Individual PPO

Base Benefit Book

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

azblue.com/MyBlue

Welcome!

Thank you for making Blue Cross® Blue Shield® of Arizona (BCBSAZ) a part of your healthcare team. Making it easy for you to take your next step for health is what we're all about.

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

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

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

QUICK START: USING YOUR HEALTH PLAN

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

Know the Lingo—Top Terms

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

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

Out-of-pocket coinsurance maximum **Does not apply to high deductible health plans**	The most you pay in coinsurance for covered services in a calendar year before your health insurance begins paying 100% of the cost of covered services. Any payments you make for noncovered services will not count toward your out-of-pocket coinsurance maximum. This out-of-pocket maximum is strictly limited to coinsurance payments. Any other type of payment you make toward covered services does not count toward this maximum. If you have family coverage, there is an out-of-pocket coinsurance maximum for each individual member as well as for your family.
Out-of-pocket maximum **Applies to high deductible health plans only**	The amount you pay each calendar year before the plan begins paying 100% of the allowed amount (on most covered services) for the remainder of the calendar year. The following types of payments do not count toward the out-of-pocket maximum: amounts for balance billing, amounts for noncovered services, charges for lack of prior authorization, and amounts above the maximum allowed for a specific benefit. Even though you pay these expenses, they don't count toward the out-of-pocket maximum and you must keep paying these expenses after your out-of-pocket maximum has been met.

Discover Your Care Choices

Who to see or call …	When you need …	How to use …
BCBSAZ plan in-network providers	Routine and specialty care	Log in to your MyBlue℠ account and click "Find a Doctor." You can search by name, type, or location.
BlueCare Anywhere℠	A visit with a board-certified doctor, counselor, or psychiatrist without going to an office. Have a video appointment by computer, tablet, or mobile device wherever you are.	Set up your account at BlueCare Anywhere to connect any day, any time, including weekends and holidays. You can also call **1-844-606-1612.**
Urgent care center	Treatment for conditions that require prompt medical attention	Log in to MyBlue, click "Find a Doctor," and select "Doctors by name or specialty, hospitals, and clinics." Choose "Places by Type" and enter "urgent care" in the search bar.
Walk-in clinic (may be freestanding, or located inside a retail store)	Same-day care for a cold, flu, rashes, and other minor medical needs, as well as vaccinations and wellness screenings. You don't need an appointment, but calling ahead is a good idea.	Use our "Find a Doctor" tool in your MyBlue account . Click "Find a Doctor," and select "Doctors by name or specialty, hospitals, and clinics." Choose "Places by Type" and enter "Health Service Clinic/Center" to search for locations closest to you.
Nurse On Call	Advice from a registered nurse for illnesses like fevers and the flu, and minor injuries.	Call **1-866-422-2729** (open 24 hours a day, seven days a week).

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

Ask for Prior Authorization When Required

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

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

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

Connect with Us!

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

Online	Your plan comes with a personalized online MyBlue account. Set up your account today so you can: • See an overview of what your health plan covers and how it works (this is your Summary of Benefits and Coverage, available under "Plan Benefits") • Check the status of a claim (under "Claims Search") • Find doctors, hospitals, or other healthcare providers in your plan's network using the "Find a Doctor" tool • Use the Drug Cost/Copay Calculator (under "Pharmacy"), and much more.
By phone	Our Customer Service team is here for you from 8 a.m. to 5 p.m. Arizona time, Monday through Friday. We're closed on holidays. • You'll find the phone number for Customer Service on the back of your ID card. • We also have special lines for: – TTY: 1-800-770-8973 or 711 – Help in Spanish (en español): 602-864-4884 – A new ID card: 602-864-4400 (within Phoenix Metro area) 1-800-232-2345 (outside Phoenix Metro) – Pharmacy: 1-866-325-1794 (open 24/7) – Chiropractic: 1-800-678-9133 – Fraud & Abuse Hotline: 602-864-4875 or 1-800-232-2345, ext. 4875 – Telehealth Services (provided by BlueCare Anywhere): 1-844-606-1612
By mail	Blue Cross Blue Shield of Arizona P.O. Box 13466 Phoenix, AZ 85002-3466
Social media	Like us on **Facebook:** facebook.com/bcbsaz Follow us on **Instagram:** instagram.com/bcbsaz Follow us on **X:** x.com/bcbsaz Email complaints and concerns to socialcares@azblue.com

Tip!

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

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

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

YOUR HEALTH PLAN BENEFITS

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

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

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

What's Covered

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

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

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

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

Note about changes in level of care

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

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

A. AMBULANCE SERVICES

Services covered:

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

Not covered:

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

B. BEHAVIORAL HEALTH SERVICES

Behavioral health services include treatment for mental health, chemical dependency, and substance use disorder. Behavioral health services for minors that are otherwise covered under this section will not be denied solely on the basis that the services are provided in a school setting or are ordered by a court.

B.1 Inpatient Hospital Services

Services covered:

- Diagnostic testing
- Intensive care units and other special care units
- Medications, biologicals (medications that come from a living source, such as a vaccine or human insulin), and solutions
- Room and board in a semi-private room, or a standard private room (not deluxe) if the hospital only has private rooms, or if a private room is medically necessary
- Treatment and recovery rooms and equipment for covered services

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

Services covered:

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

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

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

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

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

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

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

C. CANCER CLINICAL TRIALS

Your plan covers services related to *eligible cancer clinical trial*s, which BCBSAZ defines as a Phase 1, 2, 3, or 4 clinical trial conducted for the prevention, detection, or treatment of cancer and approved or funded by at least one of the following:

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

Services covered:

- Benefits are limited to those services covered under this plan that would be required if you received standard, non-investigational treatment.
- Services may include laboratory, radiology, physician services, medical diagnostic, and/or surgical procedures.

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

- You are enrolled in a cancer clinical trial;
- The trial meets the requirements of Arizona law; **and**

- The services to be rendered are directly associated with the trial.

Otherwise, BCBSAZ only covers services associated with 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.

Not covered:

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

D. CARDIAC AND PULMONARY REHABILITATION—OUTPATIENT SERVICES

Your plan covers outpatient Phase 1 and 2 cardiac rehabilitation programs and pulmonary rehabilitation services.

E. CATARACT SURGERY AND KERATOCONUS

Services covered:

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

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

F. CHIROPRACTIC SERVICES

Your plan covers services for chiropractic services.

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

G. DENTAL SERVICES—MEDICAL

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

G.1 Dental Accident Services

There are some terms to know for this benefit:

Accidental dental injury is an accidental injury to the structure of one or more teeth that is caused by an external force or element such as a blow or fall. A tooth injured while you are chewing is not considered an accidental dental injury, even if the injury happens because you were chewing on a foreign object.

A *sound natural tooth* is a tooth that is:

- Whole or virgin; **or**
- Restored with amalgam (silver filling) or composite resin (tooth-colored filling) or restored by cast metal, ceramic/resin-to-metal, or laboratory processed resin/porcelain restorations (crowns); **and**
- Without current 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.

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

Services covered:

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

Not covered:

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

G.2 Dental Services Required for Medical Procedures

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

Services covered:

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

Not covered:

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

G.3 Medical Services Required for Dental Procedures

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

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

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

H.1 Durable Medical Equipment (DME)

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

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

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

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

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

Not covered:

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

H.2 Medical Supplies

Services covered:

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

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

H.3 Prosthetic Appliances and Orthotics

Services covered:

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

  Types of therapeutic shoes that are covered:

- *Custom-molded shoes* are shoes built over a model of the member's foot. They are made from leather or other material of equal quality suitable to the shoe's purpose (dress, walking, work, etc.), have removable inserts that can be changed or replaced as the member's condition warrants, and have some sort of shoe closure. May include an internally seamless

toe. (**Note:** Custom-molded shoes are covered only when the member has a foot deformity that cannot be accommodated by a depth shoe.)

- *Depth shoes* are shoes that come with a full-length, heel-to-toe filler that, when removed, leaves at least of 3/16 of an inch of extra depth. The extra depth accommodates custom-molded or customized inserts. The shoes are made of leather or other material of equal quality suitable to the shoe's purpose (dress, walking, work, etc.); have some sort of shoe closure; and are available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.
- Wigs and hairpieces for members diagnosed with:
- A behavioral health condition; **or**
- Alopecia (absence of hair) caused by chemotherapy, radiation therapy, or second- or third-degree burns.

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

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

Coverage limits:

- Certain equipment and medical supplies are covered under Pharmacy and Medications Benefits at BCBSAZ's sole discretion.
- Coverage is limited to one breast pump with breast-pump supplies per member, per calendar year, per Health Resources and Services Administration guidelines (See Preventive Services). This limit does not apply to claims submitted with a primary behavioral health diagnosis.
- Coverage is limited to one unit or one pair of prosthetic appliances and orthotics per member, per calendar year. This limit does not apply to claims submitted with a primary behavioral health diagnosis.
- Benefits are limited to the allowed amount for the DME item or medical supply base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded DME items or medical supplies may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Not covered:

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

• Adjustable beds • Air cleaners • Air-fluidized beds • Air conditioners • Air purifier • Assistive eating devices • Atomizers • Bathroom equipment • Bed boards • Biofeedback devices • Braille teaching texts	• Foot stools • Garter belts • Grab bars • Hair transplants • Health spas • Hearing aid batteries • Heating and cooling units • Helmets • Hospital-grade breast pumps and related supplies • Humidifiers	• Portable and permanent spa and whirlpool equipment and units • Reaching and grabbing devices • Reclining chairs • Replacement of external prosthetic devices due to loss or theft • Saunas • Strollers of any kind

• Car seats • Corsets • Cushions • Dentures • Diathermy machines • Disposable hygienic items • Dressing aids and devices • Elastic/support/compression stockings (except Thrombo-Embolic Deterrent hose) • Elevators • Exercise equipment	• Incontinence devices/alarms • Items used mainly for help in daily living, socialization, personal comfort, convenience, or other nonmedical reasons • Language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools • Massage equipment • Mineral baths	• Supplies used by a doctor or other healthcare provider during office treatments • Tilt or inversion tables or suspension devices • Vehicle or home modifications • Wigs and hair pieces for alopecia caused by anything other than chemotherapy, radiation therapy, second- or third-degree burns, a diagnosed behavioral health condition

I. EDUCATION AND TRAINING

I.1 Diabetes and Asthma Education and Training

Education and training are available from providers whose services are:

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

I.2 Nutritional Counseling and Training

Your plan covers six nutritional counseling and training visits per member, per calendar year for members diagnosed with one or more of the following conditions:

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

J. EMERGENCY SERVICES

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

K. EOSINOPHILIC GASTROINTESTINAL DISORDER

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

- At risk of mental or physical impairment if deprived of the formula;
- Diagnosed with EGID; **and**

- Under the continuous supervision of a doctor or a registered nurse practitioner.

L. FAMILY PLANNING—CONTRACEPTIVES AND STERILIZATION

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

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

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

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

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

M. HOME HEALTH SERVICES

Services covered:

- Home infusion medication administration therapy, including:
- Blood and blood components
- Hydration therapy
- Intravenous catheter care
- Intravenous, intramuscular, or subcutaneous administration of medication
- Specialty medications, as defined by BCBSAZ, that are not covered under the Pharmacy benefit (see Pharmacy and Medications Benefits)
- Total parenteral nutrition services
- 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

The above services must meet all of the following criteria:

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

Coverage limits: Benefits are limited to any combination of skilled nursing services needed in order to provide home infusion medication administration, enteral nutrition, and/or other services requiring skilled nursing care, up to a maximum of six hours per member, per day. The home health visit limit does not apply to home health services provided instead of hospitalization or

hospital outpatient services, or to claims for home health services submitted with a primary behavioral health diagnosis.

Not covered:

- All dietary, caloric, and nutritional supplements, such as specialized formulas for infants, children, or adults or other special foods or diets, even if prescribed, except as stated in the Eosinophilic Gastrointestinal Disorder and the Medical Foods for Inherited Metabolic Disorders sections of this book
- Services beyond the six hour per member, per day maximum, except as stated in the coverage limits

N. HOSPICE SERVICES

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

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

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

Services covered:

- Continuous home care—24-hour skilled care provided by an LPN or RN during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving in-home services
- Home health services
- Individual and family counseling provided by a psychologist, social worker, or family counselor
- Inpatient acute care—Inpatient admission for pain control or symptom management that cannot be provided in the home setting
- Outpatient services
- Respite care—Admission of the member to an approved facility so the member's family or primary caregiver can rest
- Routine care—Intermittent visits provided by a member of the hospice team

Coverage limits: Benefits are limited to a maximum of five days of respite care for every 21-day period. This limit does not apply to claims for respite care services submitted with a primary behavioral health diagnosis.

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

O. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

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

P. INPATIENT HOSPITAL

Services covered:

- Adjustments to previous bariatric surgery that was performed while the member was covered by a different health plan
- Blood transfusions, whole blood, blood components, and blood derivatives
- Covered cellular immunotherapies and gene therapies at in-network cost share only when administered in a contracted Blue Distinction® Center
- Diagnostic testing, including radiology, laboratory services, and biomarker testing
- Gender-affirming care
- General, spinal, and caudal anesthetic provided in connection with a covered service
- Intensive care units and other special care units
- Medications, biologicals, and solutions
- Operating, recovery, and treatment rooms and equipment for covered services
- Radiation therapy or chemotherapy, unless performed 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
- Surgery and other invasive procedures

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

Q. INPATIENT REHABILITATION—EXTENDED ACTIVE REHABILITATION SERVICES

Your plan covers an intense therapy program provided in a facility licensed to provide extended active rehabilitation (EAR) that meets *all* of the following criteria:

- A doctor or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- Room and board in a semi-private room, or a standard private room (not deluxe) is covered if the hospital only has private rooms or if a private room is medically necessary;
- The facility has 24/7 onsite RN coverage;
- The facility has enough professional staff to provide the needed treatment;
- The facility's designated medical director is a doctor or registered nurse practitioner, and provides direction for services provided at the facility;
- The patient must require 24-hour rehabilitation nursing and have the ability to meet rehabilitation goals within a reasonable period of time; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care (see Medical necessity definition, guidelines, and criteria).

Coverage limits: Benefits are limited to 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.

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

R. LONG-TERM ACUTE CARE—INPATIENT

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

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

Coverage limits: Benefits are limited to 365 days of long-term acute-care services per member. This limit does not apply to claims for long-term acute-care services submitted with a primary behavioral health diagnosis.

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

S. MATERNITY—COMPLICATIONS OF PREGNANCY ONLY

Your plan only covers services provided to treat a condition that BCBSAZ has determined is a complication of pregnancy, as defined by current evidence-based criteria. BCBSAZ does not classify all conditions associated with or caused by the pregnancy as complications of pregnancy. For more information on what is covered under this benefit, please call Customer Service at the number on your ID card.

Not covered:

- Cesarean section delivery, unless medically necessary in order to treat the BCBSAZ-defined pregnancy complication
- High-risk maternity and delivery
- Normal maternity and delivery, including 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 delivery, except for limited services that are covered under Preventive Services

T. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Your plan covers medical foods for inherited metabolic disorders. Inherited metabolic disorder is a disease caused by an inherited abnormality of body chemistry that meets *all* of the following requirements:

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

Medical foods are modified low-protein foods and metabolic formulas that are *all* of the following:

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

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

Not covered:

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

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

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

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

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

U. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Your plan covers testing for decreased mental function or developmental delay. Physical Therapy, Occupational Therapy, and Speech Therapy Services are the only benefits available to cover treatment for developmental delay.

Not covered: Except for therapy listed above, any treatment for developmental delay that is provided after an initial evaluation for developmental delay, regardless of the cause of the delay.

V. OUTPATIENT SERVICES

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

- Adjustments to previous bariatric surgery that was performed while the member was covered by a different health plan
- Allergy testing, antigen administration, and desensitization treatment
- Blood transfusions, whole blood, blood components, and blood derivatives
- Covered cellular immunotherapies and gene therapies at in-network cost share only when administered in a contracted Blue Distinction Center
- Diagnostic radiology services, including:
  - CAT/CT imagery
  - Mammograms and other modalities for breast cancer screening and diagnosis, as recommended by the National Comprehensive Cancer Network
  - Outpatient and ambulatory magnetic resonance imaging (MRI/MRA), PET scans, ECT, BEAM (Brain Electrical Activity Mapping)
  - X-rays
- Diagnostic testing, including but not limited to, laboratory services and biomarker testing
- Dialysis
- End-stage renal disease services
- Epidural and facet injections, and radio frequency ablation for pain management
- Gender-affirming care
- Infusion/IV therapy in an outpatient setting
- Medications, and the administration of medications, in an outpatient setting
- Orthognathic treatment and surgery, including, but not limited to, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)
- Outpatient and ambulatory cardiac testing, angiography, and video EEG
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant
- Sleep studies
- Surgery and other invasive procedures
- Treatment of temporomandibular joint (TMJ) disorders

W. PHARMACY AND MEDICATIONS BENEFITS

W.1 Pharmacy Benefit

Your plan covers prescription medications that:

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

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

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

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

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

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

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

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

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

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

Not covered:

- Abortifacient (abortion-causing) medications, except those covered under the Pregnancy, Termination and Physician Services sections
- All prescription and over-the-counter contraceptive medications and devices for male plan members
- Biologic serums

- Compounded medications obtained from a mail order pharmacy
- Designated medications prescribed by an ineligible provider or dispensed by an unapproved pharmacy or provider to members who are enrolled in the Designated Prescription Network program
- Medication delivery implants
- Medications designated as clinic packs
- Medications designed for weight gain or loss, regardless of the condition for which it is prescribed
- Medications, devices, equipment, and supplies lawfully obtainable without a prescription, except as stated in your Benefit Book (Base Benefit Book + Plan Attachment + any Rider)
- Medications for athletic performance
- Medications for lifestyle enhancement
- Medications for sexual dysfunction
- Medications for which the principal ingredient(s) are already available in greater and lesser strengths and/or combinations, as well as medications which modify the dosage form (tablet, capsule, liquid, suspension, extended release, tamper resistant) of drugs already available in a common dosage form, as described in the BCBSAZ Medication Benefit exclusion policy in addition to all other exclusions in your Benefit Book. Go to azblue.com/pharmacy for a list of these specific exclusion details.
- Medications given to a member who is an inpatient in any facility, except those covered under Inpatient Hospital
- Medications labeled “Caution—Limited by federal law to investigational use,” or words to that effect, and any experimental medications as determined by BCBSAZ and/or the PBM
- Medications obtained from an out-of-network mail order or specialty pharmacy
- Medications packaged with more than one medication or supply (including an over-the-counter medication, vitamin, or other excluded product) and billed as a single medication
- Medications that exceed BCBSAZ and/or the PBM’s limitations, including, but not limited to, quantity, age, gender, and refill limits
- Medications to improve or achieve fertility or treat infertility
- Medications used for any cosmetic purpose
- Medications used to treat a condition not covered under this plan
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging, or name
- Prescription medications dispensed in unit-dose packaging, unless that is the only form in which the medication is available
- Prescription refills for medications that are lost, stolen, spilled, spoiled, or damaged

W.2 Medications for the Treatment of Cancer

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

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

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

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

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

X. PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY SERVICES

Your plan covers therapy services related to a specific illness or injury. There are some terms to know for this benefit:

- *Physical therapy (PT)* is treatment of disease or injury using therapeutic exercise and other measures to improve posture, locomotion, strength, endurance, balance, coordination, range of motion, flexibility, and ability to perform activities of daily living, and to help reduce pain.
- *Occupational therapy (OT)* is treatment of *neuromusculoskeletal dysfunction* (injuries or disorders of the musculoskeletal system, such as muscles, tendons, ligaments, nerves, discs, and blood vessels) using specific tasks or goal-directed activities to improve functional performance.
- *Speech therapy (ST)* is treatment of communication impairment and swallowing disorders.

Not covered:

- Cognitive therapy
- OT for any purpose other than training the member to perform the activities of daily living
- PT or OT services performed in a group setting of two or more people

Y. PHYSICIAN SERVICES

Physician services are services provided by a doctor.

Services covered:

- Abortifacient medications for the abortions covered under this plan, including oral medications as described in current evidence-based criteria
- Allergy testing, antigen administration, and desensitization treatment
- Foot care, including trimming of nails or treatment of corns or calluses, when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg
- Gender-affirming care
- Inpatient medical visits
- Medications and the administration of medications in a doctor's office
- Office, home, or walk-in clinic visits for the diagnosis and treatment of a sickness or injury (**Note:** Urgent care facilities are not walk-in clinics)
- Orthognathic treatment and surgery
- Second diagnostic surgical opinions

- Services for FDA-approved implanted contraceptive devices
- Services for FDA-approved patches, rings, and contraceptive injections; FDA-approved diaphragms, cervical caps, cervical shields, condoms, sponges, and spermicides; and FDA-approved emergency contraception (see the preventive medications list for contraceptive methods covered as preventive services under the Pharmacy benefit)
- Services for FDA-approved sterilization procedures
- Services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices
- Sleep studies
- Surgical procedures (including assistance at surgery)
- Only certain surgical assistants are eligible providers.
- Call Customer Service at the number on your member ID card to verify that the surgical assistant chosen by your doctor is eligible and to determine whether the surgical assistant and anesthesiologist selected by your doctor are in-network providers.
- Treatment of temporomandibular joint (TMJ) disorders

About your cost share for physician services:

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

Z. POST-MASTECTOMY SERVICES

Federal and state laws require certain breast reconstruction services following a medically necessary mastectomy. Your plan covers these legally required services, and include:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, including postoperative implanted or external prostheses; **and**
- Treatment of physical complications for all stages of the mastectomy, including lymphedema.

Notice of rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA):

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For members receiving the mastectomy-related benefits described in this section, BCBSAZ will provide coverage in a manner determined in consultation between the attending physician and the member being treated. These benefits are subject to the same cost share generally applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Customer Service at the number on your ID card.

AA. PREGNANCY, TERMINATION

Your plan covers abortions that meet the following requirements:

- The fetus is or will be nonviable, as defined by current evidence-based criteria; **or**
- The *treating provider* (the doctor who performs the procedure) certifies in writing the abortion is medically necessary because the pregnancy would endanger the life or health of the mother.

Your plan also covers abortifacient medications for the abortions covered under this plan, including some oral medications, as described in current evidence-based criteria.

BB. PREVENTIVE SERVICES

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

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

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

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

For a list of covered preventive medications, see the preventive medications list, or call Pharmacy Benefit Customer Service.

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

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

Coverage limits:

- All preventive services, except for mammography, foreign travel immunization, and nutritional counseling and training must be received from in-network providers, or the services will not be covered.
- Preventive services do not include diagnostic tests performed because you have a condition or an active symptom of a condition. Active symptoms and conditions are determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.
- If you have a service or test that falls under this benefit, but the service or test is being done because of a specific diagnosis or because you are experiencing signs or symptoms of a condition or disease, the service or test may be covered through another benefit section of this plan.

Not covered:

- Abortifacient medications, except those covered under the Pregnancy, Termination and Physician Services sections
- All prescription and over-the-counter contraceptive medications and devices for male plan members

CC. RECONSTRUCTIVE SURGERY AND SERVICES

Your plan covers services for reconstructive surgery, which is surgery performed to improve or restore the impaired function of a body part or organ resulting from one of the following:

- Congenital defects
- Illness and disease
- Injury and trauma
- Surgery
- Therapeutic intervention

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

DD. SKILLED NURSING FACILITY

Your plan covers inpatient skilled nursing facility (SNF) services provided in a facility licensed to offer 24-hour skilled nursing services that meets *all* of the following criteria:

- A doctor or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- 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;

- 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 enough professional staff to provide the needed treatment;
- The facility's designated medical director is a doctor or registered nurse practitioner, and provides direction for services provided at the facility;
- The patient must require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care (see Medical necessity definition, guidelines, and criteria).

Coverage limits: Benefits are limited to 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.

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

EE. TELEHEALTH SERVICES—BLUECARE ANYWHERE

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

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

To use BlueCare Anywhere telehealth services:

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

After you connect with a provider, if he or she determines that your condition is not appropriate for telehealth services, the provider will suggest that you see a doctor in person.

Not covered:

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

FF. TELEHEALTH SERVICES—IN-NETWORK PROVIDERS

Your plan covers telehealth services delivered by an in-network provider through interactive electronic media. Benefits are also available for emergency or urgent telehealth services from out-of-network providers.

Not covered:

- Non-emergency and non-urgent telehealth services from an out-of-network provider
- Services delivered through the sole use of an audio-only telephone, a video-only system, a facsimile (fax) machine, instant messages, or electronic mail, unless otherwise required by law

- Services covered under the Telehealth Services—BlueCare Anywhere benefit described above

GG. TRANSPLANT OR GENE THERAPY TRAVEL AND LODGING

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

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

- BCBSAZ has given prior authorization for the service or, if BCBSAZ did not give prior authorization for the service, upon review we determine the service meets the requirements of this benefit plan;
- The distance from the member's or caregiver's residence is more than 60 miles from the facility;
- The expenses are incurred by the member or the member's caregiver; **and**
- The expenses are for *any* of the following:
- Meals;
- Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; or bus, train, or air fare; **or**
- Room charges from hotels, motels, and hostels or apartment rental.

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

Not covered:

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

Claims for reimbursement: To request reimbursement of eligible travel and lodging expenses, you must submit a transplant travel and lodging claim form along with dated receipts to BCBSAZ. See the Medical Claims section for details on how and where to submit a claim.

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

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

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

In-network benefits are available for covered transplant services from: 1) providers contracted with the plan network, 2) providers contracted with host Blue plans, **and** 3) Blue Distinction Centers for Transplants. Your plan covers the following types of transplants when they meet current evidence-based criteria:

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

Your plan covers the following services in connection with, or in preparation for, a covered transplant:

- Air and ground transportation of a medical team to and from the site in the 48 contiguous United States to obtain tissue that is later transplanted into a member
- Bone marrow search and procurement of a suitable bone marrow donor when a member is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
- Chemotherapy or radiation therapy associated with transplant procedures
- Harvest and reinfusion of stem cells or bone marrow
- Inpatient and outpatient facility and professional services
- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ (covered donor expenses include complications and follow-up care related to the donation for up to six months post-transplant, as long as the recipient's coverage with or administered by BCBSAZ 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

Not covered:

- Expenses related to a noncovered transplant

- Expenses related to donation of an organ to a recipient who is not covered by BCBSAZ
- Transplants that do not meet current evidence-based criteria

II. URGENT CARE

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

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

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

What's Not Covered

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

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

Abortions, except those covered under the Pregnancy, Termination and the Physician Services sections of this book

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

Acupuncture

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

Autism spectrum disorder (ASD)—Services related to the treatment of ASD

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

Biofeedback

Blood administration for the purpose of general improvement in physical condition

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

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

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

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

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

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

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

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

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

Cosmetics and health and beauty aids

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

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

Custodial care

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

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

Dietary and nutritional supplements—All dietary, caloric, and nutritional supplements, such as specialized formulas for infants, children, or adults or other special foods or diets, even if prescribed, except as stated in the Eosinophilic Gastrointestinal Disorder 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 that are a) associated with the collection or donation of blood or blood products; b) other than for medically necessary, in-person, direct member services; c) for concierge medicine services; **or** d) for direct primary care

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

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

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

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

Hearing aids and associated services—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

IQ testing

Laboratory services provided without an order from an eligible provider

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

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

Maintenance services—Services rendered after a member has met functional goals; services rendered when no objectively measurable improvement (as determined by BCBSAZ) is reasonably expected; services to prevent backtracking to a lower level of function; services to prevent future injury; and services to improve or maintain posture

Manipulation of the spine under anesthesia

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 BCBSAZ, including online sources such as eBay, Craigslist, or Amazon; or at garage sales, swap meets, and flea markets

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

Medications that are:

- Not FDA approved
- Not required by the FDA to be obtained with a prescription
- Not used in accordance with current evidence-based criteria or Pharmacy Coverage Guidelines
- Off-label, unlabeled, and orphan medications, except as stated in the Pharmacy and Medications Benefits section of this book
- Used to treat a condition not covered by BCBSAZ

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

Neurofeedback

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

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

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

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

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

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

Phase 3 cardiac rehabilitation

Private-duty nursing

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

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

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

Respite care, except as covered under the Hospice Services benefit

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

Screening tests—Any testing done on a person who does not have a specific diagnosis or acute signs or symptoms of a condition or disease for which the test is being run, regardless of whether the person has a family history or other risk factors for the disease or condition, except as stated in the Preventive Services section of this book, or as required by law

Sensory integration, LOVAAS therapy, and music therapy

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

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

Services for conditions Medicare identifies as hospital-acquired conditions (HACs), and/or national quality forum (NQF) "Never Events"

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

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

Services for weight loss and gain, except as stated in the 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 paid for by other organizations, or those required by law to be paid for by other organizations—Other organizations include, but are not limited to, the government, a school, and/or biotechnical, pharmaceutical, medical, or dental device industry organizations.

Services performed by ineligible providers (see eligible providers)

Services provided after the member's coverage termination date, except as stated in this benefit plan

Services provided prior to member's coverage effective date

Services related to or associated with noncovered services

Services related to developmental delays

Services related to the treatment of conduct disorders and intellectual and learning disabilities, except for the initial evaluation to diagnose the condition

Services without a prescription—Services and supplies that are required by this plan to have a prescription and which are not prescribed by a doctor or other provider licensed to prescribe

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

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

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

Telephonic and electronic consultations, except as stated in the Telehealth Services—BlueCare Anywhere and the Telehealth Services—In-Network Providers sections of this book

Therapy services, except as stated in this benefit plan

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

Training and education, except as stated in the Behavioral Health Services, the Education and Training, the Physical Therapy, Occupational Therapy, and Speech Therapy Services, and the Preventive Services sections of this book

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

Vision—Routine vision exams; vision therapy; eye exercises; all types of refractive keratoplasties, including, but not limited to, radial keratotomy and/or LASIK surgery; any other procedures, treatments, and devices for refractive correction; eyeglass frames and lenses, contact lenses, and other eyewear; and vision examinations for fitting of eyeglasses and contact lenses, except as stated in the Cataract Surgery and Keratoconus section of this book

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

Waivered conditions—If you signed a waiver that excludes coverage of a particular condition, there is no coverage for that condition or for 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. BCBSAZ will decide whether or not to remove the waiver.

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

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

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

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

USING YOUR PHARMACY BENEFITS

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

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

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

Covered Medications

BCBSAZ works with a Pharmacy and Therapeutics (P&T) committee to review new medications and certain devices and supplies, as well as new information about medications, devices, and supplies that are already on the market. The P&T committee is made up of licensed pharmacists and doctors from within the community. In making decisions regarding medication coverage, the P&T committee takes into consideration safety, effectiveness, and information about how the medication is currently being used.

Getting Your Prescriptions

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

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

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

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

Medication Synchronization Program

If you are taking two or more prescription medications for a chronic (ongoing) condition, you may request early or short refills of eligible covered medications by calling the Pharmacy Benefit Customer Service number on your ID card and asking to be enrolled in the BCBSAZ medication synchronization program. If you are enrolled in the BCBSAZ medication synchronization program, your cost share for eligible covered medications will be adjusted for any early or short refills of those medications.

Specialty Medications

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

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

Prescription Cost Share

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

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

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

Submission of Claims and Cost Adjustments

If you submit a claim for a medication to BCBSAZ, BCBSAZ will review your request to determine if you should be reimbursed for some or all of the money you paid to the pharmacy, and will send you an Explanation of Benefits (EOB). If BCBSAZ denies your claim, you will receive a document describing

your appeal rights along with the EOB. Submitting a prescription to a pharmacy is not considered submitting a claim, and will not result in an EOB.

If you believe you have paid more for a self-administered version of a cancer treatment medication than for an injected or intravenously administered version of a cancer treatment medication, please call the Pharmacy Benefit Customer Service number on your ID card.

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

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

FINDING & WORKING WITH HEALTHCARE PROVIDERS

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

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

A few quick tips:

Consider choosing a primary doctor

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

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

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

After you receive services:

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

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

About Covered Services and Choosing Providers

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

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

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

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

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

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

Eligible providers

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

Professional Providers	Facility/Ancillary Providers
• Certified registered nurse first assist (CRNFA) • Certified nurse midwife • Certified registered nurse anesthetist (CRNA) • Doctor of chiropractic (DC) • Doctor of dental surgery (DDS) • Doctor of medical dentistry (DMD) • Doctor of medicine (MD) • Doctor of optometry (OD) • Doctor of osteopathy (DO) • Doctor of podiatry (DPM) • First assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner (NP) • Licensed professional counselor • Perfusionist • Physician assistant (PA) • Psychologist (PhD, EdD, and PsyD) • Registered dietician	• 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

• Registered nurse first assist (RNFA) • Speech, occupational, or physical therapist • Surgical assist (SA) • Surgical technician (ST)	• Specialty laboratory • Sub-acute behavioral health facility (including residential treatment) • Urgent care facility

Benefits may also be available from other healthcare professionals whose services are mandated by federal or Arizona law, or who are accepted as eligible by BCBSAZ.

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

Balance billing

In most cases, the provider's contract does not allow the provider to charge you more than the allowed amount for covered services. However, when there is another source of payment, such as liability insurance, all providers may be entitled to collect their balance bill from this other source (a third-party insurer), or from proceeds received from the other source, for covered services. BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan pays in-network providers for our portion of the allowed amount of a claim.

Except in emergencies, any covered service you receive from an in-network provider must be provided to you within the United States for the services to be considered in-network and subject to in-network member cost share. If you receive covered services outside the United States from an in-network provider, the services will be considered out-of-network and will be subject to out-of-network member cost share, including the full amount of the provider's balance bill (except in emergencies).

In-network Providers

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

Save money by staying in-network

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

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

Billed Charges	Allowed Amount	Costs with In-Network Providers		Costs with Out-of-Network Providers	
$1,000	$400	**You pay:**	20% of the allowed amount: **$80** (20% x $400)	**You pay:**	40% of the allowed amount, *plus* any amount not covered by BCBSAZ: $160 (40% x $400) + $600 balance bill **$760**
		BCBSAZ pays:	Remainder of allowed amount: $320 ($400 – $80)	**BCBSAZ pays:**	$240 ($400 – $160)

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

Finding an in-network provider in and outside of Arizona

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

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

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

Provider treatment decisions and disclaimer of liability

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

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

Out-of-network Providers (contracted and noncontracted)

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

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

Participating-only providers

Participating-only providers are contracted with BCBSAZ or a host Blue plan as "Participating," and are not contracted as PPO or preferred providers. Participating-only providers will submit your claims to the plan with which they are contracted. Except for emergency services, and ancillary services provided in an in-network facility, if you receive covered services from a participating-only provider, you will pay out-of-network deductible, coinsurance, and access fees. However, you will not have to pay a balance bill.

Providers contracted with BCBSAZ who are not in the plan network

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

Noncontracted providers

Eligible providers who have no provider participation agreement with BCBSAZ or any host Blue plan are noncontracted providers. Except for emergency services, and ancillary services provided in an in-network facility, if you receive covered services from an eligible noncontracted provider, you will pay out-of-network deductible, coinsurance, access fees, and the balance bill. Noncontracted providers may bill you up to their full billed charges. The difference between their billed charges and what this plan will pay can be very large. Before you receive services from a noncontracted provider, ask them about the amount of your financial responsibility.

Except for claims covered by the No Surprises Act, or unless BCBSAZ agrees to pay the provider directly, BCBSAZ will send payment to you for whatever benefits are covered under your plan and you will be responsible for paying the out-of-network provider. A noncontracted provider will not receive a copy of your EOB and will not know the amount this benefit plan paid you for the claim.

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

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

Eligible Provider Status & Payment Summary
Subject to all terms and conditions noted in this section

Provider Contract Status	Provider Network Status and Applicable Cost Share	Provider Required to File Claim on Member's Behalf?	Provider Accepts BCBSAZ Allowed Amount and Does Not Balance Bill?	Who Receives Payment?
Providers contracted with BCBSAZ as plan network providers*	In-network*	**Yes***	**Yes***	**The provider** BCBSAZ pays the provider the allowed amount, minus your cost share.
Providers contracted with another Blue Cross or Blue Shield plan ("host Blue") as PPO providers*	In-network*	**Yes***	**Yes***	**The provider** The host Blue, on behalf of BCBSAZ, pays the provider the allowed amount, minus your cost share.*
Providers contracted with host Blue as participating-only providers*	Out-of-network	**Yes**	**Yes**	**The provider** The host Blue, on behalf of BCBSAZ, pays the provider the allowed amount, minus your cost share.
Providers contracted with Blue Cross Blue Shield Global Core	Out-of-network	**Yes**	**No**	**The provider** Blue Cross Blue Shield Global Core pays the provider the allowed

				amount, minus your cost share.
Noncontracted providers for non-emergency or non-ancillary services rendered in an in-network facility—in and outside Arizona, including providers who are contracted with BCBSAZ but not for your plan network (must be eligible providers)*	Out-of-network	**No** (although the provider may choose to file the claim for you as a courtesy)	**No** You may be responsible for the provider's full billed charges. There may be a large difference between billed charges and what you can get back from BCBSAZ. Ask about billed charges before you receive services.	**You or the provider** BCBSAZ pays you or the provider the allowed amount, minus your cost share.
Noncontracted emergency service providers—in and outside Arizona (must be eligible providers)	Out-of-network	**No** (although provider may choose to file the claim for you as a courtesy)	**Yes** If the provider disputes the allowed amount, the provider must resolve the dispute with BCBSAZ directly.	**The provider** BCBSAZ pays the provider the allowed amount, minus your cost share.

**Except as noted elsewhere in this Benefit Book*

Continuing care from an out-of-network provider

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

New members

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

1. A life-threatening disease or condition, in which case the transitional period is not more than 30 days from the effective date of coverage; **or**

   Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered provider services for complications of pregnancy only; **and**

2. The member's provider agrees, in writing, to:

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

Current members

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

1. An active course of treatment means the member is:

    - Determined to be terminally ill and is receiving treatment for such illness from such provider or facility;
    - In the third trimester of pregnancy on the effective date of the provider's termination, in which case the transitional period includes the covered provider services for 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.

2. The member's provider agrees, in writing, to:

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

Out-of-area Services

Overview

BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called inter-plan arrangements. Inter-plan arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Anytime you obtain healthcare services outside of BCBSAZ's geographic service area, the claims for these services may be processed through one of these inter-plan arrangements.

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

Inter-plan arrangements eligibility—claim types

All claim types may be processed through inter-plan arrangements as described above, except for all dental care benefits (except when paid as medical claims/benefits), and any prescription drug benefits or vision care benefits that may be provided by a third party that is contracted by BCBSAZ to provide the specific service or services.

BlueCard program

Under the BlueCard program, when you receive covered services within the geographic area served by a host Blue plan, BCBSAZ will remain responsible for doing what we agreed to in the contract. However, the host Blue plan is responsible for contracting with and generally handling all interactions with its participating providers.

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

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

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

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

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

If you receive covered services under a value-based program inside a host Blue plan's service area, you will not be responsible for paying the provider for any of the provider incentives, risk-sharing fees, and/or care-coordinator fees that are part of such an arrangement, except when a host Blue plan passes these fees on to BCBSAZ through average pricing or fee schedule adjustments. Provider incentives, risk-sharing, and care coordinator fees are incorporated into the premium and/or contribution percentage members pay for coverage.

Inter-plan programs—federal/state taxes/surcharges/fees

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

Nonparticipating providers outside BCBSAZ's service area

What you pay:

When covered services are provided outside of BCBSAZ's service area by nonparticipating providers, the amount you pay for such services will normally be based on either the host Blue plan's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCBSAZ will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Exceptions:

In certain situations, BCBSAZ may use other payment methods, such as 1) billed charges for covered services, 2) the payment we would make if the healthcare services had been obtained within our service area, **or** 3) a special negotiated payment to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be responsible for paying the difference between the amount that the nonparticipating provider bills and the payment BCBSAZ will make for the covered services as set forth in this paragraph.

Blue Cross Blue Shield Global Core program

If you are outside the United States (what we call the BlueCard service area), you may be able to take advantage of the Blue Cross Blue Shield Global Core program when you receive covered services. The Blue Cross Blue Shield Global Core program is different from the BlueCard program in certain ways. For instance, although the Blue Cross Blue Shield Global Core program connects you with a network of inpatient, outpatient, and professional providers, the network is not served by a host Blue plan. So, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers at the time of service, and submit the claims to BCBSAZ yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Service Center at **1-800-810-BLUE (2583),** or call collect at **804-673-1177.** The Service Center is available 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will set up a doctor appointment or hospitalization, if necessary.

- **Inpatient services:** In most cases, if you contact the Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost share amounts. In such cases, the hospital will submit your claims to the Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. You must also contact BCBSAZ to obtain prior authorization for non-emergency inpatient services.
- **Outpatient services:** Doctors, urgent care centers, and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services.
- **Submitting a Blue Cross Blue Shield Global Core claim:** When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. The claim form is available from BCBSAZ Customer Service, from the Service Center, or online at bcbsglobalcore.com. If you need help with your claim submission, call the Service Center at **1-800-810-BLUE (2583)**. You can also call collect at **804-673-1177**, anytime, 24 hours a day, seven days a week.

Services received on cruise ships

If you receive healthcare services while on a cruise ship, you will pay your in-network cost share, and the allowed amount will be based on billed charges. A cruise ship claim is not considered an out-of-country claim. Claims should be submitted and processed through BCBSAZ, not through the Blue Cross Blue Shield Global Core program. Please call the BCBSAZ Customer Service department at the phone number listed on your ID card for more information, or mail copies of your receipts to the BCBSAZ address for cruise ship claims.

PRIOR AUTHORIZATION

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

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

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

When to Get a Prior Authorization

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

On the BCBSAZ website, you'll find a list of services that need prior authorization at azblue.com/individualsandfamilies/resources/forms and medications that need prior authorization at

azblue.com/pharmacy. You can also call Customer Service at the number on your ID card to request a prior authorization list.

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

How to Get a Prior Authorization

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

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

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

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

If you don't ask for prior authorization

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

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

Prescription medication exception

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

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

Your claim for the medication will not be denied for lack of prior authorization, but all other exclusions and limitations of your plan will apply.

Prior authorization for in-network cost share for services from an out-of-network provider

If there is no in-network provider who offers the covered services you need, your treating provider may contact BCBSAZ and ask for prior authorization for the in-network cost share for services you will receive from an out-of-network provider. BCBSAZ will first look for an in-network alternative. If we determine that an in-network provider is available to treat you, BCBSAZ will not provide prior authorization for services from an out-of-network provider.

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

Concurrent care decisions

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

When BCBSAZ Provides Prior Authorization for Your Service

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

If BCBSAZ denies your prior authorization request

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

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

Urgent requests for prior authorization

When your provider submits an urgent prior authorization request, a determination will be made as soon as possible, but no later than 72 hours after receipt of the request. Federal law defines an urgent medical situation as one that falls under one of these scenarios:

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

To appeal a denial of prior authorization for urgently needed services you have not yet received, please call Customer Service at the number on your ID card.

Part II: Managing Your Plan

MEDICAL CLAIMS

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

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

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

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

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

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

Claim Forms

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

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

- Billed charges
- Date of service
- Diagnosis code
- Member ID number
- Member name
- Name of provider
- Patient name
- Patient's birth date
- Procedure code
- Provider ID number

Time limit for claim filing

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

- When Medicare or another carrier was the primary payer on a claim where BCBSAZ was secondary payer, and the delay was caused by the need to coordinate benefits with the primary payer

- When the member can show good cause for delay. Examples of good cause:
  - BCBSAZ gave the member wrong information about the filing date
  - The member did not have legal capacity
  - The member had an extended illness that prevented them from filing the claim
  - Other similar situations outside the member's reasonable control

Other information needed to process a claim

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

Where to Send Claims

Claims for medical services:	Blue Cross Blue Shield of Arizona P.O. Box 2924 Phoenix, AZ 85062-2924
Claims for transplant travel and lodging:	Attention: Transplant Travel Claim Processor Mail Stop: 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

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

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

Explanation of Benefits and Monthly Member Health Statement

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

An EOB shows services billed, whether the services are covered or not covered, the allowed amount, and the application of cost-sharing amounts. Carefully review your EOB to make sure it shows the same amounts your provider actually bills to or collects from you. If you paid a larger cost share than you should have for a covered service, the provider will be responsible for refunding you. BCBSAZ will also send your in-network provider the information that appears on your EOB.

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

Notice of determination

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

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

Time period for claim decisions

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

ELIGIBILITY FOR BENEFITS

This eligibility section explains who is covered, when, and what to do if something changes.

You'll find an in-depth list of terms in Appendix A. It's a good place to check if you come across a word that is not familiar. Please also review the premium payment and grace period details so you don't risk losing your health coverage.

Eligibility Overview

Effective date of coverage

BCBSAZ 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 BCBSAZ.

Eligible dependents will have the same effective date as the contract holder when the dependents are listed 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 dependent's date of birth, adoption, or placement for adoption; **or**
- The date BCBSAZ assigns after approving the dependent for coverage

Eligibility requirements for dependents

The following family members can be covered as dependents under your 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 explained below under disabled dependent child
  - Legally adopted children
  - Natural children
  - Stepchildren

A child of your dependent cannot be added as a dependent on your plan unless you are the legal guardian of your dependent's child.

Adding your spouse

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

Adding a child

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 BCBSAZ in writing of the birth, adoption, or placement for adoption so that BCBSAZ can add the child to the policy. If the contract holder does not notify BCBSAZ in writing, BCBSAZ will be unaware of the birth, adoption, or placement for adoption, and will be unable to add the child to the policy.

If BCBSAZ receives written notice within 45 days after the birth, adoption, or placement for adoption, BCBSAZ will automatically add the child to the policy for the 31-day period. BCBSAZ will continue coverage for the child after the 31-day period, and you will be responsible for any additional premium, unless you notify BCBSAZ 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 BCBSAZ in writing if you wish to remove the child from the plan.

If BCBSAZ 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 BCBSAZ and request an application. The contract holder must complete the application. After receiving the contract holder's application for the child, BCBSAZ will underwrite the child for the purpose of setting a premium for the child. If the child is age 19 or older, the child also must pass medical underwriting to be accepted for coverage.

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 by 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 BCBSAZ criteria.

Medical reports, acceptable to BCBSAZ, must substantiate the incapacity and must be submitted by the contract holder within 31 days of the date such dependent child reaches age 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 BCBSAZ.

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

Benefit-specific eligibility for non-members

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

- If a transplant recipient is covered under this plan and the donor is not a BCBSAZ member, the donor may be eligible for limited benefits (see benefit descriptions for Transplants—Organ, Tissue, and Bone Marrow and Stem Cell Procedures).

- If a non-member is pregnant with a baby that is to be adopted by a member of this plan, the non-member may be eligible for benefits under Maternity—Complications of Pregnancy Only in the following circumstances:
  - The child is adopted by a member of this plan within one year of birth;
  - The member is legally obligated to pay the costs of birth; **and**
  - The member notified BCBSAZ that a court has certified the member as acceptable to adopt within 60 days of the court order or the effective date of this plan, whichever occurs later.

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

Arizona residency requirement

If you move outside of Arizona, BCBSAZ will not reissue your policy at the end of its term because you are outside of the service area in which BCBSAZ is licensed and authorized to do business. Under the transfer policy that exists between individual licensees of the Blue Cross Blue Shield Association, you will have the opportunity to apply for coverage with the Blue Cross and/or Blue Shield plan in your new state of residence. That policy will not have the same benefits or premium rates as this policy.

Third-party beneficiaries

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

Changes to Your Information

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

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

- A disabled dependent age 30 or older who is no longer disabled;
- Eligibility of you or your dependents for the Arizona Health Care Cost Containment System (AHCCCS) or other Medicaid coverage during the term of this contract;
- Eligibility of you or your dependents for Basic Health Program (BHP) coverage during the term of this contract;
- Eligibility of you or your dependents for individual coverage through 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 changes in benefits; **or**
- Your mailing address or phone number.

Child-Only Coverage

Child-only coverage is coverage that a parent or other legal guardian buys on behalf of a child for the benefits described in this plan. The parent or guardian is responsible for the child's compliance with all terms, conditions, and requirements of this plan. These include paying the premium and cost-share amounts, getting prior authorization when needed, and providing consent requirements necessary to provide plan benefits.

Child-only coverage is only available under this benefit plan in the following limited circumstances:

- The child-only policy was issued on a different BCBSAZ benefit plan on or before September 23, 2010, and the child-only coverage was transferred into this plan following transfer rules established by BCBSAZ; **or**
- • A dependent child can retain coverage on a child-only policy if *all* of the following occur:
  - An adult contract holder obtained coverage under this Plan with one or more children under age 19;
  - The adult contract holder paid premiums for the adult and dependent children;
  - The adult contract holder subsequently terminated his or her coverage under this plan; **and**
  - The children remain eligible for coverage under this plan.

No additional children may be added to a child-only policy under this plan.

Non-Duplication of Benefits

With Medicare

If you have Medicare coverage, 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, BCBSAZ coordinates the benefits available under this plan with Medicare as the primary payer. This means that 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, BCBSAZ 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. The combined total payments by Medicare and BCBSAZ will never exceed the amount a provider is permitted to bill the member under applicable Medicare law.

With secondary coverage under a BCBSAZ group plan

If you have coverage under this plan and also under a BCBSAZ group benefit plan, this plan is primary. This means that this plan pays benefits first. Payment of claims is subject to all applicable deductibles, coinsurance, and copays. Any combined benefit payments will not total more than 100% of the allowed amount under the plan offering the higher level of benefits.

With coverage under another BCBSAZ individual plan

If a member has coverage under this plan and also under one or more additional BCBSAZ individual plans, here is how and when we coordinate benefits with the other plan:

- If the member is covered as a contract holder under one individual plan and as a dependent under another individual plan, the plan under which the member is the contract holder 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 BCBSAZ 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 a BCBSAZ individual plan:
  - If a court decree specifies which parent is financially responsible for the child's health insurance expenses, that parent's coverage pays first regardless of which parent has custody.
  - 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 third, and a noncustodial stepparent's coverage pays last.
- When none of the above applies, the coverage you have had for the longest continuous period of time pays first.

BCBSAZ does not coordinate benefits for covered services provided by a retail or mail order pharmacy.

With coverage under a non-BCBSAZ plan including other BCBS plans

BCBSAZ does not coordinate coverage with non-BCBSAZ plans.

Rescission of Coverage

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

If your plan is rescinded:

- The policy is null and void for the contract holder or dependent whose coverage is rescinded, and that person has no benefits.
- The contract holder or dependent whose coverage was rescinded is responsible for all medical expenses incurred in excess of premiums paid to BCBSAZ from the date on which the policy originally went into effect.
- Any prior authorization given is null and void, as though it was never given.
- 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, BCBSAZ 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.

Termination of Coverage

BCBSAZ does not automatically terminate a contract holder or dependent when that person turns age 65 or becomes eligible for Medicare for some other reason. If you are eligible for Medicare and/or age 65 or older, BCBSAZ has other coverage options that may offer lower premium rates. Please call us for additional information. If you continue your coverage under this plan, BCBSAZ will not duplicate benefits for covered services paid by Medicare as primary payer (see Non-Duplication of Benefits).

Benefits after termination

Except as described below, you have no coverage on and after the date coverage ends, regardless of the reason for termination, with 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 received during the stay but after the date of termination will not be 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 whose coverage has been 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

If the premium is not paid within the grace period, the plan will be terminated as of 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 as of the date of the final divorce decree.
- **Adult child turning age 30:** If the child does not qualify as a disabled dependent, coverage ends on the adult child's 30th birthday.
- **Adult child over age 30:** If the adult child was previously disabled but has recovered, coverage ends as of the date the disability or incapacity ends.
- **Child covered by a qualified medical support order:** If the child is no longer eligible for coverage under a court order or administrative order, coverage ends as of the last day of the time period specified in the court order or administrative order.

If a contract holder dies, BCBSAZ will terminate the contract holder's policy and transfer any dependents to a new policy.

Involuntary termination based on misrepresentation or fraud

BCBSAZ may end your coverage with 45 days' written notice if BCBSAZ finds that your use of service or benefits or conduct under this plan involved intentional misrepresentation or fraud.

Termination under this section does not prejudice BCBSAZ from exercising any other legal rights and remedies it may have for a member's fraud.

Voluntary termination of coverage

Except as explained 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 BCBSAZ. BCBSAZ will terminate the plan on the first or 15th day of the month following BCBSAZ's receipt of the request.

YOUR RIGHTS

Your Right to Information; Availability of Notice of Privacy Practices

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

The BCBSAZ “Notice of Privacy Practices” describes how BCBSAZ may use and disclose your information to administer your health plan. It also describes some of your individual rights and BCBSAZ’s responsibilities under federal privacy regulations. BCBSAZ mails a copy of this Notice of Privacy Practices to your address shortly after you enroll for coverage with BCBSAZ. Please keep this notice with your other health plan documents. You can also view the “Notice of Privacy Practices” by visiting the BCBSAZ website, azblue.com, and clicking on the Legal link at the bottom of the home page. If you would like BCBSAZ to mail you another copy of the “Notice of Privacy Practices,” please call the Customer Service number on your ID card, or call **602-864-4400** or **1-800-232-2345** to make your request.

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 。

APPENDIX A: TERMS TO KNOW

Allowed amount	The amount a provider receives as payment for a covered service. The allowed amount includes both the BCBSAZ payment and your cost share (see definition). BCBSAZ calculates your coinsurance amount and how much applies toward your deductible based on the allowed amount, less any access fees or prior authorization charges. The allowed amount does not include any balance bills from noncontracted providers. The allowed amount isn't tied to the amounts providers in a given area usually charge for their services. If the allowed amount is based on a fee schedule (see table below), a change to the fee schedule may result in a higher member cost share.

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

Type of Provider	Type of Claim	How We Determine the Allowed Amount
Providers contracted with BCBSAZ as plan network providers	Emergency and non-emergency	We compare the provider's billed charges to the applicable fee schedule, and generally use the lower of the two amounts. Then, we adjust the amount as needed to meet the contractual arrangements we have made with the provider, as well as to comply with certain operational guidelines.
Providers contracted with a third party (vendor)	Emergency and non-emergency	We compare the provider's billed charges to the vendor's fee schedule, and generally use the lower of the two amounts. Then, we adjust the amount as needed to meet our contractual arrangements with the vendor.
Providers contracted with another Blue Cross or Blue Shield plan ("host Blue")	Emergency and non-emergency	We compare the provider's billed charges to the price the host Blue plan has negotiated with the provider. The allowed amount will be the lower of the two amounts.
Noncontracted providers in Arizona, including providers contracted with another BCBSAZ network, but not contracted as a plan network provider for this benefit plan	Non-emergency claims and emergency ground ambulance claims	We compare the provider's billed charges to the applicable BCBSAZ fee schedule (with adjustments for certain operational guidelines). The allowed amount will be the lower of the two amounts. For emergency ground ambulance claims, the allowed amount is based upon the ambulance provider's billed charges.
Noncontracted providers outside Arizona	Non-emergency claims	We compare the provider's billed charges to the amount the host Blue normally pays for a local nonparticipating provider. The allowed amount will be the lower of these two amounts. If the host Blue has not set an amount it normally pays for a nonparticipating provider, we may then base the allowed amount on the applicable fee schedule with adjustments for certain operational guidelines.
Noncontracted ground ambulance providers, including providers contracted with another BCBSAZ network, but not contracted as a plan network provider for this benefit plan, in and outside Arizona	Emergency	The allowed amount is based upon the ambulance provider's billed charges.
Noncontracted providers in an in-network facility in and outside Arizona	Non-emergency and non-ancillary	The Qualifying Payment Amount, as defined by federal law, is the allowed amount. If you sign a consent for a noncontracted provider to perform services at an in-network facility, you are responsible for the difference between the

		Qualifying Payment Amount and the provider's billed charges.
Noncontracted providers, excluding air ambulance, in and outside Arizona	Emergency	The Qualifying Payment Amount, as defined by federal law, is the allowed amount.
Noncontracted air ambulance providers in and outside Arizona	Emergency and non-emergency	We compare the provider's billed charges to the applicable BCBSAZ fee schedule (with adjustments for certain operational guidelines). The allowed amount will be the lower of the two amounts. The member's cost share will be based on the lesser of the provider's billed charges or the Qualifying Payment Amount, as defined by federal law.

Ancillary services	Ancillary services include emergency medicine, anesthesiology, pathology, radiology, neonatology, certain laboratory services, or as otherwise required by law.
Balance bill	The difference between a noncontracted provider's billed charges and the allowed amount. In-network providers will accept the allowed amount for covered services. Except for emergency services, and ancillary services provided in an in-network facility, noncontracted providers have no obligation to accept the allowed amount. You are responsible for paying a noncontracted provider's billed charges, even though BCBSAZ will reimburse you for approved claims based on the allowed amount. Depending on what billing arrangements you make with a noncontracted provider, they may charge you for full billed charges at the time of service, or send you a balance bill for the difference between billed charges and the amount that BCBSAZ reimburses you. Any amounts paid for balance bills do not count toward the deductible, coinsurance, out-of-pocket coinsurance maximum, or out-of-pocket maximum.
Bariatric surgery	A surgical procedure to promote weight loss for the treatment of morbid obesity. Bariatric surgery also includes any revisions to a prior bariatric surgical procedure.
Base Benefit Book	This document (see also Benefit Book and benefit plan).
BCBSAZ	Blue Cross Blue Shield of Arizona, when we are the issuer of the insurance coverage, as well as when we are the administrator of a benefit plan. Within this book, BCBSAZ also may include contracted vendors, when a contracted vendor is performing functions on behalf of BCBSAZ. Blue Cross Blue Shield of Arizona is an independent licensee of the Blue Cross Blue Shield Association. BCBSAZ is a not-for-profit corporation organized under the laws of the state of Arizona as a hospital, medical, dental, and optometric services corporation, and is authorized to operate a healthcare services organization as a line of business.
Behavioral health benefits	Benefits for services to treat behavioral health conditions that are classified as behavioral health conditions based on generally recognized independent standards of current mental health, including the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or the most current version of the International Classification of Diseases (ICD).
Benefit Book	Your Base Benefit Book plus your Plan Attachment and any rider(s).
Benefit plan or plan	The contract of insurance between an individual member and BCBSAZ. Your benefit plan includes: • This book and any Plan Attachment; • The Summary of Benefits and Coverage (SBC); • Your application for coverage, any waivers issued in connection with your benefit plan; • Any plan that is issued to replace this plan; **and** • Any rider, amendment, or modification to this plan, including, but not limited to, any changes in deductible, coinsurance, or copay amounts. Changing deductible options within a product does not constitute a new plan.

Billed charges	For a provider that has a participation agreement governing the amount of reimbursement, the term billed charges refers to the amount the provider normally charges for a service. For a provider that does not have a participation agreement governing the amount of reimbursement, billed charges refers to the lowest amount that the provider is willing to accept as payment for a service.
Blue Distinction	A national designation awarded by Blue Cross Blue Shield (BCBS) plans to recognize providers that demonstrate expertise in delivering quality specialty care that is safe, effective, and cost-efficient.
Cancer treatment medication	Prescription drugs and biologicals that are used to kill, slow, or prevent the growth of cancerous cells.
Caregiver	The person primarily responsible for providing daily care, basic assistance, and support to a member who is eligible for transport, lodging, and reimbursement.
Chiropractic Benefits Administrator (CBA)	The CBA is an independent company that develops and manages the BCBSAZ network of chiropractic providers, processes chiropractic claims, determines medical necessity, and handles utilization management, grievances, and appeals related to chiropractic services. The CBA for BCBSAZ is a company called American Specialty Health Networks, Inc.
Coinsurance	The percentage of the allowed amount that you pay when you receive a covered service (after meeting your deductible). BCBSAZ subtracts any applicable access fees and prior authorization charges from the allowed amount before calculating coinsurance. Coinsurance applies to every covered service unless the specific benefit section says it does not apply. In most cases, your coinsurance percentage is higher when you use an out-of-network provider. While BCBSAZ normally uses the allowed amount to figure out your coinsurance amount, there is an exception: If a hospital provider's billed charges are less than the hospital's reimbursement, BCBSAZ will calculate your coinsurance based on the lesser billed charge.
Complications of pregnancy	A medical illness or sickness that is separate from the pregnancy but is made worse by the pregnancy or caused by the pregnancy, and is considered to be life- or health-threatening to the mother and/or fetus. Complications of pregnancy are determined by BCBSAZ based on evidence-based criteria.
Compounded medications	Medications that contain at least one FDA-approved component and that are custom-mixed by a pharmacist.
Contract holder	The person to whom a benefit plan is issued. • For individual coverage, this is the person who signs the application for coverage and in whose name the benefit plan/policy is issued. • For family coverage, this is the person who signs the application on behalf of himself or herself plus any dependents included on the policy • For child-only coverage, this is the parent or legal guardian of the child covered under the benefit plan, who has signed the application on behalf of the child.
Copay or copayment	The amount you pay your healthcare provider when you receive certain covered services. Different services may have different copay amounts. The Plan Attachment we sent along with this Base Benefit Book tells you which services have a copay, and what the amount is. Usually, if a copay does not apply, you will have a deductible and/or coinsurance to pay.
Cosmetic	Surgeries, procedures, treatments, and other services performed primarily to enhance or improve appearance, including, but not limited to (and except as otherwise required by federal or state law), those surgeries, procedures, treatments, and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological, or mental condition or function.
Cost share	The total amount you owe for a covered service. Depending on your plan type, your cost share may include one or more of the following: deductible, copay, coinsurance, access fee, or prior authorization charge.

Coverage limit	A limit that applies to a specific benefit. The limit may be based on the number of days or visits, a type of service, timeframe (calendar year), age, gender, or other factors. If you reach a coverage limit, depending on the specific benefit, no further services may be covered, and you may have to pay the provider's billed charges for those services. However, if you reach the coverage limit on a particular line of a claim, you will be responsible for paying only up to the allowed amount for the remaining charges on that line of the claim. All coverage limits are described in Your Health Plan Benefits, along with the benefit they apply to.
Covered service	A medically necessary healthcare service or item that is a benefit of your health plan. Covered services are listed in the Your Health Plan Benefits section of this book.
Custodial care	Health services and other related services that: • Are for comfort or convenience; • Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition, or other self-care; • Are provided when acute care is not required or does not require continued administration by licensed skilled medical personnel, such as an LPN, RN, or licensed therapist; **or** • Do not seek to cure.
Deductible	The amount you pay toward covered healthcare services each calendar year before BCBSAZ begins to pay its share. The deductible applies to every covered service unless otherwise specified. The deductible is calculated based on the allowed amount. Amounts you pay for copays and access fees do not count toward the deductible. 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. Your deductible amount is listed in the enclosed Plan Attachment, as well as in your SBC document.
Dependents	The contract holder's spouse, under a legally valid, existing marriage; **and** The contract holder's children or the children of the contract holder's spouse, including natural children, legally adopted children, stepchildren, children placed for adoption, children under legal guardianship substantiated by a court order, and children who are entitled to coverage under a medical support order.
Designated prescription network program	A program that requires certain members who take certain medications to get prescriptions for those covered medications from one designated eligible provider, and to get all medications designated by BCBSAZ or the PBM from one network pharmacy or provider. BCBSAZ or the PBM determines which members are required to participate in this program.
Disabled dependent child	A child who has reached age 30 and who meets criteria for coverage under this plan as described in the eligibility overview.
Doctor or physician	For purposes of classifying benefits and member cost shares in your plan, we use the terms doctor and physician to mean a properly licensed MD, DO, DPM, or DC.
Domiciliary care	A supervised living arrangement in a home-like environment for people who are unable to live on their own because they need assistance with the activities of daily living, such as bathing, dressing, and food preparation.
Emergency medical condition	A medical or behavioral health condition that appears suddenly with severe symptoms (such as severe pain, unconsciousness, or other serious symptom). The condition is one that would make the average person with a basic understanding of health and illness think that failing to get immediate medical attention would result in *any* of the following: • Harm to the member or others; • Permanent disability; • Serious impairment to a bodily function or part; **or** • Serious jeopardy to the patient's health, including mental health.

Evidence-based criteria	Medical, pharmaceutical, dental, and administrative criteria that are based on industry-standard research and technology. These criteria help BCBSAZ determine whether a service, procedure, device, or drug meets the industry standard for medical necessity and/or is a covered benefit. Criteria may include prescription medication or service limitations. BCBSAZ ensures that evidence-based criteria are reviewed regularly and updated in response to changes and advancements in the healthcare industry. Decisions are based on the evidence-based criteria in effect at the time of service. A BCBSAZ contracted vendor may establish evidence-based criteria for services they provide or administer as stated in the vendor's contract with BCBSAZ. You can get more information about the criteria by calling the Customer Service number on your ID card.
Fee schedule	A proprietary schedule of provider fees collected and put together by BCBSAZ. BCBSAZ develops its fee schedule based on annual reviews of information from numerous sources, including, but not limited to: • Medicare fee schedules from the Centers for Medicare and Medicaid Services (CMS) • BCBSAZ's past claims experience • Other pricing information that may be available to BCBSAZ • Information and comments from providers • Negotiated contractual arrangements with providers BCBSAZ may change its fee schedule at any time without prior notice to members. If the allowed amount for a service is based on a fee schedule, a change to the fee schedule may result in higher member cost share for that service.
Gender-affirming care	Treatment for gender dysphoria, including hormone replacement therapy and testing to monitor safety, psychotherapy, surgical treatment, and other medical services required by federal or state law.
Generic medications	Medications defined as generic by the national database system used by BCBSAZ to pay prescription claims.
In-network provider	A doctor, hospital, outpatient surgery center, pharmacy, lab, or other professional or place that belongs to the network that serves members of your health plan.
Maintenance medications	Medications taken on an extended and continual basis for treatment of a chronic or ongoing health condition, and which are not subject to frequent dosage or other changes, all as determined by BCBSAZ or the PBM. BCBSAZ and/or the PBM ("BCBSAZ/PBM") may designate or use national databases to designate certain medications as maintenance medications.
Medical/surgical benefits	Benefits for services to treat medical conditions that are classified as medical/surgical based on generally recognized independent standards of current medical practice, including the most current version of the ICD.
Medication synchronization	If you are taking two or more medications for a chronic condition, and the medications are being dispensed by a single network pharmacy, the pharmacy may synchronize them for you. This means they can put the refills for these medications on the same schedule, so that you always have them filled at the same time. In order to begin medication synchronization, the pharmacy may need to have BCBSAZ approve what is called a short refill.
Member	An individual, employee, participant, or dependent covered under a benefit plan.
Occupational therapy	Treatment of *neuromusculoskeletal dysfunction* (injuries or disorders of the musculoskeletal system, such as muscles, tendons, ligaments, nerves, discs, and blood vessels) using specific tasks or goal-directed activities to improve functional performance.
Out-of-network provider	A doctor, clinic, hospital, or other healthcare provider that is not a part of any BCBSAZ plan network.

Out-of-pocket coinsurance maximum (individual)	For plans other than a high deductible health plan, this is the amount each member pays as coinsurance each calendar year before the plan begins paying 100% 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. You have separate out-of-pocket coinsurance maximums for in-network and out-of-network providers. Accruals toward the out-of-pocket coinsurance maximum are generally calculated on a calendar year and not on your policy year. The following types of payments do not count toward the out-of-pocket coinsurance maximum. You must keep paying for the following even after you reach your out-of-pocket coinsurance maximum: • Amounts above the maximum allowed for a specific benefit (coverage limits are included in Your Health Plan Benefits) • Amounts for medical foods • Any amounts for balance billing • Any amounts for noncovered services • Any charges for lack of prior authorization (see prior authorization below) • Copays for covered medications, including specialty medications • Coinsurance for days 61-120 of inpatient rehabilitation services in a calendar year* • Coinsurance for days 91-180 of skilled nursing facility services in a calendar year* • Coinsurance for 101 or more days of long-term acute care services* • Access fee, copay, and deductibles *Coinsurance for services submitted with a primary behavioral health diagnosis counts toward the out-of-pocket coinsurance maximum. See your Plan Attachment for any other types of payments that may not count toward the out-of-pocket coinsurance maximum for your specific plan.
Out-of-pocket maximum (individual and family)	For high deductible health plans, this is the amount you pay each calendar year before the plan begins paying 100% of the allowed amount (on most covered services) for the remainder of the calendar year. BCBSAZ applies deductible, coinsurance, and access fees toward any out-of-pocket maximum that applies to the member's benefit plan. You are still responsible for other types of cost-share payments, even after you have met your out-of-pocket maximum. You have separate out-of-pocket maximums for in-network and out-of-network providers. Accruals toward the out-of-pocket maximum are calculated on a calendar year, and not on your policy year. The following types of payments do not count toward the out-of-pocket maximum. Other than the deductible, which you have to meet before coinsurance applies, you must keep paying for the following even after you reach your out-of-pocket maximum: • Amounts above the maximum allowed for a specific benefit (coverage limits are included in Your Health Plan Benefits) • Any amounts for balance billing • Any amounts for noncovered services • Any charges for lack of prior authorization (see prior authorization below) If you have family coverage, there is an out-of-pocket maximum for each individual member as well as for your family. Amounts applied to each member's out-of-pocket maximum also apply to the family out-of-pocket maximum. The family maximum is applied in the same way as the individual maximum described above and is subject to the same rules. When the family has met its family out-of-pocket maximum, it also satisfies the out-of-pocket maximum requirements for all the individual members.
PBM	The independent Pharmacy Benefit Manager that contracts with BCBSAZ to administer the prescription medication benefits covered under this benefit plan.
Pharmacy coverage guidelines	Pharmaceutical and administrative criteria that are developed from review of published peer-reviewed medical and pharmaceutical literature and other relevant information and are used to help determine whether a medication or other products such as devices or supplies are eligible for benefits under the Pharmacy benefit.

	Pharmacy Coverage Guidelines are available online at azblue.com/pharmacy. The guidelines are also available by calling the number for Pharmacy Benefit Customer Service number on your ID card.
Physical therapy	Treatment of disease or injury using therapeutic exercise and other measures to improve posture, locomotion, strength, endurance, balance, coordination, range of motion, flexibility, and ability to perform activities of daily living, and to help reduce pain.
Plan Attachment	A document sent with your Base Benefit Book that includes cost-sharing provisions (terms). See your ID card for the name of the plan network for this benefit plan.
Plan network	The network of providers contracted to provide services to members of this benefit plan. Plan network providers also are referred to as in-network providers. See your ID card for the name of your plan network.
Policy year	The 12-month period that starts on your policy's effective date. It is not always the same as a calendar year. Your policy year is listed at the top of your SBC, and may be called *coverage period.*
Preventive services	Services provided for screening purposes when a member does not have active signs or symptoms of a condition.
Primary Care Provider (PCP)	A healthcare professional who is contracted with BCBSAZ as a PCP and generally specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, pediatrics, or any other classification of provider approved as a PCP by BCBSAZ. Your benefit plan does not require you to have a PCP, or to see a PCP for a referral before seeing a specialist.
Prior authorization	A review done by BCBSAZ to approve a service, treatment plan, doctor visit, or medication before you make the appointment or fill the prescription. Some services and medications require this review in order for the service or medication to be covered under your plan. If an out-of-network provider does not get a prior authorization from BCBSAZ for a service that requires it, you are subject to either a prior authorization charge or a complete loss of benefit. If you have to pay a prior authorization charge, it does not count toward the calendar-year deductible, out-of-pocket coinsurance maximum, or out-of-pocket maximum.
Provider	Any properly licensed, certified, or registered person or facility furnishing medical care to you, such as a doctor, hospital, laboratory, or other health professional. A provider can be related to a member.
Rehabilitation services	Services that help a person restore skills and functioning for daily living that have been lost due to injury or illness.
Respite care	The provision of short-term, temporary relief of the daily routine and stress to provide those who are caring for family members a personal break from their role as caregiver.
Service	A generic term referencing any type of healthcare treatment, test, procedure, supply, medication, technology, device, or equipment.
Short refill	A prescription refilled with less medication than usual.
Specialist	A doctor or other healthcare professional who practices in a specific area other than those practiced in by PCPs, family doctors, and other general practitioners; or a properly licensed, certified, or registered individual healthcare provider whose practice is limited to rendering behavioral health services. For purposes of cost share, this definition of the term specialist does not apply to dentists. Your benefit plan does not require you to get a referral from a PCP before you see a specialist.
Specialty medications	Medications that treat chronic or complex conditions. BCBSAZ/PBM determine which medications are specialty medications.
Specialty pharmacy	A pharmacy contracted with BCBSAZ/PBM to fill member prescriptions for specialty medications.
Speech therapy	Treatment of communication impairment and swallowing disorders.
Step therapy	A program that requires members to first try the generic version of a certain medication before BCBSAZ or the PBM will consider covering the brand-name version of that medication. BCBSAZ/PBM determines which medications are part of the step therapy program. **Note:** Certain medications are not considered to be medically necessary (and therefore are not covered) unless you are participating in a step therapy program.

Summary of Benefits and Coverage (SBC)	A federally required document with information on access fees, coinsurance percentages, copays, deductible amounts, other cost-sharing amounts, benefits, exclusions, limitations, and other important information.
Telehealth Services Administrator (TSA)	Amwell, an independent company that is contracted with BCBSAZ to offer members the services of contracted healthcare providers over an interactive web platform or app. Amwell also provides technical support for the telehealth services (i.e., BlueCare Anywhere) covered under this plan.
Telehealth services from BlueCare Anywhere	Medical and behavioral health services provided online via video using a computer, tablet, smartphone, or other mobile device through the telehealth services administrator. BlueCare Anywhere is BCBSAZ's telehealth service.
Telehealth services from in-network providers	Services delivered through interactive qualified electronic media.
Treating provider	A provider you are currently seeing for a particular health concern or condition.
Urgent care	Treatment for conditions that require prompt medical attention, but which are not emergencies.

APPENDIX B: OTHER HEALTH PLAN DETAILS

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

Access to information about dependent children

BCBSAZ does not take part in domestic disputes. Parental disputes over dependent coverage and information must be resolved between the parents of the dependent child. Under Arizona law, both parents have equal rights to information about their children, unless a court order denies such access. Without a copy of such order and subject to the confidentiality provisions described below, BCBSAZ provides equal parental access to information.

Appeal and grievance process

Members may participate in BCBSAZ's appeal and grievance processes, which are described in detail in the BCBSAZ Appeal and Grievance Guidelines. You can find these guidelines in your MyBlue account. You can also call Customer Service at the number on your ID card to ask for a printed copy. You do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ.

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

If you receive a bill from an out-of-network provider for services provided at an in-network facility and want to dispute the amount of the bill, you may be able to initiate a dispute resolution process as defined under Arizona law. This process is not available for all balance bills. Call Customer Service at the number on your ID card for information on any of the following:

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

Basis of operational guidelines

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

Billing limitations and exceptions

When there is another source of payment, such as a liability insurer, in-network providers may be entitled to collect any difference between the allowed amount and the provider's billed charges from the other source or from proceeds received from the other source, pursuant to A.R.S. (Arizona Revised Statute) § 33-931. A.R.S. § 33-931 may give providers medical lien rights apart from this benefit plan or any contract with BCBSAZ. BCBSAZ will not be involved with any collection dispute that may arise under the provisions of A.R.S. § 33-931.

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

Blue Cross Blue Shield Association

This paragraph shall not create any additional obligations whatsoever on the part of BCBSAZ other than those obligations created under other provisions of this agreement. The contract holder, on behalf of self and all dependent members, expressly acknowledges and agrees that:

- This agreement is a contract solely between the contract holder and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross Blue Shield Association (Association), an association of independent Blue Cross and Blue Shield plans, permitting BCBSAZ to use the Blue Cross and/or Blue Shield service marks in the state of Arizona;
- BCBSAZ is not contracting as the agent of the Association;
- 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 BCBSAZ; **and**
- Contract holder and members shall not seek to hold the Association or any Blue Cross or Blue Shield plan other than BCBSAZ accountable or liable for BCBSAZ's obligations created under this agreement.

Broker commissions

BCBSAZ sells products either directly or through independent licensed insurance brokers. Commission payments to brokers are one of the costs factored into premiums, but BCBSAZ's premium calculation is not based on whether a product is sold directly or by a broker. BCBSAZ generally pays a commission to the broker of record or legal assignee designated by the broker until the insurance contract is terminated, the contract holder terminates his or her relationship with the broker and notifies BCBSAZ, or the broker becomes ineligible for receipt of commissions. Brokers are required under their agreement with BCBSAZ to provide information on commission rates with BCBSAZ. For more detailed information about broker commissions and compensation to BCBSAZ employees who are licensed sales representatives for BCBSAZ Individual products, visit azblue.com or call BCBSAZ at 602-864-4021.

Confidentiality and release of information

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

Cost of records

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

Court orders for health insurance coverage of dependent children

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 meets BCBSAZ 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 BCBSAZ.

To obtain coverage for the child, the contract holder must submit an application. After receiving the contract holder's application for the child, BCBSAZ will underwrite the child for the purpose of setting a premium for the child. If the child is age 19 or older, the child must pass medical underwriting to be accepted for coverage. If BCBSAZ accepts the child for coverage, coverage will not be effective until the date assigned by BCBSAZ. 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.

The contract holder acknowledges and agrees that the contract holder will not cancel coverage for a minor child whose coverage is mandated by court or administrative order unless the contract holder provides BCBSAZ 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.

Discretionary authority

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

Experimental or investigational services

BCBSAZ or BCBSAZ's contracted vendor, in its sole and absolute discretion, decides whether a service or item is experimental or investigational. If a service or item meets *all* of the following criteria, it is **not** considered experimental or investigational:

- It is possible for the service or item to result in improvement outside the investigational setting;
- The scientific evidence permits conclusions concerning the effect of the service or item on health outcomes;
- The service or item is as beneficial as any established alternative;
- The service or item has final approval from the appropriate governmental regulatory bodies (unless otherwise required by applicable law, final approval of a regulatory body does not, in and of itself, qualify a service or item for coverage), if applicable; **and**
- The service or item improves the net health outcome.

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

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

Identity protection services

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

Increasing your deductible or changing your BCBSAZ plan

To see what your options are for increasing your deductible or changing your BCBSAZ plan, visit MyBlue or contact Customer Service. In order to make some changes, you will need to complete a new application. BCBSAZ has sole discretion to decide whether or not to approve a request to increase your deductible. After BCBSAZ processes a request for a higher deductible, claims for dates of service after the change date are paid based on the new deductible or plan. If the deductible or plan is changed on a date other than January 1, amounts paid toward the previous plan deductible during the calendar year may be credited toward the new

deductible, depending on the type of plan selected. Any plan or deductible changes approved by BCBSAZ will take effect at the beginning of your next billing cycle.

Lawsuits against BCBSAZ

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

Under Arizona's Health Care Insurer Liability Act, before suing BCBSAZ, a member must first either:

- Complete all available levels of the BCBSAZ appeal process; **or**
- Give BCBSAZ written notice of intent to sue at least 30 days before filing the lawsuit.

The written notice must clearly explain the basis for the lawsuit, and must be sent by certified mail to:

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

Failure to follow these steps may result in dismissal of the lawsuit. A member must complete all applicable levels of appeal before bringing a lawsuit other than a suit filed pursuant to the Health Care Insurer Liability Act. Failure to complete the mandatory levels of the appeal process may result in dismissal of the lawsuit for failure to exhaust BCBSAZ's administrative remedies (that is, for not using all of our available solutions). By providing this notice, BCBSAZ does not waive but expressly reserves all applicable defenses available under federal and Arizona law.

Legal action and applicable law

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

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

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

Medicaid reimbursement

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

Medical necessity definition, guidelines, and criteria

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

- It is consistent with the diagnosis or treatment of a symptom, illness, disease, or injury;
- It is not primarily provided for the convenience of a member or a provider;

- It is the most appropriate site, supply, or service level that can safely be provided; **and**
- It meets BCBSAZ's or its contracted vendor's medical necessity guidelines and criteria in effect when the service gets prior authorization or is rendered. If no such guidelines or criteria are available, BCBSAZ or its contracted vendor will base its decision on the judgment and expertise of a medical professional or medical consultant retained by BCBSAZ or the vendor.

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

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

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

Decisions about medical necessity may differ from your provider's opinion. A provider may prescribe, order, recommend, or approve a service that BCBSAZ decides is not medically necessary and, therefore, is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered. If you have an adverse determination, refer to the Explanation of Benefits and Monthly Member Health Statement and the Appeal and grievance process sections.

Also, not all medically necessary services are covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A service may be medically necessary and still not be covered (see the What's Covered section).

Member notices and communications

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

Non-assignability of benefits

Except as otherwise specified in this section, the benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer, or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against BCBSAZ and imposes no duty or obligation on BCBSAZ. If you receive covered services from an out-of-network provider and wish to assign your right to payment to the provider, you or the provider may submit the documents requesting assignment to BCBSAZ. BCBSAZ, at our sole discretion, will determine whether to honor the assignment and, if approved, remit any payment due directly to the provider.

No Surprises Act

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

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

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

cms.gov/nosurprises

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

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

Payments made in error

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

Plan amendments/changes

There is no guarantee that the benefits listed here will not change. Benefits be added, deleted, or changed upon notice to the contract holder and/or participant or as required according to federal or state laws.

BCBSAZ will give you 60 days' advance written notice of major changes to this plan. Changes include retroactive changes that are permitted under federal or state laws. Please review and retain this book, replacement books, plan attachments, SBCs, riders, amendments, and other communications concerning your coverage.

Premium change notice

BCBSAZ will provide you with notice of any change to your premium in accordance with applicable federal and state law. If your premium changes due to family size, age, or other factors after BCBSAZ sends you an initial notice of a premium change, your premium may be further adjusted in accordance with that change in family size, age, or other factors.

Premium determination

For a contract holder of age 19 or older and their spouse of age 19 or older:

- The contract holder, spouse, and any dependents age 19 or older must meet BCBSAZ medical underwriting guidelines. Each applicant is evaluated and assigned a rate based on the results of the underwriting process.
- Premiums vary for each deductible level within a product.
- Premiums vary based on the contract holder's and spouse's age and gender and the contract holder's county of residence.
- BCBSAZ applies an additional premium to rates for smokers.
- When a member on a child-only contract turns age 19, the member's premium is automatically adjusted to an adult rate on the next billing date following the member's 19th birthday. All other premium changes due to a change in a member's age class will be effective on the member's annual renewal date. Information on premiums including age classes are available upon request from BCBSAZ.
- The premium may also change when the contract holder changes his or her county of residence, changes the deductible level of their plan, or changes to a different BCBSAZ plan.

For children covered as dependents:

- Adult children ages 19-29 must meet BCBSAZ medical underwriting guidelines to be eligible for coverage as dependents under this benefit plan. Dependent children under age 19 must be underwritten, but the results of the underwriting will not be a factor in determining eligibility for coverage. Underwriting results will only be used to establish the premium.
- Premiums vary for each deductible level within a product. Premiums also vary based on the contract holder's county of residence. Premiums do not vary based on the age of a child covered as a dependent.
- BCBSAZ applies an additional premium to rates for smokers.

- The premium may change when the contract holder changes his or her county of residence, changes the deductible level of their plan, or changes to a different BCBSAZ plan.

For a contract holder age 18, a spouse under age 19, children under age 19 covered as dependents, and a child only under age 19:

- Applicants will not be denied coverage due to a medical condition.
- Applicants under age 19 must be underwritten, but the results of the underwriting will not be a factor in determining eligibility for coverage. Underwriting results will only be used to establish the premium.
- Premiums vary for each deductible level within a product.
- Premiums vary depending on the contract holder's county of residence.
- Premiums will change and will vary by age when the contract holder or spouse reaches age 19.
- Premiums for children under age 19 who are covered as dependents do not vary by age.
- Premiums for children under age 19 who are covered under a child-only policy do vary by age.
- BCBSAZ applies an additional premium to rates for smokers.
- When a child covered by a child-only policy reaches age 19, the child is automatically considered an adult contract holder and the section above regarding premiums for contract holders age 19 and older applies.
- The premium may change when the contract holder changes his or her county of residence or changes deductible levels or products.

Child-only policies are available only under limited circumstances. See Child-Only Coverage.

Premium payment grace period

If you do not pay your premium by the premium due date, BCBSAZ allows you a 31-day grace period to make the payment. BCBSAZ is not responsible or liable for claims incurred during the grace period, unless BCBSAZ 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.
- If no payment is received by the end of the grace period, the plan will terminate as of the date the premium was originally due.
- Any services you received during the grace period will not be covered if the plan terminates.
- If BCBSAZ 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 during the grace period if the plan is later retroactively terminated for non-payment of premium.

If this plan is terminated for non-payment of premium, the contract holder may request reinstatement. BCBSAZ has sole discretion and authority as to whether to allow reinstatement. If reinstatement is not granted, the contract holder must reapply for coverage and qualify under BCBSAZ's medical underwriting guidelines. The same coverage may not be available. If the application is approved, members are subject to the applicable waiting periods, deductibles, out-of-pocket coinsurance maximums, and out-of-pocket maximums required under the new plan.

Premium payments

You pay premiums monthly. Premium payments must be made to BCBSAZ 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. BCBSAZ mails a premium notice to the contract holder before each due date (unless you signed up for Sure Pay). Regardless of whether or not you receive a notice, BCBSAZ will not continue the plan unless BCBSAZ receives your payment within 31 days after the premium due date. This 31-day period is called the grace period.

Premium payments by third parties

You are responsible for making your premium payment. BCBSAZ 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; state and federal government programs; or family

members. If we learn that an unauthorized third party paid your premium, BCBSAZ may reject the payment, and the premium will remain due.

Prescription medication rebates

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

The rebates BCBSAZ receives on your prescription drug utilization are not reimbursable to you, including prescription costs applied to any copay, deductible, coinsurance calculation, out-of-pocket coinsurance maximum, or out-of-pocket maximum that may apply under your plan. You acknowledge and agree that BCBSAZ will keep all rebates. Pharmacy rebates may cause the overall cost of a drug to fall below the amount you pay for that drug under the coverage described in this benefit plan. Other discount programs offered by a pharmacy may result in members of the public paying a lower cost for some medications than you pay under this benefit plan.

Provider contractual arrangements

The BCBSAZ allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors. For that reason, BCBSAZ in-network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate. This means that your in-network cost share for a particular service can vary based on the in-network provider you choose because not all providers have the same negotiated reimbursement rate for the same service.

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

Release of records

Subject to federal or Arizona law, the member agrees that BCBSAZ may obtain, from any provider, insurance company, or third party, all records or information relating to the member's health, condition, treatment, prior health insurance claims, or health benefit program. If you haven't released all of the records we need in order to process a claim, we may deny the claim.

Retroactive changes

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