means a medical illness or sickness that is distinct from the pregnancy, but is adversely affected by the pregnancy or caused by the pregnancy and is considered to be life- or health-threatening to the mother and/or fetus. Covered Complications of Pregnancy are determined by AZ Blue based on Evidence-based Criteria.

"Contract" means a member's application for coverage and the Benefit Plan.

"Contract Holder" means:
- For individual coverage, the individual who signs the application for coverage and in whose name the Benefit Plan is issued.
- For family coverage, the individual who signs the application on behalf of himself or herself and any Dependents in whose name the Benefit Plan is issued.
- For Child-only Coverage, the parent or legal guardian of the child covered under the Benefit Plan, who has signed the application on behalf of the child.

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

"Cost Share" means the member's financial obligation for a covered Service. Depending on the plan type, Cost Share may include one or more of the following: deductible, Copay, Access Fee, Coinsurance, pharmacy deductible, Prior Authorization Charges, and balance bills.

"Custodial Care" means health services and other related services that meet any of the following criteria:

- Are for comfort or convenience;
- Do not seek to cure;
- Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition, or other self-care; or
- Are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as a licensed practical nurse (LPN), registered nurse (RN), or licensed therapist.

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

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

"Evidence-based Criteria" means medical, pharmaceutical, dental, and administrative criteria, which are based on industry-standard research and technology. These criteria help AZ Blue 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. AZ Blue ensures that Evidence-based Criteria is reviewed regularly and updated in response to changes and advancements in the healthcare industry. Decisions are based on the Evidence-based Criteria in effect at the time of Service. You can obtain additional information by calling the Customer Service number on your ID card. AZ Blue contracted vendor(s) may establish Evidence-based Criteria of their own for services the vendor provides or administers pursuant to the vendor's contract with AZ Blue.

"Fee Schedule" means a proprietary schedule of Provider fees compiled by AZ Blue or AZ Blue's contracted vendors. AZ Blue or AZ Blue's contracted vendors develop proprietary schedules of fees based on annual reviews of information from numerous sources, including but not limited to: Medicare fee schedules from the Centers for Medicare and Medicaid Services (CMS), AZ Blue's or the contracted vendor's historical claims experience, pricing information that may be available to AZ Blue or the vendor, information and comments from Providers, and negotiated contractual arrangements with Providers. AZ Blue and/or AZ Blue's contracted vendors may change their fee schedules at any time without prior notice to members. If the Allowed Amount is based on a Fee Schedule, a change to the Fee Schedule may result in higher Member Cost Share.

"Gender-affirming Care" means 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.

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

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

"Member" or "You" means an individual, employee, participant, or dependent covered under a Benefit Plan.

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

"Physician," for purposes of classifying benefits and Member cost shares in this Benefit Plan, means a properly licensed MD, DO, DPM, or DC.

“Policy Year” means the 12-month period that begins on the effective or renewal date of the contract holder’s coverage. A Policy Year often differs from the calendar year, even though AZ Blue calculates certain Cost-share accruals based on a calendar year.

“Primary Care Provider (PCP)” means a healthcare professional who is contracted with AZ Blue 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 AZ Blue. Your Benefit Plan does not require you to have a PCP or to have a PCP authorize Specialist referrals.

“Prior Authorization” is a review done by AZ Blue 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 AZ Blue for a Service that requires it, you are subject to either a Prior Authorization charge or a complete loss of benefit. If you have to pay a Prior Authorization charge, it does not count toward the Calendar-year Deductible or Out-of-pocket Coinsurance Maximum.

“Provider” means any properly licensed, certified, or registered person or facility furnishing medical care to you, such as a doctor, hospital, laboratory, or other health professional. A Provider can be related to a member.

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

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

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

“Specialist” means either a Physician or other healthcare professional who practices in a specific area other than those practiced by PCPs, or a properly licensed, certified, or registered individual healthcare Provider whose practice is limited to rendering Behavioral Health Services. This definition of “Specialist” does not apply to dentists. AZ Blue does not require you to obtain an authorization or referral to see a Specialist.

“Summary of Benefits and Coverage (SBC)” means a federally required document in a specified template with information on applicable access fees, Coinsurance percentages, copays, deductible amounts, other cost-sharing amounts, benefits, exclusions, limitations, and other important information.

“Telehealth Services Administrator (TSA)” means Amwell, an independent company that is contracted with AZ Blue to provide contracted Providers, an interactive web platform allowing members to interact with Providers, and technical support for Telehealth Services (i.e., BlueCare Anywhere) covered under this Benefit Plan.

“Telehealth Services from BlueCare Anywhere” means medical and Behavioral Health Services provided online via video using a computer, tablet, smartphone, or other mobile device through the Telehealth Services Administrator. BlueCare Anywhere is AZ Blue’s telehealth Service.

“Telehealth Services from In-network Providers” means services delivered through interactive qualified electronic media.

UNDERSTANDING THE BASICS

Your Responsibilities

Before you receive services:
- Check your provider's network status and know whether your Provider is a network Provider with AZ Blue.
- Know how much Cost Share you will have to pay.
- Know the limits and exclusions on coverage.
- Know your coverage.
- Read your benefit materials.

After you receive services:
- Read your explanation of benefits (EOB) and Member Health Statements.
- Tell AZ Blue if you see any differences between the Member Cost Share listed on your claims documents and what you actually paid.

AZ Blue Member ID

Your Member ID will have basic information about your coverage:
- Cost-share amounts
- Identification number(s)
- Important phone numbers and addresses
- Who is covered (Contract Holder and dependent names)

Your Member ID is always available in your AZ Blue Portal Account. When you seek healthcare services, your Provider can accept your Member ID several ways:
- Access your digital ID card: Members can access their ID card 24/7 in the Member portal.
- Email your ID card: Email your Member ID card right from your Member portal to trusted emails.
- Member verification: Members can give their ID number, full name, and date of birth to the provider, who can then use this information to verify eligibility.
- Mobile wallet: You can download a copy of your ID card to your mobile wallet by logging in to your AZ Blue Portal on your smartphone and selecting My ID Card to get started.
- Print your ID card: Members can log in to their AZ Blue Portal at www.azblue.com/member to print their ID card.

Changes

You will be notified of any Changes as required by law. AZ Blue will provide you with 60 days' advance written notice of material modifications to this plan.

Covered Services

To be covered, a Service or item must be all of the following:
- A benefit of this plan;
- Approved when Prior Authorization is required;
- Medically Necessary as determined by AZ Blue or AZ Blue's contracted vendor(s);
- Not excluded under any provision of this plan;
- Not experimental or investigational as determined by AZ Blue or AZ Blue's contracted vendor(s) (does not apply to Covered Services as part of an eligible cancer clinical trial);
- Provided while this Benefit Plan is in effect and while the person claiming benefits is eligible for benefits; and
- Rendered by an eligible Provider acting within the provider's scope of practice, as determined by AZ Blue or AZ Blue's contracted vendor(s).

Experimental or Investigational Services

AZ Blue, or AZ Blue's contracted vendor, in its sole and absolute discretion, decides whether a Service or item is experimental or investigational. A Service or item is considered experimental or investigational unless it meets all of the following criteria:
- The improvement resulting from the Service or item must be attainable outside the investigational setting;
- The scientific evidence must permit conclusions concerning the effect of the Service or item on health outcomes;
- The Service or item must be as beneficial as any established alternative;

- The Service or item must have final approval from the appropriate governmental regulatory bodies (unless otherwise required by applicable law, final approval of a regulatory body does not, in and of itself, qualify a Service or item for coverage), if applicable; and
- The Service or item must improve the net health outcome.

In addition to classifying a Service or item as experimental or investigational using the above criteria, AZ Blue or its contracted vendor may also classify the Service or item as experimental or investigational if any one or more of the following apply:
- Published reports and articles in authoritative (peer reviewed) medical and scientific literature show that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, appropriate selection, efficacy or efficacy as compared with the standard treatment for the diagnosis;
- The Provider rendering the Service or item documents that the Service or item is experimental or investigational; or
- The Service or item cannot be lawfully marketed or used without full (unrestricted) approval of appropriate governmental regulatory bodies and approval for marketing or use has not been given at the time the Service or item is submitted for Prior Authorization or rendered.

Grandfathered Status of Plan

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

Medically Necessary

AZ Blue, or AZ Blue’s contracted vendor, in its sole and absolute discretion, decides whether a Service is Medically Necessary based on the following definition. A Medically Necessary Service is a Service that meets all of the following requirements:
- Is consistent with the diagnosis or treatment of a symptom, illness, disease, or injury;
- Is not primarily for the convenience of a Member or a Provider;
- Is the most appropriate site, supply, or Service level that can safely be provided; and
- Meets AZ Blue’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, AZ Blue or its contracted vendor will base its decision on the judgment and expertise of a medical professional or medical consultant retained by AZ Blue or the vendor.

Medical Necessity Guidelines and Criteria

AZ Blue uses Evidence-based Criteria to make medical necessity decisions. Call the Customer Service number on your ID card for additional information on Evidence-based Criteria.

Decisions about medical necessity may differ from your provider’s opinion. A Provider may prescribe, order, recommend, or approve a Service that AZ Blue decides is not Medically Necessary and therefore is not a covered benefit. You and your Provider should decide whether to proceed with a Service that is not covered. If you have an adverse determination, refer to the *“Explanation of Benefits (EOB) Form and Member Health Statement”* and the *“Appeal and Grievance Process”* sections. Also, not all Medically Necessary services are covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A Service may be Medically Necessary and still excluded from coverage (see *“Covered Services”* section).

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

AZ Blue contracts with vendors to administer some or all of the benefits covered under this plan. These contracted vendors make medical necessity determinations based on their own Medical Necessity Criteria, which are also available to you on request.

MEMBER COST SHARING

Members pay part of the costs for benefits received under this plan. Depending on your particular Benefit Plan, the Service you receive, and the Provider you choose, you may have an Access Fee, Balance Bill, Coinsurance, Copay, deductible, or some combination of these payments. Each Cost-share type is explained below. This section, the benefit descriptions in this book, and your SBC will explain which Cost-share types apply to each benefit. AZ Blue uses your claims to track whether you have met certain Cost-share obligations. We apply claims based on the order in which we process the claims and not based on date of Service.

Access Fee

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

Annual Physician Visit Copay Limit

There is an annual limit for Physician outpatient visits with a Copay Cost Share. The limit applies per Member, per calendar year, to Copay cost shares for in-network Physician office, home, and walk-in clinic visits. After you reach the Annual Physician Visit Copay Limit, visits to in-network physicians will be subject to in-network deductible and Coinsurance.

See your SBC for the Annual Physician Visit Copay Limit, applicable copays for Physician visits, and applicable deductible and Coinsurance. AZ Blue will apply claims toward this limit in the order that claims are processed, which may be different from the date order in which you received services.

Balance Bill

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

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

Benefit Maximums

Some benefits may have a specific benefit maximum or limit based on the number of days or visits, type, timeframe (calendar year or Benefit Plan), age, gender, or other factors. If you reach a benefit maximum, any further services are not covered under that benefit, and you may have to pay the provider's Billed Charges for those services. However, if you reach the benefit maximum on a particular line of a claim, you will be responsible for paying only up to the Allowed Amount for the remaining charges on that line of the claim. All Benefit Maximums are included in the applicable benefit description.

Calendar-Year Deductible (Individual and Family)

A Calendar-year Deductible is the amount each Member must pay for Covered Services each calendar year before the Benefit Plan begins to pay for Covered Services. The deductible applies to every covered Service unless the specific benefit section says it does not apply. The deductible is calculated based on the Allowed Amount. You may have separate deductibles for in-network Providers and out-of-network Providers. Amounts you pay for copays and access fees do not count toward the deductible. If the amount of your Calendar-year Deductible increases on your annual renewal date, you must pay the additional deductible amount during the calendar year in which the increased deductible takes effect.

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

Coinsurance

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

AZ Blue normally calculates Coinsurance based on the Allowed Amount. There is one exception. If a hospital provider's Billed Charges are less than the hospital's DRG reimbursement, AZ Blue will calculate your Coinsurance based on the lesser billed charge.

Copay

A Copay is a specific dollar amount you must pay to the Provider for some Covered Services. If a Copay applies to a covered Service, you must pay it when you receive services. Different services may have different Copay amounts and are shown on your SBC. Usually, if a Copay does not apply, you will pay applicable deductible and Coinsurance.

Out-of-Pocket Coinsurance Maximum (Individual)

An Out-of-pocket Coinsurance Maximum is the amount each Member must pay as Coinsurance each year before AZ Blue begins paying 100 percent of the Allowed Amount on most Covered Services with Coinsurance, for the remainder of the calendar year. You are still responsible for other types of Cost-share payments, even after you have met your Out-of-pocket Coinsurance Maximum. Depending on your Benefit Plan, you may have separate out-of-pocket coinsurance maximums for in-network and out-of-network Providers. Accruals toward the Out-of-pocket Coinsurance Maximum are calculated on a calendar year and not on your Policy Year.

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

- Amounts above a benefit maximum
- Amounts for Medical Foods
- Any amounts for balance billing
- Any amounts for noncovered services
- Any charges for lack of Prior Authorization
- Coinsurance and copays for *"Pharmacy Benefit"* medications
- Coinsurance for 61 or more days of Inpatient Rehabilitation Services in a calendar year*
- Coinsurance for 91 or more days of skilled nursing services in a calendar year*
- Coinsurance for 366 or more days of Long-term Acute Care services*
- Copays and access fees
- Copays for Specialty Medications

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

Prior Authorization Charges

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

PROVIDERS

Provider Directory

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

Provider Eligibility and Network Status

Know your provider's network and eligibility status before you receive services. To be eligible for coverage, a Service must be rendered by an eligible individual Provider acting within his or her scope of practice, and, when applicable, performed at an eligible facility that is licensed or certified for the type of procedure and services rendered.

Eligible Providers

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

Benefits may also be available from other healthcare professionals whose services are mandated by federal or Arizona law, or who are accepted as eligible by AZ Blue. The following are examples of ineligible Providers: acupuncturists and doctors of naturopathy and homeopathy. Other Provider types may also be ineligible. The fact that a Service is rendered by an eligible Provider does not mean that the Service will be covered. Not all Eligible Providers are contracted with AZ Blue.

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

Choosing a Provider

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

In-Network Providers (Contracted)

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

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

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

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

Out-of-Network Providers (Contracted and Noncontracted)

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

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

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

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

- *Providers contracted with Blue Cross Blue Shield Global Core*: Providers who are contracted with Blue Cross Blue Shield Global Core are out-of-network Providers. For Covered Services from these Providers, you will pay out-of-network deductible, Coinsurance, and access fees (except for Emergency Services), plus the Balance Bill.

Eligible Provider Status and Payment – Summary Table Subject to all terms and conditions noted in this section.				
Provider Contract Status	**Network Status and Applicable Cost Share**	**Provider Required to File Claim on Member's Behalf**	**Accept AZ Blue Allowed Amount and do not Balance Bill**	**Payee for Reimbursement**
Providers contracted with AZ Blue	In-network	Yes	Yes	AZ Blue reimburses the Provider the Allowed Amount, less any Member Cost Share.
Providers contracted with another Blue Cross or Blue Shield plan ("Host Blue") as PPO Providers	In-network	Yes	Yes	The Host Blue, on behalf of AZ Blue, reimburses the Provider the Allowed Amount less any Member Cost Share.
Providers contracted with Host Blue as Participating-only Providers	Out-of-network	Yes	Yes	The Host Blue, on behalf of AZ Blue, reimburses the Provider the Allowed Amount less any Member Cost Share.
Providers contracted with Blue Cross Blue Shield Global Core	Out-of-network	Yes	No	Blue Cross Blue Shield Global Core reimburses the Provider the Allowed Amount less any Member Cost Share.
Noncontracted Providers for non-emergency or non-ancillary services rendered in an in-network facility (in and outside Arizona) (must be Eligible Providers)	Out-of-network	No (Provider may elect to do so as courtesy to Member)	No. May charge up to full Billed Charges. Difference between Billed Charges and AZ Blue Member reimbursement may be substantial.	AZ Blue reimburses the Member or the Provider the Allowed Amount, less any Member Cost Share.
Noncontracted emergency Service Providers (in and outside Arizona) (must be Eligible Providers)	Out-of-network	No (Provider may elect to do so as courtesy to Member)	Yes, If the Provider disputes the Allowed Amount, the Provider must resolve the dispute with AZ Blue directly.	AZ Blue reimburses the Provider the Allowed Amount, minus your Cost Share.

Sample Differences in Financial Responsibility Based on Provider Choice

The following example shows how out-of-pocket expenses can differ depending on the Provider you choose. This example is provided for demonstration purposes only. Your savings may vary depending on your Benefit Plan and your chosen Provider. In this example, the Member has already satisfied the Calendar-year Deductible and has a 20 percent Coinsurance for an in-network Provider and 50 percent Coinsurance for an out-of-network Provider.

Billed Charges	**Allowed Amount**	**Financial Responsibility**	**In-Network Providers 20% Coinsurance**	**Out-of-Network (Noncontracted) Providers 50% Coinsurance**
$1,000	$400	AZ Blue pays:	$320	$200
		You pay:	$80 Coinsurance	$200 Coinsurance +$600 Balance Bill $800

Locating an In-Network Provider

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

Prior Authorization for Out-of-Network Providers

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

Continuing Care from an Out-of-Network Provider

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

New Members

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

- A life-threatening disease or condition, in which case the transitional period is not more than 30 days from the Effective Date of Coverage; or
- Entered the third trimester of pregnancy on the Effective Date of Coverage, in which case the transitional period includes the covered Provider services for Complications of Pregnancy only; and

The member's Provider agrees, in writing, to:

- Accept the AZ Blue 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 AZ Blue with any necessary medical information related to your care; and
- Comply with AZ Blue'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 AZ Blue is terminated or non-renewed (except for reasons of medical incompetence or unprofessional conduct) a Member may continue an active course of treatment with that Provider until the treatment is complete or for 90 days from the notice provided to the Member, whichever is shorter. This continuity of care timeframe extends through a new policy year period if the Member remains enrolled in this Benefit Plan.

An active course of treatment means the Member is:

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

The member's Provider agrees, in writing, to:

- Accept the AZ Blue 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 AZ Blue with any necessary medical information related to your care; and
- Comply with AZ Blue's policies and procedures as applicable, including those surrounding Prior Authorization, network referrals, claims processing, quality assurance, and utilization review.

Out-of-Area Services

Overview

AZ Blue has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and

procedures issued by the Blue Cross and Blue Shield Association. Whenever you access healthcare services outside the geographic area AZ Blue serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits (except when paid as medical claims/benefits), and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by AZ Blue 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, AZ Blue will remain responsible for doing what we agreed to in the Contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

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

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

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

Special Cases: Value-Based Programs

BlueCard program

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

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

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to individual insured accounts. If applicable, AZ Blue will include any such surcharge, tax, or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside AZ Blue's Service Area

- *Liability calculation*: When Covered Services are provided outside of AZ Blue's service area by nonparticipating Providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating Provider bills and the payment AZ Blue 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, AZ Blue may use other payment methods, such as Billed Charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount AZ Blue will pay for services provided by nonparticipating Providers. In these situations, you may be liable for the difference between the amount that the nonparticipating Provider bills and the payment AZ Blue will make for the Covered Services as set forth in this paragraph.

Blue Cross Blue Shield Global Core Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Service Center at (800) 810-BLUE (2583), or call collect at (804) 673-1177, 24 hours a day, 7 days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- *Inpatient services*: In most cases, if you contact the Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your Cost-share amounts. In such cases, the hospital will submit your claims to the Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Covered Services. You must contact AZ Blue to obtain Prior Authorization for non-emergency inpatient services.

- *Outpatient Services*: Physicians, Urgent Care centers, and other outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Covered Services.

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

Services Received on Cruise Ships

If you receive healthcare services while on a cruise ship, you will pay in-network Cost Share, and the Allowed Amount will be based on Billed Charges. A cruise ship claim is not considered an out-of-country claim. Claims should be submitted and processed through AZ Blue, not through the Blue Cross Blue Shield Global Core program. Please call Customer Service at the number on the back of your ID card for more information, or mail copies of your receipts to the AZ Blue general correspondence address listed at the front of this book.

PRIOR AUTHORIZATION

When Is Prior Authorization Required

Not all services or medications require Prior Authorization. Prior Authorization is not required for Emergency Services or Urgent Care services. If it is required, your treating Provider must obtain it on your behalf before rendering services. If Prior Authorization is not obtained for medications that require it, the medications will not be covered. Prior Authorization may be required for services to be covered when provided in certain settings.

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

How to Obtain Prior Authorization

Ask your treating Provider to contact AZ Blue for Prior Authorization before you receive services and medications that require it. Your Provider must contact AZ Blue because he or she has the information and Medical Records we need to make a benefit determination. AZ Blue will rely on information supplied by your Provider. If that information is inaccurate or incomplete, it may affect the decision on your request or claim.

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

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

- Applicability of other Benefit Plan provisions (limitations, exclusions, waivers, and Benefit Maximums);
- If the treating Provider or location of Service is in-network;
- Whether the Service is Medically Necessary or investigational; and
- Whether your coverage is active.

Prescription Medication Exception

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

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

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

Prior Authorization for In-Network Cost Share for Services from an Out-of-Network Provider is a process separate from Prior Authorization for services. If you want an out-of-network Provider to render services that require Prior Authorization, and you also want to be eligible for the in-network Cost Share, you must ensure that your Provider makes two separate Prior Authorization requests: one for the Service itself and one for use of the out-of-network Provider. If AZ Blue provides you Prior Authorization for the in-network Cost Share, your services will be subject to the in-network Cost Share. You will still be responsible for any Balance Bill, plus your in-network Cost Share.

If AZ Blue Provides Prior Authorization for Your Service

You and your Provider will receive a letter explaining the scope of the Prior Authorization. Payment will be made for the Service that has received Prior Authorization in accordance with plan benefits.

If AZ Blue Denies Your Prior Authorization Request

Denial of Prior Authorization is an adverse benefit determination. As explained in the *"Notice of Determination"* section of this book, AZ Blue will send you a notice explaining the reason for the denial, and your right to appeal the AZ Blue decision. Information on where to file an appeal is in the AZ Blue Appeal and Grievance Guidelines.

If your request for Prior Authorization for a Service is denied because AZ Blue decides that the Service is not Medically Necessary, remember that AZ Blue's interpretation of medical necessity is a benefits determination made in accordance with the provisions of this plan. Your Provider may recommend services or treatment not covered under this plan. You and your Provider should decide whether to proceed with the Service or procedure if AZ Blue denies Prior Authorization.

DESCRIPTION OF BENEFITS

Please review this section for an explanation of Covered Services and benefit-specific limitations and exclusions. Also, be sure to review the information about Covered Services in *"Understanding the Basics"* and refer to *"What is Not Covered"* for general exclusions and limitations that apply to all benefits. AZ Blue does not determine whether a Service is covered under this Benefit Plan until after services are provided and AZ Blue receives a complete claim describing the services actually rendered.

A. AMBULANCE SERVICES

Your Cost Share: Deductible is waived. You pay in-network Coinsurance, which counts toward your in-network Out-of-pocket Coinsurance Maximum.

Benefit Description: Benefits are available for:

- Air or water ambulance transportation to the nearest facility capable of providing appropriate treatment when the emergency, accident, or acute illness occurs in an area inaccessible by ground vehicles or transport by ground ambulance would be harmful to the member's medical condition; or
- Ground ambulance transportation from the site of an emergency, accident, or acute illness to the nearest facility capable of providing appropriate treatment; or
- Interfacility ground, water, or air ambulance transfer for admission to a facility when the transferring facility is unable to provide the level of Service required.

Benefit-Specific Exclusions:

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

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

B.1 Inpatient Hospital

Your Cost Share:

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

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

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

Benefit Description: Benefits are available for:

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

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

Your Cost Share:

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

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

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

Benefit Description: Benefits are available for:
- Diagnostic testing
- Medications, biologicals, and solutions
- Room and board in a semi-private room or a standard private room (not deluxe) if the facility only has private rooms or if a private room is Medically Necessary
- Treatment and recovery rooms and equipment for Covered Services

Benefits are available for inpatient Behavioral Health Services that meet all the following criteria:
- A Physician or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- The facility has 24/7 onsite RN coverage;
- The facility has sufficient behavioral health professional staff to provide appropriate treatment;
- The facility is licensed to provide Behavioral Health Services to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time;
- The facility's designated clinical director is a behavioral health professional and provides direction for the Behavioral Health Services provided at the facility; and
- The facility's designated medical director is a Physician or registered nurse practitioner and provides direction for physical health services provided at the facility.

Benefit-Specific Exclusions:
- Custodial Care
- Medications dispensed at the time of discharge from a hospital
- Respite Care

B.3 Outpatient Facility and Professional Services

Your Cost Share:

In-network: Your Cost Share is waived.

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

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

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

Your Cost Share:

In-network: Your Cost Share is waived.

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

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

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

Benefit Description: Behavioral Therapy services for the treatment of Autism Spectrum Disorder are available for members who have been diagnosed with Autism Spectrum Disorder. Covered Behavioral Therapy services must be delivered by a Provider who is licensed or certified as required by law.

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

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

C. CANCER CLINICAL TRIALS

Your Cost Share: You pay applicable deductible, Coinsurance, and copays. Physician visit copays count toward the Annual Physician Visit Copay Limit. The Cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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

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

For services associated with an Eligible Cancer Clinical Trial to be covered, you or your Provider must inform AZ Blue that you are enrolled in a cancer clinical trial, that the trial meets the requirements of Arizona law, and that the services to be rendered are directly associated with the trial. Otherwise, AZ Blue only covers Cancer Clinical Trials as required by law and will administer your benefits according to the other terms of your Benefit Plan, which may result in a denial of benefits. If

you have any questions about whether a particular Service is covered, please call Customer Service at the number on your ID card.

Benefit-Specific Exclusions:

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

D. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

Your Cost Share: You pay applicable deductible, Coinsurance, and copays. Physician visit copays count toward the Annual Physician Visit Copay Limit. The Cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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

E. CATARACT SURGERY

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

Benefit Description: Benefits are available for the removal of cataracts, including placement of a single intraocular lens at the time of the cataract removal, and for 1 pair of eyeglasses or external contact lenses following Cataract Surgery. The eyeglasses or external contact lenses must be prescribed and purchased within 6 months following the date of the Cataract Surgery.

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

F. CHIROPRACTIC SERVICES

Your Cost Share:

In-network: You pay 1 Copay per Member, per Provider, per day for office, home, or walk-in clinic visits, up to the Annual Physician Visit Copay Limit. You pay in-network deductible and Coinsurance for Covered Services provided by a chiropractor during an office, home, or walk-in clinic visit after you have reached the Annual Physician Visit Copay Limit. The Copay does not apply if you receive only physical medicine and Rehabilitation Services and no other covered Service during your visit. For physical medicine and Rehabilitation Services, you pay in-network deductible and Coinsurance. You pay in-network deductible and Coinsurance for services provided in any location other than an office, home, or walk-in clinic, including but not limited to inpatient and outpatient facilities and emergency rooms.

Out-of-network: You pay out-of-network deductible and Coinsurance for all services rendered by an out-of-network Provider, regardless of the location of Service. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Benefit Description: Benefits are available for Chiropractic Services.

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

G. DENTAL SERVICES – MEDICAL

Not all dentists who are contracted with AZ Blue are contracted to provide medical-related Dental Services. Call Customer Service at the number on your ID card with questions.

G.1 Dental Accident Services

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

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

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

Benefit Description: Benefits are only available for the following services to repair or replace a Sound Tooth damaged or lost by an Accidental Dental Injury:
- Extraction of teeth damaged as a result of Accidental Dental Injury
- Original placement of fixed or removable complete or partial dentures
- Original placement, repair, or replacement of crowns
- Original placement, repair, or replacement of veneers
- Orthodontic services directly related to a covered accidental injury
- Treatment for a fractured jaw
- Other services required by federal or state law to be covered

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

G.2 Dental Services Required for Medical Procedures

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

Benefit Description: Benefits are available for Dental Services required to perform the medical services listed in this benefit. These Dental Services may either be part of the medical procedure or may be performed in conjunction with and made Medically Necessary solely because of the medical procedure:
- Diagnostic services prior to planned organ or stem cell transplant procedures
- Removal of teeth required for covered treatment of head and neck cancer or osteomyelitis of the jaw
- Restoration of teeth made Medically Necessary because of the covered treatment of head and neck cancer or osteomyelitis of the jaw
- Other services required by federal or state law to be covered

Benefit-Specific Exclusions:
- Dental implants and any related services
- Gold foil restorations and inlays
- Occlusal rehabilitation and reconstruction

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

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

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

Benefit Description: Benefits are available for facility and professional anesthesiologist charges to perform Dental Services under anesthesia in an inpatient or outpatient facility due to one or more of the following concurrent or co-morbid conditions:
- Children 5 years or younger who, in the opinion of the treating dental Provider, cannot be safely treated in the dental office
- Intellectual disability
- Malignant hypertension
- Senility or dementia
- Uncontrolled seizure disorder
- Unstable cardiovascular condition
- Other conditions for which these services are required by federal or state law to be covered

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

Your Cost Share: You pay applicable deductible, Coinsurance, and copays. Physician visit copays count toward the Annual Physician Visit Copay Limit. The Cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

H.1 DME

Benefit Description: To be eligible for coverage, DME must meet all of the following criteria:
- Be designed for appropriate use in the home setting;
- Be specifically designed to improve or support the function of a body part; and
- Cannot be primarily useful to a person in the absence of an illness or injury.

Benefits are available for DME rental or purchase, as determined by AZ Blue, and for DME repair or replacement, as determined by AZ Blue, due to normal wear and tear caused by use of the item in accordance with the manufacturer's instructions or due to growth of a child. Benefits are limited to the Allowed Amount for the DME item base model. AZ Blue determines what is covered as the base model. Deluxe or upgraded DME items may be eligible for coverage based upon AZ Blue Medical Necessity Criteria.

Benefit-Specific Exclusions:
- Charges for continued rental of a DME item after the purchase price is reached, if applicable
- Repair costs that exceed the Allowed Amount for the DME item
- Repair or replacement of DME items lost or damaged due to neglect or use that is not in accordance with the manufacturer's instructions or specifications

H.2 Medical Supplies

Benefit Description: Benefits are available for the following Medical Supplies:
- Any device or supply permitted under current Evidence-based Criteria
- 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
- Other Medical Supplies required by federal or state law to be covered

Benefits are limited to the Allowed Amount for the medical supply base model. AZ Blue determines what is covered as the base model. Deluxe or upgraded Medical Supplies may be eligible for coverage based upon AZ Blue Medical Necessity Criteria. Note that certain equipment and supplies are covered under the Pharmacy benefit at the discretion of AZ Blue (see the *"Pharmacy Benefit"* section).

H.3 Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

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

Benefits are limited to the Allowed Amount for the prosthetic appliance or orthotic base model. AZ Blue determines what is covered as the base model. Deluxe or upgraded Prosthetic Appliances or Orthotics may be eligible for coverage based upon AZ Blue Medical Necessity Criteria.

Benefit-Specific Exclusion: Prosthetic Appliances and Orthotics exceeding 1 unit or 1 pair, as applicable, per Member, per calendar year. This exclusion does not apply to claims for wigs submitted with a primary behavioral health diagnosis.

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

- Biomechanical devices, which are any external devices operated through or in conjunction with nerve conduction or other electrical impulses
- Certain equipment and supplies that can be purchased over the counter, as determined by AZ Blue. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, breast pumps, car seats, corsets, cushions, dentures, diathermy machines, disposable hygienic items, dressing aids and devices, elastic/support/compression stockings (except TED hose), elevators, exercise equipment, foot stools, garter belts, grab bars,

health spas, hearing aid batteries, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, mineral baths, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas, and vehicle or home modifications.
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for assistance in daily living, socialization, personal comfort, convenience, or other non-medical reasons
- Replacement of external prosthetic devices due to loss or theft
- Strollers of any kind
- Supplies used by a Provider during office treatments
- Tilt or inversion tables or suspension devices

I. EDUCATION AND TRAINING

I.1 Diabetes and Asthma Education and Training

Your Cost Share: Waived.

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

Benefit-Specific Exclusion: Diabetes and asthma Education and Training provided by an out-of-network Provider.

I.2 Nutritional Counseling and Training

Your Cost Share: Waived for services provided and billed by an in-network dietician, regardless of the location where services are provided. If you have not reached the Annual Physician Visit Copay Limit, you pay a Physician visit Copay for services provided during an office, home or walk-in clinic visit with an in-network Physician that is billed by the in-network Physician. After you reach the Annual Physician Visit Copay Limit, you pay in-network deductible and Coinsurance for services provided during a visit with an in-network Physician that is billed by the in-network Physician. You pay in-network deductible and Coinsurance for services provided and billed by any other in-network Providers. You pay out-of-network deductible and Coinsurance for services provided and billed by out-of-network Providers. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Benefit-Specific Maximum: Benefits are available for a maximum of 6 nutritional counseling and training visits per Member, per calendar year.

Benefit Description: Nutritional counseling and training is available only for members diagnosed with the following conditions:
- Behavioral health
- Coronary artery disease
- Diabetes and pre-diabetes
- Eating disorders
- Heart failure
- High cholesterol
- Hypertension
- Obesity
- Renal failure/renal disease

J. EMERGENCY SERVICES

Your Cost Share: For Emergency Services, you will pay your in-network Cost Share, even for services from out-of-network Providers. If you receive services from a noncontracted Provider, the Allowed Amount will be based on the Qualifying Payment Amount, as defined by federal law.

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

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

If you are admitted for observation or as an outpatient: You pay an emergency room Access Fee. You pay in-network deductible and Coinsurance for professional, facility, and Ancillary Services related to the emergency and provided after admission for observation or as an outpatient.

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

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

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

Benefit Description: Benefits are available for services needed to treat an Emergency Medical Condition, whether the Providers of these services are in or out of network. This includes Emergency Services provided in an emergency department of a hospital or in an independent freestanding emergency department and certain post-stabilization services as required by law. Benefits are also available for Teletrauma Consultation services that meet the following criteria:

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

K. EOSINOPHILIC GASTROINTESTINAL DISORDER (EGID)

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

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

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

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

L. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Your Cost Share: You pay applicable deductible, Coinsurance, and copays. Physician visit copays count toward the Annual Physician Visit Copay Limit. The Cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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

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

M. HOME HEALTH AND HOME INFUSION – MEDICATION ADMINISTRATION THERAPY

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

If you believe you have paid more for a self-administered version of a Cancer Treatment Medication than for an injected or intravenously administered version of a Cancer Treatment Medication, please contact Pharmacy Benefit Customer Service at the number on your ID card.

Benefit-Specific Maximum: Any combination of skilled nursing services necessary to provide Home Infusion medication administration, enteral nutrition, and/or other services requiring skilled nursing care, up to a maximum of 6 hours per Member, per day. The Home Health visit limit does not apply to Home Health services provided in lieu of hospitalization, or to claims for Home Health services submitted with a primary behavioral health diagnosis.

Benefit Description: Benefits are available for the following services:

- Home Infusion Medication Administration Therapy, including:
  - Blood and blood components
  - Hydration therapy
  - Intravenous catheter care
  - Intravenous, intramuscular, or subcutaneous administration of medication
  - Specialty Medications, as defined by AZ Blue
  - Total parenteral nutrition services
- Physical Therapy, Occupational Therapy, and Speech Therapy
- Skilled nursing services necessary to provide Home Infusion Medication Administration Therapy, enteral nutrition (tube feeding), and other services that require skilled nursing care
- Other Home Health services required by federal or state law to be covered

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

- A healthcare Provider must order the services pursuant to a specific plan of home treatment;
- A licensed Home Health agency must provide the services in the member's residence;
- The healthcare Provider must review the appropriateness of the services at least once every 30 days, or more frequently if appropriate under the treatment plan; and
- The services must be provided by an LPN, RN, or another eligible Provider.

Benefit-Specific Exclusions:

- 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
- Any combination of skilled nursing services necessary to provide Home Infusion medication administration, enteral nutrition, and/or other services requiring skilled nursing care in excess of 6 hours per Member, per day, except as described in this section
- Custodial Care
- Respite Care

N. HOSPICE SERVICES

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

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

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

Benefit Description: When a Member elects to use the hospice benefit, it is in lieu of other medical benefits available under this plan, except for care unrelated to the terminal illness or related complications. The hospice agency determines the required level of care, which is subject to the medical necessity provision of the Benefit Plan. Once the Member selects the hospice benefit, the hospice agency coordinates all of the member's healthcare needs related to the terminal illness.

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

Benefits are available for the following:

- Continuous home care: 24-hour skilled care provided by an LPN or RN during a period of crisis, as determined by the hospice agency, in order to maintain the Member at home, if the Member is receiving services in his or her home
- Home Health services
- Individual and family counseling provided by a psychologist, social worker, or family counselor
- Inpatient acute care: inpatient admission for pain control or symptom management that cannot be provided in the home setting
- Outpatient Services
- Respite Care: admission of the Member to an approved facility for up to 5 days to provide rest to the member's family or primary Caregiver; Respite Care is available once every 21 days. This limit does not apply to claims for Hospice Services submitted with a primary behavioral health diagnosis.
- Routine care: intermittent visits provided by a member of the hospice team

O. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

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

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

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

P. INPATIENT HOSPITAL

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

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

Benefit Description:

- Blood transfusions, whole blood, blood components, and blood derivatives
- Diagnostic testing, including radiology, laboratory services, and biomarker testing
- Gender-affirming care
- General, spinal, and caudal anesthetic provided in connection with a covered Service

- In-network benefits are available for covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction® Center
- Intensive care units and other special care units
- Medications, biologicals, and solutions
- Operating, recovery, and treatment rooms and equipment for Covered Services
- Radiation therapy or chemotherapy, except in conjunction with a noncovered transplant
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is Medically Necessary
- Other inpatient services required by federal or state law to be covered

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

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

Your Cost Share:

First 60 days of services in a calendar year: You pay applicable deductible and Coinsurance.

Second 60 days of services in a calendar year: You pay applicable deductible and 50 percent Coinsurance (at both in-network and out-of-network Providers), regardless of whether you have met your Out-of-pocket Coinsurance Maximum, for the remainder of the calendar year. Your 50 percent Coinsurance does not count toward any Out-of-pocket Coinsurance Maximum. However, for claims submitted with a primary behavioral health diagnosis, you continue to pay applicable deductible and Coinsurance after the first 60 days of services in a calendar year. Such services count toward the Out-of-pocket Coinsurance Maximum.

If you receive EAR services at a noncontracted Provider during the 120 days of care, you also pay the Balance Bill in addition to out-of-network deductible and Coinsurance. After 120 days of care, you pay all charges for EAR services for the remainder of the calendar year.

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

Benefit-Specific Maximum: Plan coverage is limited to 120 days of EAR services per Member, per calendar year. This limit does not apply to claims for EAR services submitted with a primary behavioral health diagnosis.

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

Benefit-Specific Exclusions:
- Activity therapy and milieu therapy, including community immersion or integration, home independence, and work re-entry therapy, or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Domiciliary Care
- Medications dispensed at the time of discharge from the facility
- Respite Care

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

R. LONG-TERM ACUTE CARE (INPATIENT)

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

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

Benefit Description: Benefits are available for specialized acute, medically complex care for patients who require extended hospitalization and treatment in a facility that is licensed to provide Long-term Acute Care and which offers specialized treatment programs and aggressive clinical and therapeutic interventions. Room and board is only covered in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is Medically Necessary.

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

S. MATERNITY – COMPLICATIONS OF PREGNANCY ONLY

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

Your Cost-share obligations may be affected by the automatic addition of a newborn or adopted child, as described in the *"Plan Administration"* section of this book. If you have individual coverage, automatic addition of a child will result in a change from individual coverage to family coverage, and you may be required to pay additional Premium. If you currently have individual coverage, when a child is added to your plan, you will also be required to meet a family deductible and Out-of-pocket Coinsurance Maximum.

Benefit Description: Benefits are available only for Covered Services to treat a condition that AZ Blue has determined is a complication of pregnancy, as set forth in current Evidence-based Criteria. AZ Blue does not classify all conditions associated with or caused by the pregnancy as a complication of pregnancy. Call Customer Service at the number on your ID card for additional information on the "Complications of Pregnancy" Evidence-based Criteria.

A Member who has a complication of pregnancy, as determined by AZ Blue, may receive services for conditions that occur during her pregnancy, but are not diagnosed as a complication of pregnancy. Such services may be covered under another benefit in this plan.

Benefit-Specific Exclusions: The following services are not covered unless the services are required to treat a condition that the Evidence-based Criteria have defined as a complication of pregnancy:
- Cesarean section unless Medically Necessary to treat the AZ Blue-defined complication of pregnancy
- High-risk Maternity and delivery
- Normal Maternity and delivery, to include prolonged, preterm, or difficult labor or difficult delivery
- Services common to every pregnancy, such as prenatal office visits, labs, and ultrasounds, as well as the costs associated with the delivery

T. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Your Cost Share: Deductible is waived. You pay the lesser of applicable Coinsurance or 50 percent of the Cost of Medical Foods. Your payments for Medical Foods do not count toward any out-of-pocket coinsurance maximums.

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

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

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

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

- Administered for the medical and nutritional management of a Member who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation;
- Essential to the member's optimal growth, health, and metabolic homeostasis;
- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an MD, DO, or a registered nurse practitioner;
- Processed or formulated to be deficient in 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).

Benefit Description: Benefits are available for Medical Foods to treat inherited metabolic disorders.

Benefit-Specific Exclusions:

- Food thickeners, baby food, or other regular grocery products
- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available for purchase without a prescription or order from an MD, DO, or registered nurse practitioner
- Foods and formulas that do not require supervision by an MD, DO, or a registered nurse practitioner
- Medical food benefits are not available for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
- Nutrition for a diagnosis of anorexia
- Nutrition for nausea associated with mood disorder, end stage disease, etc.
- Spices and flavorings
- Standard oral infant formula

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

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

Medical Foods claim forms are available from AZ Blue. Submit the completed Medical Foods claim form and the dated receipt to the address for claims submission in the Customer Service section of this book. Medical Foods also may be covered under the *"Home Health and Home Infusion –*

Medication Administration Therapy" benefit. Medical Foods are not covered under *the "Pharmacy Benefit"* or the *"Specialty Medications"* benefits.

U. MEDICATIONS FOR THE TREATMENT OF CANCER

Your Cost Share: You pay applicable deductible, Coinsurance, and copays. The Cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted Provider, you also pay the Balance Bill. For cancer treatment medications that are also classified as Specialty Medications, you pay the generic retail/mail order pharmacy Copay. AZ Blue determines which cancer treatment medications are classified as Specialty Medications.

For certain cancer treatment medications, as determined by AZ Blue, you will receive a 15-day supply, and pay one-half of the generic retail/mail order pharmacy Copay the first time you receive the medication. You will be able to refill the medication every 15 days, and you will continue to pay one-half of the generic retail/mail order pharmacy Copay for each refill during your first 3 months of treatment with the medication. If you experience side effects from the medication during the 3-month period, your prescribing Provider may change your medication. If you tolerate the medication, you will be able to refill the Cancer Treatment Medication for up to 30 days after 3 months of treatment. If you believe you have paid more for a self-administered version of a Cancer Treatment Medication than for an injected or intravenously administered version of a Cancer Treatment Medication, please contact Pharmacy Benefit Customer Service at the number on your ID card.

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

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

In administering claims for an Off-label Prescription Medication, AZ Blue does not represent or warrant that the prescribed medication is safe or effective for the purpose for which your treating Provider has prescribed the medication. Decisions regarding whether the medication is safe and effective for the type of cancer for which it has been prescribed and whether it is appropriate for you, are decisions to be made by your Provider using his or her independent medical judgment. If the medication is subject to Prior Authorization, your Provider must specifically notify AZ Blue that your Provider is requesting approval for this off-label use. After receiving your provider's request, AZ Blue will review the criteria and eligibility for benefits.

V. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

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

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

W. OUTPATIENT SERVICES

Your Cost Share: Outpatient Services are often available in multiple settings and generally result in separate charges for professional and facility services. Your Cost Share will vary depending on the type of outpatient Service, the location of the Service, and the provider's network status. If you receive services from a noncontracted Provider, you also pay the Balance Bill. Deductible is waived for mammography services.

Diagnostic laboratory services

- In-network physician's office: You pay the Physician visit Copay up to the Annual Physician Visit Copay Limit (Copay is waived if you receive only covered laboratory services during your visit).

You pay in-network deductible and Coinsurance after you reach the Annual Physician Visit Copay Limit.
- In-network clinical laboratory: Your Cost Share is waived.
- In-network hospital outpatient laboratory department: You pay in-network deductible and Coinsurance.
- Out-of-network physician's office, clinical laboratory, or hospital outpatient laboratory department: You pay out-of-network deductible and Coinsurance. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Radiology services
- In-network physician's office: You pay the Physician visit Copay, up to the Annual Physician Visit Copay Limit, except covered professional services provided by a radiologist will be subject to applicable deductible and Coinsurance. You pay in-network deductible and Coinsurance for all Covered Services from in-network physicians after you reach the Annual Physician Visit Copay Limit.
- In-network hospital radiology department and freestanding radiology facility: You pay in-network deductible and Coinsurance.
- Out-of-network physician's office, freestanding radiology facility, or hospital radiology department: You pay out-of-network deductible and Coinsurance. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Professional services provided by a radiologist or pathologist, including a dermapathologist, are always subject to applicable deductible and Coinsurance, even when the services are provided in a physician's office. You also pay applicable deductible and Coinsurance for medications administered in an outpatient facility.

Benefit Description: Benefits are available for the following Outpatient Services and include, but are not limited to, any services that would be covered if performed as an inpatient Service:
- Blood transfusions, whole blood, blood components, and blood derivatives
- Diagnostic radiology services, including:
  - CAT/CT imagery
  - Mammograms and other modalities for breast cancer screening and diagnosis, as recommended by the National Comprehensive Cancer Network
  - Outpatient and ambulatory magnetic resonance imaging (MRI/MRA), PET scans, ECT, brain electrical activity mapping (BEAM)
  - X-rays
- Diagnostic testing, including but not limited to, laboratory services and biomarker testing
- Dialysis
- Gender-affirming care
- In-network benefits are available for covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction Center
- Medications and the administration of medications in an outpatient setting
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant
- Surgery and other invasive procedures

X. PHARMACY BENEFIT

Information about this benefit: AZ Blue works with a Pharmacy and Therapeutics (P&T) Committee to review new medications and certain devices and supplies, as well as new information about medications, devices, and supplies that are already on the market. The P&T Committee is comprised of licensed pharmacists and doctors from within the community. The P&T Committee takes into consideration safety, effectiveness, and current use in therapy information when making decisions regarding medication coverage. Call the Pharmacy Benefit Customer Service number on your ID card to request any of the following:
- A list of covered medications that require Prior Authorization;
- A list of covered vaccines;
- A list of Specialty Medications;
- An exception to AZ Blue prescription medication limitations;
- Information on the assigned Cost-share tier of a covered medication;
- Information regarding Maintenance Medications; or
- Other information about this Pharmacy Benefit.

Your Cost Share:

In-network retail or mail order pharmacy: You pay the lesser of the AZ Blue price (the price for which AZ Blue has contracted with the pharmacy) or the applicable brand or generic medication Copay. You pay the greater of the brand Copay or 50 percent Coinsurance for covered Compounded Medications. Some pharmacies may charge you a lower price if the pharmacy's regular price for the medication is less than your Copay. If your prescription exceeds AZ Blue quantity limits, your total Cost Share may be higher than the amount of your Copay.

Noncontracted retail pharmacy: You must pay for prescriptions in full and submit a claim to AZ Blue. If you received a generic medication, you will be reimbursed for the amount exceeding the generic medication Copay, up to the Allowed Amount for the prescription. If you received a brand medication, you will be reimbursed for the amount exceeding the brand medication Copay, up to the Allowed Amount for the prescription. You must pay the Balance Bill.

You may obtain up to a 90-day supply of covered medications from the in-network mail order pharmacy. Not all medications are available for more than a 30- or 60-day supply. Coinsurance payments for prescription medications do not apply toward any Out-of-pocket Coinsurance Maximum.

If you are taking two or more prescription medications for a chronic condition, you may request early or short refills of eligible covered medications by contacting Pharmacy Benefit Customer Service at the number on your ID card and requesting enrollment in the AZ Blue Medication Synchronization program. If you are enrolled in the AZ Blue Medication Synchronization program, your Cost Share for eligible covered medications will be adjusted for any early or short refills of those medications.

If you believe you have paid more for a self-administered version of a Cancer Treatment Medication than for an injected or intravenously administered version of a Cancer Treatment Medication, please contact Pharmacy Benefit Customer Service at the number on your ID card.

Additional information about brand vs. generic medication tiers

Copays are based on whether the medication is brand or generic at the time the prescription is filled. Information on whether medications are brand or generic is available at www.azblue.com or by calling Pharmacy Benefit Customer Service at the number on your ID card.

If you purchase a brand-name medication when a generic equivalent is available, you will be responsible for the generic medication Cost Share plus the difference between the Allowed Amount for the generic and the brand-name medication, even if the prescribing Provider indicates on the prescription that the brand-name medication should be dispensed. If you have completed Step Therapy and are taking a brand-name medication with a generic equivalent as a result of the Step Therapy process, you pay the Cost Share applicable to the brand-name medication.

Except as set forth in this section, no exceptions will be made concerning the Copay or Coinsurance that will apply, regardless of the medical reasons requiring use of a particular medication. This means if you are taking a brand or compounded medication, you pay the applicable Cost Share for brand or Compounded Medications even when there is no equivalent generic medication or if you are unable to take a generic medication for any reason. The assignment of a Copay amount is not a recommendation for the use of a medication.

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

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

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

"Maintenance Medications" are medications taken on an extended and continual basis for treatment of a chronic or ongoing health condition, and which are not subject to frequent dosage or

other adjustments, all as determined by AZ Blue or the PBM. AZ Blue and/or the PBM may designate or use national databases to designate certain medications as Maintenance Medications.

"PBM" means the independent Pharmacy Benefit Manager that contracts with AZ Blue to administer the prescription medication benefits covered under this Benefit Plan.

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

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

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

You may obtain most prescription medications from retail pharmacies or the in-network mail order pharmacy. Compounded Medications must be obtained from pharmacies that have been credentialed by AZ Blue (or AZ Blue's vendor) to dispense Compounded Medications. Please call Pharmacy Benefit Customer Service at the number on your ID card for a list of pharmacies credentialed to dispense Compounded Medications.

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

- Blood glucose monitors, including monitors 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 for controlling blood sugar that are included on the plan
- Spacer devices for asthma medications

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

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

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

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

Certain members, as determined by AZ Blue or the PBM, will be required to participate in the Designated Prescription Network Program to obtain coverage of certain medications under this

Benefit Plan. AZ Blue or the PBM decide which network pharmacies or Providers are eligible to dispense designated medications to members in the Designated Prescription Network Program.

Benefit-Specific Exclusions:

- Abortifacient medications
- Administration of a covered medication
- All over-the-counter contraceptive methods and devices
- Biologic serums
- Compounded Medications obtained from a mail order pharmacy
- Designated medications prescribed by an ineligible Provider or dispensed by an unapproved pharmacy or Provider to members enrolled in the Designated Prescription Network Program
- Medication delivery implants
- Medications designated as clinic packs
- Medications designed for weight gain or loss, regardless of the condition for which it is prescribed
- Medications, devices, equipment, and supplies lawfully obtainable without a prescription
- Medications dispensed to a Member who is an inpatient in any facility
- Medications for athletic performance
- Medications for lifestyle enhancement
- Medications for sexual dysfunction
- Medications for which the principal ingredient(s) are already available in greater and lesser strengths and/or combinations, as described in the AZ Blue Medication Benefit exclusion policy, in addition to all other exclusions in this Benefit Book. See the "Other Forms and Resources" section within the pharmacy information on www.azblue.com for a list of these specific exclusion details.
- Medications labeled "Caution – Limited by Federal Law to Investigational Use" or words to that effect and any experimental medications as determined by AZ Blue
- Medications obtained from an out-of-network mail order pharmacy
- Medications packaged with one other or multiple other prescription products
- Medications packaged with over-the-counter medications, supplies, vitamins, or other excluded products
- Medications to improve or achieve fertility or treat infertility
- Medications used for any Cosmetic purpose
- Medications used to treat a condition not covered under this plan
- Medications which modify the dosage form (tablet, capsule, liquid, suspension, extended release, tamper resistant) of drugs already available in a common dosage form, as described in the AZ Blue Medication Benefit exclusion policy, in addition to all other exclusions in this Benefit Book. See the "Other Forms and Resources" section within the pharmacy information on www.azblue.com for a list of these specific exclusion details.
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging, or name
- Prescription medications dispensed in unit-dose packaging, unless that is the only form in which the medication is available
- Prescription refills for medications that are lost, stolen, spilled, spoiled, or damaged
- Smoking cessation medications and devices of any kind
- Specialty Medications, as defined by AZ Blue

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

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

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

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

"Speech Therapy" is treatment of communication impairment and swallowing disorders.

Benefit Description: Benefits are available for PT, OT, and ST services related to a specific illness or injury.

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

Z. PHYSICIAN SERVICES

Your Cost Share:

In-network: You pay 1 Copay per Member, per Provider, per day for office, home, and walk-in clinic visits, up to the Annual Physician Visit Copay Limit. See your SBC for the amount of your Copay(s) and the Physician visit Copay limit. You pay in-network deductible and Coinsurance for Covered Services provided during an office, home, or walk-in clinic visit after you reach the Annual Physician Visit Copay Limit. If you have not reached your Annual Physician Visit Copay Limit, your Copay does not apply if you receive only the following services and no other covered Service during your visit:
- Covered allergy injections
- Covered immunizations
- Covered laboratory services
- Covered PT, OT, ST; these services are subject to in-network deductible and Coinsurance

However, if you have reached the Physician visit Copay limit, and receive only these services, your visit will be subject to deductible and Coinsurance. AZ Blue will apply claims toward the Annual Physician Visit Copay Limit in the order that claims are processed, which may be different from the date order in which you received services.

You pay in-network deductible and Coinsurance for services provided in any location other than an office, home, or walk-in clinic, including but not limited to inpatient and outpatient facilities and emergency rooms.

Out-of-network: You pay out-of-network deductible and Coinsurance for services rendered by an out-of-network Physician, regardless of the location of Service. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Professional services provided by a radiologist or pathologist, including a dermapathologist, are always subject to applicable deductible and Coinsurance, regardless of where the radiologist or pathologist performs the services. You also pay applicable deductible and Coinsurance for medications administered in an outpatient facility.

Benefit Description: Benefits are available for the following:
- Abortifacient medications, including oral medications as described in current Evidence-based Criteria
- FDA-approved diaphragms, cervical caps, and cervical shields
- FDA-approved emergency contraception
- FDA-approved implanted contraceptive devices
- FDA-approved patches, rings, and contraceptive injections
- Gender-affirming care
- Inpatient medical visits
- Medications and the administration of medications in an outpatient setting
- Office, home, or walk-in clinic visits (Urgent Care facilities are not walk-in clinics) for the diagnosis and treatment of a sickness or injury
- Professional Physician Services for FDA-approved sterilization procedures

- Professional Physician Services for fitting, implantation, and/or removal of FDA-approved contraceptive devices
- Second diagnostic surgical opinions
- Surgical procedures (including assistance at surgery). Only certain surgical assistants are Eligible Providers. Call Customer Service at the number on your ID card to verify that the surgical assistant chosen by your Physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your Physician are in-network Providers
- Other services required by federal or state law to be covered.

The following circumstances may impact Member Cost Share for Physician Services:
- If multiple surgical procedures are performed during a single operative session, the secondary procedures are usually reimbursed at reduced amounts. Noncontracted Providers may bill you for the full amount.
- Most diagnosis, management, and treatment of behavioral health conditions that are eligible for benefits, including medication management, are covered under your behavioral health benefit. Depending on how your Provider submits a claim and the scope of services provided, certain office visits may be covered under this benefit.
- You may receive services in a physician's office that incorporate services or supplies from a Provider other than your Physician. If the other Provider submits a separate claim for those services or supplies, you will pay the Cost Share for the other Provider, plus the Cost Share for your office visit. Examples of services or supplies from another Provider include DME from a medical supply company, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices.

AA. POST-MASTECTOMY SERVICES

Your Cost Share: You pay applicable deductible, Coinsurance, and copays. Physician visit copays count toward the Annual Physician Visit Copay Limit. The Cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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

Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage, as described above under "Benefit Description," will be provided in a manner determined in consultation between the attending Physician and the Member being treated. These benefits are provided subject to the same deductibles and Coinsurance generally applicable to other medical and surgical benefits provided under this plan, as described above in "Your Cost Share" and in the SBC for this Benefit Plan. If you would like more information on WHCRA benefits, call Customer Service at the number on your ID card.

BB. PREGNANCY, TERMINATION

Your Cost Share: You pay applicable deductible, Coinsurance, and copays. Physician visit copays count toward the Annual Physician Visit Copay Limit. The Cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Benefit Description: Benefits are available for abortions that meet the following requirements:
- The fetus is or will be nonviable, as defined by current Evidence-based Criteria; or
- The treating Provider certifies in writing the abortion is Medically Necessary because the pregnancy would endanger the life or health of the mother.

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

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

CC. PREVENTIVE SERVICES

Your Cost Share: All Preventive Services, except for mammography, must be received from in-network Providers or the services will not be covered.

All Preventive Services, except mammography: Deductible is waived. You pay applicable Coinsurance and copays, depending on where services are received and whether you have met the Annual Physician Visit Copay Limit. Physician visit copays count toward the Annual Physician Visit Copay Limit.

Mammography: Deductible is waived. You pay applicable Coinsurance and copays. The Cost-share amount will depend on the provider's network status, the place you receive services, and whether you have met the Annual Physician Visit Copay Limit. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

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

Benefit-Specific Maximum: Preventive Services are limited to a maximum benefit of $1,000 per Member, per calendar year.

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

Benefit Description: Benefits are available for the following services, as appropriate for the member's age and gender and as recommended by your Provider. If a preventive Service has been denied due to your gender on file with AZ Blue, and you are undergoing or have undergone gender transition, please contact Customer Service at the number on your ID card for assistance. AZ Blue 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 AZ Blue.

- Bone density testing for osteoporosis
- Mammogram
- Preventive physical examination, (i.e., routine physical examination), including the following services when done for screening purposes only:
  - Lung function test (spirometry)
  - Vision and hearing screening (this may include newborn audiological evaluation in the hospital)
  - Fecal occult blood test
  - General health laboratory panel (bilirubin, calcium, carbon dioxide, chloride, creatinine, alkaline phosphatase, potassium, total protein, sodium, ALT, SGPT, AST, SGOT, BUN, TSH)
  - Thyroid function testing (TSH)
  - Complete blood count (CBC)
  - Lipid panel (cholesterol panel and triglycerides)
  - Fasting glucose (blood sugar)
  - Urinalysis
  - Blood lead
  - Sexually transmitted disease (STD) testing
  - Prostate specific antigen (PSA)
  - TB testing
- Routine gynecologic exam, including Pap test and other cervical cancer screening test
- Routine immunizations and immunizations for foreign travel, as determined by AZ Blue
- Screening for abdominal aortic aneurysm for members ages 65 to 75 who have ever smoked
- Screening sigmoidoscopy and colonoscopy, including related anesthesia services and prescription prep kits

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

Benefit-Specific Exclusions:
- Abortifacient medications
- All over-the-counter contraceptive methods and devices
- Any Service or test not specifically listed in this benefit description, such as chest X-rays, will not be covered when performed for preventive or screening purposes
- Services from an out-of-network Provider (except for mammography services)

DD. RECONSTRUCTIVE SURGERY AND SERVICES

Your Cost Share: You pay applicable deductible, Coinsurance, and copays. Physician visit copays count toward the Annual Physician Visit Copay Limit. The Cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted Provider, you also pay the Balance Bill.

Benefit Description: Benefits are available for Reconstructive Surgery, which is surgery performed to improve or restore the impaired function of a body part or organ resulting from one of the following:
- Congenital defects
- Illness and disease
- Injury and Trauma
- Surgery
- Therapeutic intervention
- Other services required by federal or state law to be covered

Benefit-Specific Exclusion: Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations, and other services for Cosmetic purposes. This exclusion does not apply to breast reconstruction following a Medically Necessary mastectomy, Medically Necessary breast implant removal, or surgery to correct a congenital defect. This exclusion does not apply to services required by federal or state law to be covered.

EE. SKILLED NURSING FACILITY (SNF)

Your Cost Share:

First 90 days of services in a calendar year: You pay applicable deductible and Coinsurance.

Second 90 days of services in a calendar year: You pay applicable deductible and 50 percent Coinsurance (at both in-network and out-of-network Providers), regardless of whether you have met your Out-of-pocket Coinsurance Maximum, for the remainder of the calendar year. Your 50 percent Coinsurance does not count toward any Out-of-pocket Coinsurance Maximum. However, for claims submitted with a primary behavioral health diagnosis, you continue to pay applicable deductible and Coinsurance after the first 90 days of services in a calendar year. Such services count toward the Out-of-pocket Coinsurance Maximum.

If you receive SNF services at a noncontracted Provider during the 180 days of care, you also pay the Balance Bill, in addition to out-of-network deductible and Coinsurance. After 180 days of care, you pay all charges for SNF services for the remainder of the calendar year.

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

Benefit-Specific Maximum: Plan coverage is limited to 180 days of SNF services per Member, per calendar year. This limit does not apply to claims for SNF services submitted with a primary behavioral health diagnosis.

Benefit Description: Benefits are available for inpatient SNF services provided in a facility licensed to offer 24-hour skilled nursing services and that meet the following criteria:

- A Physician or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- Room and board in a semi-private room or a standard private room (not deluxe) is covered if the hospital only has private rooms or if a private room is Medically Necessary;
- Services must be provided to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time;
- Skilled nursing services must be provided by and under the supervision of qualified and licensed professionals, such as an LPN or RN, and provided at a level of complexity and sophistication requiring assessment, observation, monitoring and/or teaching or training to achieve the medically desired outcome;
- The facility has 24/7 onsite RN coverage;
- The facility has sufficient professional staff to provide appropriate treatment;
- The facility's designated medical director is a Physician or registered nurse practitioner and provides direction for services provided at the facility; and
- The services meet the AZ Blue Medical Necessity Criteria for inpatient level of care.

Benefit-Specific Exclusions:
- Activity therapy and milieu therapy, including community immersion or integration, home independence, and work re-entry therapy, or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Domiciliary Care
- Medications dispensed at the time of discharge from the facility
- Respite Care
- Services rendered after a Member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by AZ Blue

FF. SPECIALTY MEDICATIONS

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

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

If you are taking two or more prescription medications for a chronic condition, you may request early or short refills of eligible covered medications by contacting Pharmacy Benefit Customer Service at the number on your ID card and requesting enrollment in the AZ Blue Medication Synchronization program. If you are enrolled in the AZ Blue Medication Synchronization program, your Cost Share for eligible covered medications will be adjusted for any early or short refills of those medications.

Additional information about medication tiers

Copays are based on the tier to which AZ Blue has assigned the medication at the time the prescription is filled. AZ Blue may change the tier of a medication at any time without notice. Go to www.azblue.com to view a list of contracted specialty pharmacies and the specialty medication list. To confirm the status and tier of a particular specialty medication, you may also call Pharmacy Benefit Customer Service at the number on your ID card.

No exceptions will be made concerning the assigned tier of a medication or the Copay that will apply, regardless of the medical reasons requiring use of the medication. This means if you are taking a tier B, C, or D medication, you pay the applicable Copay for that tier even if there is no equivalent medication on a lower tier or you are unable to take a medication on the lower tier for any reason. The assignment of a medication to any particular tier is not a recommendation for the use of a medication.

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

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

Benefit Description: Benefits are available for Specialty Medications obtained from a Specialty Pharmacy contracted with AZ Blue. Coverage of Specialty Medications and limitations on these medications are determined by current Evidence-based Criteria and Pharmacy Coverage Guidelines and may change at any time without prior notice.

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

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

GG. TELEHEALTH SERVICES – BLUECARE ANYWHERE

Your Cost Share:

In-network: You pay a telehealth medical Copay. Your Cost Share is waived for telehealth counseling and telehealth psychiatry.

Out-of-network: Not covered.

Benefit Description: Remote medical and behavioral health consultations between a Provider and a patient are offered by the TSA through BlueCare Anywhere, including:
- Counseling with a psychologist or other licensed therapist
- Medical consultations with a Physician, physician's assistant, or nurse practitioner
- Psychiatry consultations with a psychiatrist

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

Benefit-Specific Exclusions:
- Emergency Services
- Preventive Services
- Services covered under the *"Telehealth Services – In-Network Providers"* benefit
- Services not provided through the TSA

HH. TELEHEALTH SERVICES – IN-NETWORK PROVIDERS

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

Benefit Description: Benefits are available for Telehealth Services delivered by an in-network Provider through interactive electronic media. Benefits are also available for emergency or urgent Telehealth Services from out-of-network Providers.

Benefit-Specific Exclusions:
- Non-emergency and non-urgent Telehealth Services from an out-of-network Provider
- Services delivered through the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages, or electronic mail, unless otherwise required by law
- Services provided through the *"Telehealth Services – BlueCare Anywhere"* benefit

II. TRANSPLANT OR GENE THERAPY TRAVEL AND LODGING

Your Cost Share: Not applicable.

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

Benefit-Specific Maximum: Maximum of $10,000 per Member, per transplant or gene therapy treatment. Covered expenses incurred by a donor or Caregiver accumulate toward the member's $10,000 maximum.

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

- AZ Blue has given Prior Authorization for the Service or, if AZ Blue did not give Prior Authorization for the Service, upon review we determine the Service meets the requirements of this Benefit Plan;
- For transplant coverage, the Member or donor must be receiving Medically Necessary pre- and post-operative treatments, including without limitation, treatment of complications related to the covered transplant or routine follow-up care for a covered transplant or a transplant that occurred while the Member was covered by another insurance plan;
- The distance from the member's, donor's, or caregiver's residence must be more than 60 miles from the facility;
- The expenses are for any of the following:
  - Meals;
  - Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; bus, train, or air fare;
  - Room charges from hotels, motels, and hostels, or apartment rental; and
  - Other expenses required by federal or state law to be covered; and
- The expenses are incurred by the Member, donor, or Caregiver.

Benefit-Specific Exclusions:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning, or valet services; telephone or Internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of the benefit-specific maximum
- Ambulance transportation (ground or air)
- Caregiver salary, stipend, and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with services that do not qualify for coverage under this Benefit Plan
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Travel and lodging expenses for members, donors, or caregivers when the Member, donor, or Caregiver does not travel more than 60 miles for authorized transplant- or gene therapy-related services
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement: To request reimbursement of eligible travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to AZ Blue. The address for claims submission is listed in the Customer Service section at the front of this book. To request a claim form, call the Customer Service number on your ID card.

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

Your Cost Share: You pay applicable deductible, Coinsurance, and copays. The Cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted Provider, you also pay the Balance Bill. If both a donor and a transplant recipient are covered by an AZ Blue plan or a plan administered by AZ Blue, the transplant recipient pays the Cost Share related to the transplant.

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

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

Benefit Description: The following Transplants are eligible for coverage if they meet current Evidence-based Criteria:

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

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

- Air and ground transportation of a medical team to and from the site in the contiguous states of the United States to obtain tissue that is subsequently transplanted into a Member
- Bone marrow search and procurement of a suitable bone marrow donor when a Member is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
- Chemotherapy or radiation therapy associated with transplant procedures
- Harvest and reinfusion of stem cells or bone marrow
- Inpatient and outpatient facility and professional services
- Medical expenses incurred by a donor when the recipient is covered by AZ Blue. Covered donor expenses include complications and Medically Necessary follow-up care related to the donation for up to 6 months' post-transplant, as long as the recipient's AZ Blue coverage remains in effect.
- Pre-transplant testing and services
- Procurement of an organ from a cadaver or live donor, including surgery to remove the organ; transportation, hospitalization, and surgery of a live donor

Benefit-Specific Exclusions:

- Expenses related to a noncovered transplant
- Expenses related to donation of an organ to a recipient who is not covered by AZ Blue
- Transplants that do not meet current Evidence-based Criteria

KK. URGENT CARE

Your Cost Share: You pay 1 Urgent Care Copay per Member, per Provider, per day for services from a Provider who is contracted with AZ Blue to render Urgent Care services. You pay applicable Cost Share if you receive Urgent Care services from an in-network Provider who is not specifically contracted for Urgent Care services. You pay out-of-network deductible and Coinsurance if you receive services from an out-of-network Urgent Care Provider. If you receive services from a noncontracted Provider, you also pay the Balance Bill. Urgent Care copays do not count toward the Annual Physician Visit Copay Limit.

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

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

Please be aware that the AZ Blue network includes some Providers, such as hospitals, that offer Urgent Care services, but are not specifically contracted with AZ Blue as Urgent Care Providers. No matter what the circumstances, if you obtain Urgent Care services at a hospital or a hospital's on-site Urgent Care department, you will be responsible for the applicable emergency room Access Fee, deductible, and Coinsurance.

LL. VISION EXAMS (ROUTINE)

Your Cost Share: You pay a Routine Vision Exam Copay for an exam by an in-network vision care Provider. If you receive the exam from an out-of-network vision care Provider, you will pay the provider's Billed Charges. AZ Blue will reimburse you up to the amount listed on your SBC for an out-of-network Routine Vision Exam. Routine Vision Exam copays do not count toward the Annual Physician Visit Copay Limit. If a medical condition is identified during your Routine Vision Exam, you will be responsible for the applicable Cost Share, as described in the *"Physician Services"* section of this book.

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

Benefit Description: Benefits are available for 1 Routine Vision Exam per Member, per calendar year. Routine Vision Exam services do not have to meet the medical necessity requirement.

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

WHAT IS NOT COVERED

Waivered Conditions

If you signed a waiver that excludes coverage of a particular condition, there is no coverage for that condition or any related complications, as described on the waiver form. You may request in writing to have the waiver removed at any time, however, you must provide Medical Records and documentation to support your request. AZ Blue will decide whether to remove the waiver.

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

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

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

Acupuncture

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

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

Biofeedback

Body Art, Piercing, and Tattooing – Services related to body piercing, Cosmetic implants, body art, tattooing, and any related complications, except for services included in the *"Post-Mastectomy Services"* and the *"Reconstructive Surgery and Services"* sections of this book

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

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

Cosmetic Services and any Related Complications – Surgery and any related complications, procedures, treatment, office visits, consultations, and other services for Cosmetic purposes. This exclusion does not apply to breast reconstruction following a Medically Necessary mastectomy, Medically Necessary breast implant removal, or surgery to correct a congenital defect.

Cosmetics and Health and Beauty Aids

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

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

Custodial Care

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

Dietary and Nutritional Supplements – All dietary, caloric, and nutritional supplements, such as specialized formulas for infants, children, or adults or other special foods or diets, even if prescribed, except as stated in the *"Eosinophilic Gastrointestinal Disorder (EGID)"* and the *"Medical Foods for Inherited Metabolic Disorders"* sections of this book

Domiciliary Care

Expenses for services that exceed benefit limitations

Experimental or Investigational Services or Items

Fees – a) for concierge medicine services; b) other than for Medically Necessary, in-person, direct Member services; or c) for direct primary care

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

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

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

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

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

Growth Hormone to treat Idiopathic Short Stature (ISS)

Habilitation Services, except for certain limited services to treat autism spectrum disorder

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

Hypnotherapy

Inpatient or Outpatient Non-acute Long-term Care

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

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

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

Manipulation of the Spine Under Anesthesia

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

Massage Therapy, except in limited circumstances as described in current Evidence-based Criteria

Maternity – All Maternity services, except as stated in the *"Maternity – Complications of Pregnancy Only"* section of this book

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

Medications that are:
- Not FDA approved
- Not required by the FDA to be obtained with a prescription
- Not used in accordance with current Evidence-based Criteria or Pharmacy Coverage Guidelines
- Off-label, unlabeled, and orphan medications, except as stated in the *"Pharmacy Benefit"* section of this book
- Used to treat a condition not covered by AZ Blue

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

Neurofeedback

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

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

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

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

Private Duty Nursing

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

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

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

Sensory Integration and Music Therapy

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

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

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

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

Services for the Administration of Drugs that can be Self-administered, except when medically necessary

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

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

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

Services Prior to Member's Coverage Effective Date

Services Provided after the Member's Coverage Termination Date, except as stated in the *"Termination"* section of this book

Services Related to or Associated with Noncovered Services

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

Sexual Dysfunction – Services for sexual dysfunction, regardless of the cause, and all medications for the treatment of sexual dysfunction

Smoking Cessation programs, medications, aids, and devices

Spinal Decompression or Vertebral Axial Decompression Therapy

Strength Training – Services primarily designed to improve or increase fitness, strength, or athletic performance, including strength training, cardiovascular endurance training, fitness programs, and strengthening programs

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

Therapy Services, except as stated in this plan

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

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

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

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

Vocational Therapy – Services related to employability

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

Workers' Compensation – Services to treat illnesses and injuries that are (1) covered by workers' compensation; and (2) expressly identified as workers' compensation claims when submitted to AZ Blue. This exclusion does not apply if the Member has made a statutory opt-out election and/or is exempt from workers' compensation coverage.

CLAIMS INFORMATION

Filing Claims

In 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. Make sure you or your Providers file all your claims so AZ Blue can track your covered expenses and properly apply them toward applicable deductibles, Coinsurance, out-of-pocket coinsurance maximums, and Benefit Maximums.

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

Time Limit for Claim Filing

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

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

Complete Claims

AZ Blue claim forms are available at www.azblue.com/individualsandfamilies/resources/forms, or call the Customer Service number on your ID card to have one mailed to you. AZ Blue may reject claims that are filed without complete information needed for processing. If AZ Blue rejects a submitted claim due to lack of information, AZ Blue will notify you or the Provider who submitted the claim. Lack of complete information may also delay processing. A complete claim includes, at a minimum, the following information:

- Billed Charges
- Date of Service(s)
- Diagnosis code
- Group number
- Member ID number
- Member name
- Name of Provider
- Patient birth date
- Patient name
- Place of Service
- Procedure code
- Provider ID number

Medical Records and Other Information Needed to Process a Claim

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

Explanation of Benefits (EOB) Form and Member Health Statement

After your claim is processed, AZ Blue and/or any contracted vendors that process claims will send you an EOB. Most EOBs are consolidated and sent to you in the form of a Member Health Statement rather than as single EOBs. Your AZ Blue EOBs also will be available through the Member portal on www.azblue.com. An EOB shows services billed, whether the services are covered or not covered, the Allowed Amount, and the application of cost-sharing amounts. Carefully review your EOB for any discrepancies or inconsistencies with the amounts your Provider actually collects from you or bills to you. If you paid more Cost Share than required

for a covered Service, the Provider will be responsible for refunding you. AZ Blue and/or any contracted vendors will also send your in-network Provider the information that appears on your EOB. Save the EOB for your personal records. AZ Blue or any contracted vendor may charge a fee for duplication of claims records.

Notice of Determination

If your request for Prior Authorization is denied, or your claim is denied in whole or in part, you will receive a notice of adverse benefit determination. In most cases, your EOB or Member Health Statement will serve as the notice and will:

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

Pharmacy Prescriptions; Submission of Claims by Members

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

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

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

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

- A covered medication without a generic equivalent, or
- A covered medication with a generic equivalent and Member has obtained access to the covered medication drug through:
  - Prior Authorization
  - Step Therapy
  - AZ Blue appeal process

Time Period for Claim Decisions

Post-Service Claims: Within 30 days of receiving your claim for a Service that was already rendered, AZ Blue will send you an EOB adjudicating the claim, or a notice that AZ Blue has requested records needed to make a decision on your claim.

Except for claims covered by the No Surprises Act, if AZ Blue does not receive the requested records within 20 days, AZ Blue will deny the claim for lack of information needed to apply benefits. If you or the Provider later supply the requested records, AZ Blue will reopen the claim. Generally, you or your Provider need to send us the records and request reopening of the claim within 1 year from the date of the denial decision. You have 2 years from the date of denial decision to appeal.

Pre-Service Claims: When you request coverage for a Service that has not yet been rendered (Prior Authorization), AZ Blue will make a Prior Authorization decision within a reasonable time period considering the medical circumstances, but not later than 10 business days from receipt of the Prior Authorization request.

If AZ Blue requires Medical Records to make a Prior Authorization decision, AZ Blue will promptly advise your Provider of the needed records, but may not extend the 10-day time period for the decision. If AZ Blue denies the request for lack of needed records, your Provider may resubmit the request and records at a later date. AZ Blue will treat it as a new request for Prior Authorization. You may also appeal any denial.

Concurrent Care Decisions

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

Urgent Requests for Prior Authorization

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

- One in which application of the “non-urgent” time periods could seriously jeopardize the member’s life, health, or ability to regain maximum function, or
- One which, in the opinion of a Physician with knowledge of the member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

PLAN ADMINISTRATION

Changes to Your Information

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

While you are covered with AZ Blue, tell us right away about any changes in the following:

- A disabled dependent age 30 or older who is no longer disabled
- Eligibility of you or your Dependents for Arizona Health Care Cost Containment System (AHCCCS) coverage during the term of this Contract or other Medicaid coverage during the term of this contract
- Eligibility of you or your Dependents for Basic Health Plan (BHP) coverage during the term of this contract
- Eligibility of you or your Dependents for individual coverage purchased through a federal or state Exchange
- Eligibility of you or your Dependents for Medicare during the term of this Contract
- Eligibility of you or your Dependents for the Children's Health Insurance Program (CHIP) coverage during the term of this contract
- Individuals being added to the Benefit Plan: spouse, newborns, adopted children, children placed for adoption, stepchildren
- Individuals removed from the Benefit Plan due to divorce or death
- Other medical coverage that you or your Dependents add or lose, including any changes in benefits
- Your mailing address or phone number

Changing Your AZ Blue Plan

To determine your options for Changing Your AZ Blue Plan without losing grandfathered status, check the AZ Blue Portal Account on www.azblue.com/member or contact Customer Service at the number on your ID card. If you change to a plan not included in the grandfathered options, or cancel your AZ Blue plan, you will no longer be in a plan with "grandfathered status," and you will not be able to reinstate the grandfathered plan. For more information, see *"Grandfathered Status of Plan"* under *"Understanding the Basics."*

Child-Only Coverage

The parent or other legal guardian has contracted on behalf of the child for the benefits described in this plan. The parent or guardian is responsible for the child's compliance with all terms and conditions outlined in this plan. This includes Premium Payments, Prior Authorization, cost sharing, consent requirements necessary to provide plan benefits, and any other requirements of this plan.

New child-only policies will be issued only in the following circumstances:

- A Contract Holder terminates his or her coverage under this Benefit Plan and the contract holder's child or children were covered as Dependents under the contract holder's policy; or
- The parent or legal guardian of a child or children who are covered under a Child-Only policy requests coverage for an additional child or children. The child or children must pass AZ Blue's medical underwriting guidelines applicable to this Benefit Plan at the time of application to add the additional child or children.

Dependents

Eligible Dependents

The persons listed below are Dependents who can be covered under this Benefit Plan:

- The contract holder's spouse under a legally-valid, existing marriage.
- The contract holder's children or the children of the contract holder's spouse, if under age 30, including:
  - Children placed for adoption
  - Children under legal guardianship substantiated by a court order and living with the Contract Holder
  - Children who are entitled to coverage under a medical support order
  - Disabled dependent children meeting the criteria set forth in this Benefit Book
  - Legally-adopted children
  - Natural children
  - Stepchildren

In most cases, the individual will need to satisfy medical underwriting before being added. Children of your Dependents cannot be added as a dependent on your plan unless you are the legal guardian of your dependent's child.

Disabled Dependent Child

A child who has reached age 30 may continue coverage as a dependent under this plan if the child is otherwise eligible for the plan and meets all of the following criteria:

- Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;
- Is totally disabled due to a continuous physical or intellectual disability or condition, as defined in current Evidence-based Criteria, on the date the dependent reaches age 30; and
- Is dependent on the Contract Holder for maintenance and support, as determined by AZ Blue criteria.

Medical reports, acceptable to AZ Blue, must substantiate the incapacity and must be submitted by the Contract Holder within 31 days of the date such dependent child reaches age 30. 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 AZ Blue.

AZ Blue determines total disability in its sole and absolute discretion and will provide a copy of the Evidence-based Criteria used to make this decision upon request. A Contract Holder has an affirmative obligation to inform AZ Blue 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.

Adding Dependents

Spouse – To add a spouse to your coverage, call AZ Blue and request an application. The spouse must complete the application and pass AZ Blue's medical underwriting guidelines.

Children – A child is automatically eligible for coverage for the first 31 days beginning on the date of birth, adoption, or placement for adoption ("qualifying date"), if the parent or guardian covered under this plan remains eligible for coverage during that period and the child is otherwise an eligible dependent under this plan. The Contract Holder must notify AZ Blue in writing of the birth, adoption, or placement for adoption so that AZ Blue can add the child to the policy. If the Contract Holder does not notify AZ Blue in writing, AZ Blue will be unaware of the birth, adoption, or placement for adoption and will be unable to add the child to the policy.

If AZ Blue receives written notice within 45 days after the birth, adoption, or placement for adoption, AZ Blue will automatically add the child to the policy for the 31-day period. AZ Blue will continue coverage for the child after the 31-day period, and you will be responsible for any additional Premium, unless you notify AZ Blue in writing to remove the child from the plan. The additional Premium is prorated from the qualifying date. Even if no additional Premium is required (for example, you already have family coverage), you must notify AZ Blue in writing if you wish to remove the child from the plan.

If AZ Blue does not receive written notice within 45 days after the birth, adoption, or placement for adoption, the child will still be eligible for coverage for the first 31 days following birth, adoption, or placement for adoption. However, the child will have to complete an application and the underwriting process applicable to this product. The child will have a gap in coverage between the end of the initial 31-day period and completion of the underwriting process and issuance of an effective date in accordance with that underwriting process. You will be responsible for any additional applicable Premium.

To add an eligible dependent child who is not a newborn child, an adopted child, or a child placed for adoption (as described above), call AZ Blue and request an application. The Contract Holder must complete the application, and the child must qualify for coverage under AZ Blue's medical underwriting guidelines.

Effective Date of Coverage

Effective date for Contract Holder and Dependents:

- AZ Blue must approve you for coverage before your coverage will take effect. Your coverage will take effect on the earliest available effective date, as determined by AZ Blue.
- Eligible Dependents will have the same effective date as the Contract Holder when the dependent is included on the contract holder's application and approved for coverage at the time the plan is issued to the Contract Holder.

- If a dependent is accepted for coverage and added to the plan after the contract holder's effective date, the dependent's effective date will be one of the following:
  - The date AZ Blue assigns after approving the dependent for coverage, or
  - The date of birth, adoption, or placement for adoption.

Court Orders for Health Insurance Coverage

Coverage may be available to a contract holder's child in accordance with any court order or administrative order issued by a court of competent jurisdiction to provide health benefits coverage to a child of the Contract Holder if the child qualifies for coverage under AZ Blue's medical underwriting guidelines and meets other eligibility requirements. 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. The court's order applies to the Contract Holder. It does not bind AZ Blue or mean that AZ Blue has to accept the child for coverage.

To obtain coverage for the child, the Contract Holder must submit an application, and the children may have to meet AZ Blue's medical underwriting guidelines. If AZ Blue accepts the child for coverage, coverage will not be effective until the date assigned by AZ Blue, and the Contract Holder is required to pay any additional required Premium. If the effective date coincides with a retroactive court order date, we will prorate the Premium from the first day of the time period specified in the order.

Benefit-Specific Eligibility for Non-members

Under the following limited circumstances, a non-member may be eligible to receive benefits under this plan:
- If a transplant recipient is covered by AZ Blue and the donor is not a Member, the donor may be eligible for limited benefits (see benefit descriptions for *"Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures"* and *"Transplant or Gene Therapy Travel and Lodging"*).
- If a non-member is pregnant with a baby that is to be adopted by an AZ Blue Member, the non-member may be eligible for benefits for *"Complications of Pregnancy"* under the following circumstances:
  - The child is adopted by an AZ Blue Member within 1 year of birth;
  - The Member is legally obligated to pay the costs of birth; and
  - The Member notified AZ Blue 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. Benefits for Complications of Pregnancy are not available for surrogate birth mothers who are not members if the above requirements for legal adoption of the child are not met.

Non-Duplication of Benefits

Medicare

- The combined total payments by Medicare and AZ Blue will never exceed the amount a Provider is permitted to bill the Member under applicable Medicare law.
- This plan will not duplicate benefits for Covered Services that are paid by Medicare as primary payer. When a Member is enrolled in Medicare Part A or Part B, the benefits available under this plan are coordinated with Medicare as primary payer. Medicare must process the claim first. If Medicare Part A or Part B is the primary payer and denies coverage for a Service that is covered under this plan, AZ Blue will process the claim as if it were the primary payer, subject to all of the terms of this plan.
- We do not coordinate benefits with Medicare Part D.

AZ Blue Benefits

Secondary Coverage Under an AZ Blue Group Plan

If a Member has coverage under this plan and also under an AZ Blue group Benefit Plan, this plan is primary. This plan pays benefits first. Payment of the claim is subject to all applicable deductibles, Coinsurance, and copays. Any combined benefit payments will not exceed 100 percent of the Allowed Amount under the plan offering the higher level of benefits.

Coverage Under Another AZ Blue Individual Plan

- If a Member has coverage under this plan and also under one or more additional AZ Blue individual plans, the order of benefits is:

- If the Member is covered as a Contract Holder under one plan and as a dependent under another, the Contract Holder coverage pays first. If a child is covered under a child-only plan, the Child-only Coverage pays first.
- If a child is enrolled as a dependent under more than one individual AZ Blue plan and the parents are married, living together or share custody of the child, then the plan of the parent whose birthday occurs 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 and do not share custody, the following applies when the parents or stepparents are covered under an AZ Blue individual plan:
  - Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health insurance expenses that parent's coverage pays first.
  - If there is no court decree establishing responsibility for the child's health insurance expenses, 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 next and a noncustodial stepparent's coverage pays last.
- When none of the above applies, the coverage in force for the longest, continuous period of time pays first.

AZ Blue does not coordinate benefits for Covered Services provided by a retail or mail order pharmacy.

Coverage Under Non-AZ Blue Plans (including other BCBS Plans)

AZ Blue does not coordinate coverage with non-AZ Blue plans.

Premium

For individual coverage (an adult Contract Holder) and family coverage (an adult Contract Holder and spouse and/or child(ren) on one plan), premiums are determined by one or more of the following:
- The contract holder's age and sex
- The contract holder's county of residence
- The contract holder's spouse's age and sex
- The deductible amount you select
- The number of dependent children covered under the plan

Your Premium will automatically change upon your annual renewal. Premium rates in effect upon your renewal will be based on the age class of the Contract Holder and any spouse on the Contract. Age classes are available upon request from AZ Blue. See your ID card for more information on contacting AZ Blue. AZ Blue will provide you with notice of Premium changes in accordance with applicable law.

Your premiums will also change automatically, on your next billing date, in each of the following situations:
- A child on a child-only Contract turns age 19
- The Contract Holder changes his or her residence
- You add or remove a dependent from your Contract
- You change your deductible level

For Child-only Coverage (plan covers only one or more children), premiums are determined by each child's age, sex, county of residence for the address on file, and deductible level selected. All Premium changes due to a change in a child's age class will be effective upon annual renewal. Age classes are available upon request from AZ Blue. See your ID card for information on contacting AZ Blue.

When a child covered by a child-only Contract reaches age 19, the child is automatically considered an adult Contract Holder. AZ Blue will automatically adjust the Premium on the next billing date following the member's 19th birthday. Coverage will continue according to the rates described for individual and family coverage.

Premium Payments

You pay premiums monthly. Premium Payments must be made to AZ Blue on or before the due date. Premiums must be paid in U.S. dollars and drawn from a bank located and based in the United States. AZ Blue mails a Premium notice to the Contract Holder before each due date. If you signed up for Sure Pay, this does not apply. Regardless of whether you receive a notice, AZ Blue will not continue the plan unless AZ Blue receives your payment within 31 days after the Premium due date.

Premium Payments by Third Parties

You are responsible for your Premium payment. AZ Blue only accepts Premium Payments from the following third parties: Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services Act; Indian tribes, tribal organizations, or urban Indian organizations; federal and state government programs; or family members. If we learn that an unauthorized third party paid your Premium, AZ Blue may reject the payment, and the Premium will remain due.

Grace Period

If you do not pay your Premium by the Premium due date, AZ Blue provides you a 31-day Grace Period to make the payment. AZ Blue is not responsible or liable for claims incurred during the Grace Period, unless AZ Blue receives payment before the end of the Grace Period. A Premium not paid when due and not paid within the Grace Period, is in default. This plan terminates as of the date the Premium was originally due. If this plan is terminated for non-payment of Premium, the Contract Holder may request reinstatement. AZ Blue has sole discretion and authority as to whether to allow reinstatement.

If AZ Blue provided Prior Authorization for a Service during the Grace Period, that Prior Authorization is null and void if the plan is later retroactively terminated for non-payment of Premium. The Member is responsible for all medical expenses incurred.

Notice of Premium Change

With a 30-day prior notice, AZ Blue may change the Premium.

Rescission

In deciding whether to approve you for coverage, AZ Blue relies on the information in your application. When a Member (the Contract Holder or dependent) fraudulently misstates or intentionally misrepresents any material information on the application, AZ Blue may rescind (declare null and void) any plan issued to a Member as of the effective date of the plan. AZ Blue will give a 30-day written notice of its intent to rescind, during which time the Member may protest the decision by writing to AZ Blue at the address indicated in the notice and explaining why a Rescission is not appropriate or allowable.

What Happens If Your Plan is Rescinded

- Any Prior Authorization given is null and void as though it never existed.
- Dependents may be able to keep their coverage or switch to certain other products.
- If the contract holder's coverage is rescinded but one or more dependent children retain coverage, AZ Blue will convert the policy to a child-only plan, as of the effective date for the rescinded policy. You must pay any required Premium for the child-only policy, and the Premium may be more costly than the family coverage rates. Any Premium changes will apply as of the original effective date.
- The Contract Holder or dependent whose coverage was rescinded is responsible for all medical expenses incurred in excess of premiums paid to AZ Blue.
- The policy is null and void for the Contract Holder or dependent whose coverage is rescinded, and that person has no benefits.

Termination

AZ Blue does not automatically terminate a Contract Holder or dependent when that person turns age 65 or becomes eligible for Medicare for some other reason. For persons who are eligible for Medicare and at least age 65, AZ Blue has other coverage options that may offer lower Premium rates. Please call us for additional information. If you continue your coverage under this plan, AZ Blue will not duplicate benefits for Covered Services paid by Medicare as primary payer.

Benefits after Termination

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

Continuing Coverage for Terminated Dependents

Eligible Dependents who are terminated may be able to continue coverage on a separate plan. The dependent will automatically be transferred onto a separate policy and will not be required to apply for coverage if continuing with the same plan. An application will be required if plan changes are requested. Dependents can terminate coverage at any time.

Involuntary Termination of Coverage

The following event causes involuntary Termination of all covered individuals on the indicated date:

- The Premium is not paid within the Grace Period
  Termination date – the date the Premium was originally due

The following events cause involuntary Termination of Dependents on the indicated effective date:

- Divorce – the contract holder's spouse loses coverage
  Termination date – the date of the final divorce decree
- Dependent child turns age 30 and does not qualify as a disabled dependent
  Termination date – the 30th birthday
- Dependent child over age 30 whose disability ends
  Termination date – the date disability or incapacity ends
- Dependent child covered by a qualified medical support order is no longer eligible under the court order or administrative order
  Termination date – the last day of the time period specified in the court order or administrative order

If a Contract Holder dies, AZ Blue will terminate the contract holder's policy and transfer any Dependents to a new policy.

Involuntary Termination Based on Misrepresentation or Fraud

AZ Blue may terminate a member's coverage on 45 days' written notice if AZ Blue finds that the member's use of Service or benefits or conduct under this plan involved intentional misrepresentation or fraud. Termination under this section does not prejudice AZ Blue from exercising any other legal rights and remedies it may have for the member's fraud.

Voluntary Termination of Coverage

Except as provided in this section for Dependents subject to court order or administrative order, the Contract Holder may voluntarily cancel coverage at any time for the Contract Holder and all Dependents by sending a written notice to AZ Blue. AZ Blue will terminate the plan on the 1st or 15th day of the month following AZ Blue's receipt of the request.

The Contract Holder acknowledges and agrees that the Contract Holder shall not cancel coverage for a minor child whose coverage is mandated by court or administrative order unless the Contract Holder provides AZ Blue with satisfactory evidence that the child is enrolled or will be enrolled in other health coverage, effective on the date this coverage terminates or that the requirements of the order have been otherwise satisfied or terminated.

New Policy Required for Individuals Who Relocate Outside Arizona

If you move outside of Arizona, AZ Blue will not reissue your policy at the end of its term because you are outside of the service area in which AZ Blue is licensed and authorized to do business.

GENERAL PROVISIONS

Access to Information Concerning Dependent Children

AZ Blue is not a party to domestic disputes. Parental disputes over dependent coverage and information must be resolved between the parents of the dependent child. Under Arizona law, both parents have equal rights of access to information about their children, unless there is a court order denying such access. Absent a copy of such order and subject to the confidentiality provisions described in the *"Confidentiality and Release of Information"* section of this book, AZ Blue provides equal parental access to information.

Appeal and Grievance Process

Members may participate in AZ Blue's appeal and grievance processes, which are described in detail in the AZ Blue Appeal and Grievance Guidelines, a separate document provided to you. You do not have to pay any fees or charges to file or pursue an appeal or grievance with AZ Blue. You may obtain another copy of the AZ Blue Appeal and Grievance Guidelines by visiting us at www.azblue.com or by calling Customer Service at the number on your ID card.

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

Billing Limitations and Exceptions

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

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

Blue Cross and Blue Shield Association

This paragraph shall not create any additional obligations whatsoever on the part of AZ Blue other than those obligations created under other provisions of this Agreement. Contract Holder, on behalf of self and all members, expressly acknowledges and agrees that:

i. This Agreement is a Contract solely between Contract Holder and AZ Blue, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield plans, permitting AZ Blue to use the Blue Cross and/or Blue Shield service marks in the state of Arizona;
ii. AZ Blue is not contracting as the agent of the Association;
iii. Contract Holder has not entered into this Agreement based on any representations by the Association or any other Blue Cross or Blue Shield plan other than AZ Blue; and
iv. Contract Holder and members shall not seek to hold the Association or any Blue Cross or Blue Shield plan other than AZ Blue accountable or liable for AZ Blue's obligations created under this Agreement.

Broker Commissions

AZ Blue sells health and dental coverage products either directly or through independent licensed insurance brokers. Commission payments to brokers are one of the costs factored into Premiums, but AZ Blue's Premium calculation is not based on whether a product is sold directly or by a broker. AZ Blue generally pays a commission to the broker of record or legal assignee designated by the broker until the insurance Contract is terminated, the Contract Holder terminates his or her relationship with the broker and notifies AZ Blue, or the broker becomes ineligible for receipt of commissions. Brokers are required under their agreement with AZ Blue to provide information on commission rates with AZ Blue. More detailed information about Broker Commissions and compensation to AZ Blue employees who are Licensed Sales Representatives for AZ Blue individual products is available for review at www.azblue.com, or you may obtain a copy by calling AZ Blue at (602) 864-4124.

Claims Editing Procedures and Pricing Guidelines

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

Confidentiality and Release of Information

We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with federal and state law. If you wish to authorize someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from www.azblue.com, or call Customer Service at the number on your ID card and request a hard copy of the CIRF form.

Cost of Records

In order to process your claims, AZ Blue may need to obtain copies of your health records from your Provider. In-network Providers generally cannot charge you for providing AZ Blue with health records. Noncontracted Providers have no contractual obligation to provide records to AZ Blue free of charge. If you receive services from a noncontracted Provider who charges for record preparation or the cost of copies, you will need to arrange with your Provider to obtain any records required by AZ Blue and pay any applicable fees.

Court or Administrative Orders Concerning Dependent Children

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

Discretionary Authority

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

Identity Protection Services

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

Lawsuits against AZ Blue

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

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

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

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

Legal Action and Applicable Law

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

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 AZ Blue: Sometimes, AZ Blue 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. AZ Blue reviews these cases and makes a good faith decision based on the unique facts of each case whether to join the case. AZ Blue may also bring lawsuits against vendors or other entities to recover various economic damages. When AZ Blue participates as a plaintiff and recovers damages, those funds are not returned to individual members, but are instead retained by AZ Blue to reduce overall administrative costs. This paragraph is not intended to limit or waive any claims AZ Blue may have against any person or entity.

Medicaid Reimbursement

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

Member Notices and Communications

AZ Blue sends some notices and other communications to members by U.S. mail to the last address on file with AZ Blue Customer Service. AZ Blue may also elect to send some notices and communications electronically if the Member has consented to electronic receipt. Notice is deemed complete when sent to the member's last address of record, as follows: (1) on delivery, if hand-delivered; (2) if mailed, on the earlier of the day actually received by the Member or 5 days after deposit in the U.S. mail, postage prepaid; or (3) if transmitted electronically, on the earlier of the day of actual receipt or 24 hours after electronic transmission to the member's email address of record.

Non-Assignability of Benefits

Except as otherwise specified in this section, the benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer, or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against AZ Blue and imposes no duty or obligation on AZ Blue. 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 AZ Blue. AZ Blue, 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 AZ Blue pays them, they are required to resolve the dispute with us. As long as you pay your required Cost-share amount, they can't collect any other amounts from you.

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

www.cms.gov/nosurprises

You can also call (800) 985-3059.

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

Payments Made in Error

If AZ Blue erroneously makes a payment or overpayment to you or on your behalf, AZ Blue may obtain reimbursement from you or the Provider, or AZ Blue may offset the amount owed against a future claim arising from any covered Service. Payments Made in Error by AZ Blue do not constitute a waiver concerning the claim(s) at issue or of any right of AZ Blue to deny payment for noncovered services.

Plan Amendment

There is no guarantee of continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted, or changed by AZ Blue as required to comply with federal or state laws. Please review and retain this book, any replacement books, any SBCs, all riders, amendments, and other communications concerning your coverage.

Prescription Medication Rebates

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

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

Pharmacy rebates may cause the overall cost of a medication to fall below the amount you pay for that medication under the coverage described in this Benefit Plan. Other discount programs offered by a pharmacy may result in members of the public paying a lower cost for some medications than you pay under this Benefit Plan.

Provider Contractual Arrangements

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

Provider Treatment Decisions and Disclaimer of Liability

While rendering services to you, in-network Providers are independent contractors and not employees, agents, or representatives of AZ Blue. Their contracts with AZ Blue address reimbursement and

administrative policies. Each Provider exercises independent medical judgment in deciding what services to provide you, and how to provide them. AZ Blue'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. AZ Blue has no control over any diagnosis, treatment, care, or other services rendered by any Provider and disclaims any and all liability for any loss or injury to you caused by any Provider by reason of the provider's negligence, failure to provide treatment, or otherwise.

Release of Records

Subject to federal or Arizona law, the Member agrees that AZ Blue may obtain, from any Provider, insurance company, or third party, all records or information relating to the member's health, condition, treatment, prior health insurance claims, or health benefit program. A failure to provide records needed to adjudicate a claim can result in denial of the claim.

Retroactive Changes

AZ Blue 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.

Third-Party Beneficiaries

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

Your Right to Information and Availability of Notice of Privacy Practices

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

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

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

English: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-475-4799.

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 602-864-4884.

Navajo: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-877-475-4799.

Chinese Simplified: 如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-475-4799 。

Chinese Traditional: 如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-877-475-4799。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-475-4799.

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-475-4799.

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-475-4799.

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-475-4799.

Korean: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-475-4799.

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-475-4799.

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-475-4799.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-475-4799 ।

Farsi (Persian)

توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-877-475-4799.

Thai: หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-475-4799 หรือปรึกษาผู้ให้บริการของคุณ"

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-475-4799 。

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