

Individual HMO ACA Health Choice Off Marketplace Base Benefit Book

Plans: Core Value and Everyday Copay

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

azblue.com/member

Welcome!

Thank you for making Blue Cross® Blue Shield® of Arizona (AZ Blue) 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.

New members

Take some time to read through this book and any supporting documents when you receive them. If this benefit plan does not meet your needs for any reason, you may cancel your policy by sending AZ Blue written notice of cancellation **within 10 days of receiving this book or notification that it's been posted to your member portal.** You may also contact AZ Blue to talk about your other AZ Blue plan options. If you choose to cancel the plan, and you prepaid any premium, AZ Blue will refund that premium and cancel the contract for your benefit plan as though it was never in effect.

Renewing members

If you are a current AZ Blue member and want to cancel this plan, please follow the instructions in the Termination of Coverage section of this book.

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

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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/member. 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 AZ Blue has agreed to pay for a covered service. The allowed amount includes both the AZ Blue 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, AZ Blue 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, 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 AZ Blue 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, AZ Blue 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.

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. This plan covers services from out-of-network providers only for services that have received prior authorization, emergencies, urgent telehealth services, eosinophilic gastrointestinal disorder (EGID) formula, and medical foods.
Out-of-pocket maximum	The amount you pay each calendar year before the plan begins paying 100% of the allowed amount (on most covered services) for the remainder of the calendar year. The following types of payments do not count toward the out-of-pocket maximum: amounts for noncovered services 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.
Prior authorization	A review done by AZ Blue to approve a service, treatment plan, doctor visit, or medication before you make the appointment or fill the prescription. Some services and medications require this review in order for the service or medication to be covered under your plan.

Discover Your Care Choices

Who to see or call …	**When you need …**	**How to use …**
AZ Blue plan network providers	Routine and specialty care	Log in to your AZ Blue portal account and click "Find a Doctor." You can search by name, type, or location.
Telehealth from AZ Blue	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.	Telehealth from AZ Blue is available through the telehealth services administrator (TSA). Just log in to your AZ Blue portal account, click "Find Care," then "Telehealth" to start your visit on any device.
Urgent care center	Treatment for conditions that require prompt medical attention	Log in to your AZ Blue portal account, 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.

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 AZ Blue 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 AZ Blue website, you'll find prior authorization lists for:

- Medical services at azblue.com/priorauthorizationlist
- 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 portal account. Set up your account today at azblue.com/member so you can: • Access your digital ID card • View and track claims and deductibles • Pay your monthly premium • Find doctors, hospitals, or other healthcare providers in your plan's network using the "Find a Doctor" tool • 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") • 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 – Ordering an ID card: 602-864-4115 (within Phoenix Metro area) 1-800-232-2345, ext. 4115 (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 from AZ Blue (provided by the TSA): 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! You can always access your ID card digitally.

1. **Access your digital ID card:** Members can access their ID card 24/7 in the member portal.
2. **Mobile wallet:** Member credentials can be added to a mobile wallet for both Android and Apple® devices.
3. **Print your ID card:** Members can log in to their AZ Blue portal at azblue.com/member to print their ID card.

4. **Email your ID card:** Email your member ID card right from your member portal to trusted emails.
5. **Member verification:** Members can give their ID number, full name, and date of birth to the provider, who can then use this information to verify eligibility.

Prefer a physical card? Order one through your member portal or call us at the phone number for ordering an ID card to have a copy mailed to your home.

You can register for your AZ Blue portal account today with your Social Security number and date of birth. You can get your digital member ID in your AZ Blue portal anytime.

YOUR HEALTH PLAN BENEFITS

This section tells you about the benefits that come with your AZ Blue 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 AZ Blue 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 a contracted, network provider acting within the scope of their practice as determined by AZ Blue or AZ Blue's contracted vendor(s) with one **exception**: A network provider is not required for emergencies, or when AZ Blue has approved use of an out-of-network provider through prior authorization;
- Medically or dentally necessary as determined by AZ Blue or AZ Blue'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 AZ Blue (does not apply to covered services that are part of an approved clinical trial; see Clinical Trials in this section for more information); **and**
- Provided while this plan is in effect, and while you are eligible for benefits.

AZ Blue decides if the service or item meets all factors for coverage (see the Medical necessity definition, guidelines, and criteria section).

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 Travel and Lodging and Travel Reimbursement—Outside Service Area sections.

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 AZ Blue's Medical necessity definition, guidelines, and criteria.

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

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

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

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

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

There are some terms to know for this benefit:

- *Autism spectrum disorder* (ASD) means a pervasive, developmental disorder that meets the criteria for autism spectrum disorder, as defined by current evidence-based criteria and in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.
- *Behavioral therapy* means interactive therapies derived from evidence-based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

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

C. CATARACT SURGERY AND KERATOCONUS

Services covered:

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

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

D. CHIROPRACTIC SERVICES

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

Coverage limits: 20 chiropractic visits per member, per calendar year. Visits provided in the home count toward the 20-visit limit. This limit does not apply to claims submitted with a primary behavioral health diagnosis.

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

E. CHRONIC DISEASE EDUCATION AND TRAINING

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

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

Education and training must be from providers whose services are:

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

F. CLINICAL TRIALS

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

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

Services covered:

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

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

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

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

Not covered:

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

G. DENTAL SERVICES—MEDICAL

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

G.1 Dental Accident Services

There are some terms to know for this benefit:

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

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

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

- Not in need of the treatment provided for any reason other than as the result of an accidental dental injury.

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

Services covered:

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

Not covered:

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

G.2 Dental Services Required for Medical Procedures

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

Services covered:

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

Not covered:

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

G.3 Medical Services Required for Dental Procedures

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

- Is a child five years old or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office;
- Is likely to have an allergic reaction;

- Needs dental extractions due to cancer-related conditions; **or**
- Has any of the following:
  - A condition that could increase the danger of anesthesia
  - An unstable cardiovascular condition
  - Diabetes
  - Heart problems
  - Hemophilia
  - Intellectual disability
  - Malignant hypertension
  - Senility or dementia
  - Uncontrolled seizure disorder

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

H.1 Durable Medical Equipment (DME)

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

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

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

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

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

Not covered:

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

H.2 Medical Supplies

Services covered:

- Any device or supply recommended under current evidence-based criteria
- Insulin pumps (except when delivery through a pharmacy is required by the manufacturer) and insulin pump supplies
- Ostomy and urinary catheter supplies

- Peak flow meters
- Supplies associated with oxygen or respiratory equipment
- Volume nebulizers

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

H.3 Prosthetic Appliances and Orthotics

Services covered:

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

  Types of therapeutic shoes that are covered:
  - *Custom-molded shoes* are shoes built over a model of the member's foot. They are made from leather or other material of equal quality suitable to the shoe's purpose (dress, walking, work, etc.), have removable inserts that can be changed or replaced as the member's condition warrants, and have some sort of shoe closure. May include an internally seamless toe. (**Note:** Custom-molded shoes are covered only when the member has a foot deformity that cannot be accommodated by a depth shoe.)
  - *Depth shoes* are shoes that come with a full-length, heel-to-toe filler that, when removed, leaves at least 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 AZ Blue's sole discretion.
- Coverage is limited to one manual or electric (not hospital grade) breast pump with breast-pump supplies per member, per calendar year, per Health Resources and Services Administration guidelines (see Preventive Services). This limit does not apply to claims submitted with a primary behavioral health diagnosis.
- Coverage is limited to one set of new and four replacement sets of compression garments for the treatment of lymphedema per member, per calendar year. This limit does not apply to claims submitted with a primary behavioral health diagnosis.
- Coverage is limited to one wig and one hairpiece per member, per calendar year. This limit does not apply to claims submitted with a primary behavioral health diagnosis.
- Benefits are limited to the allowed amount for the DME item or medical supply base model. AZ Blue determines what is covered as the base model. Deluxe or upgraded DME items or medical supplies may be eligible for coverage based upon AZ Blue 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 AZ Blue. Examples include:

• Adjustable beds • Air cleaners • Air-fluidized beds • Air conditioners • Air purifier • Assistive eating devices • Atomizers • Bathroom equipment • Bed boards • Biofeedback devices • Braille teaching texts • Car seats • Corsets • Cushions • Dentures • Diathermy machines	• Foot stools • Garter belts • Grab bars • Hair transplants • Health spas • Hearing aid batteries, except for cochlear implants • Heating and cooling units • Helmets • Hospital-grade breast pumps and related supplies • Humidifiers • Incontinence devices/alarms • Items used mainly for help in daily living, socialization, personal comfort, convenience, or other nonmedical reasons	• Myoelectric limbs • Portable and permanent spa and whirlpool equipment and units • Reaching and grabbing devices • Reclining chairs • Replacement of external prosthetic devices due to loss or theft • Saunas • Strollers of any kind • Supplies used by a doctor or other healthcare provider during office treatments • Tilt or inversion tables or suspension devices • Vehicle or home modifications

• Disposable hygienic items • Dressing aids and devices • Elastic/support/compression stockings (except for treating lymphedema) • Elevators • Exercise equipment	• Language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools • Massage equipment • Mineral baths	• Wigs and hair pieces for alopecia caused by anything other than chemotherapy, radiation therapy, second- or third-degree burns, a diagnosed behavioral health condition

I. EMERGENCY SERVICES

Your plan covers services needed to treat an emergency medical condition, whether the providers of these services are in or out of network. 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.

J. EOSINOPHILIC GASTROINTESTINAL DISORDER

Your plan covers formula (amino acid-based) for Eosinophilic Gastrointestinal Disorder (EGID) that is available from network and out-of-network providers, and is covered for members who are:

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

K. FAMILY PLANNING—CONTRACEPTIVES AND STERILIZATION

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

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

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

More information about contraceptives can be found on the FDA's website at fda.gov/consumers/womens-health-topics/birth-control.

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

L. HEARING AIDS AND SERVICES

Services covered:

- Batteries for cochlear implants
- Cleaning and repair of hearing devices
- Cochlear implants

- Dispensing fees for hearing devices
- New or replacement hearing devices no longer under warranty
- Routine hearing exams, except hearing screenings performed as part of a routine well exam

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

Coverage limits:

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

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

Not covered:

- Additional warranties for hearing aids
- Batteries or battery replacement for hearing aids other than cochlear implants
- Disposable hearing aids
- Earmolds
- Replacement of lost, stolen, or damaged hearing aids when the member has already met the coverage limit of one hearing aid per member, per ear, per calendar year
- Replacement or repair of hearing devices still under warranty

M. HOME HEALTH SERVICES

Services covered:

- Home infusion medication administration therapy, including:
  - Blood and blood components
  - Hydration therapy
  - Intravenous catheter care
  - Intravenous, intramuscular, or subcutaneous administration of medication
  - Specialty medications, as defined by AZ Blue, that are not covered under the Pharmacy benefit (see Pharmacy and Medications Benefits)
  - Total parenteral nutrition services
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition (tube feeding), and other services that require skilled nursing care

The above services must meet all of the following criteria:

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

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

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

Not covered:

- All dietary, caloric, and nutritional supplements, such as specialized formulas for infants, children, or adults or other special foods or diets, even if prescribed, except as stated in the Eosinophilic Gastrointestinal Disorder and the Medical Foods for Inherited Metabolic Disorders sections of this book
- Services beyond the 42-visit calendar year maximum, except as stated in the coverage limits

N. HOSPICE SERVICES

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

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

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

Services covered:

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

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

O. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

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

P. INPATIENT HOSPITAL

Services covered:

- Bariatric surgery and bariatric surgery adjustments, even if the previous surgery was covered by a different health plan
- Blood transfusions, whole blood, blood components, and blood derivatives
- Covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction® Center
- Diagnostic testing, including radiology, laboratory services, and biomarker testing
- General, spinal, and caudal anesthetic provided in connection with a covered service
- Intensive care units and other special care units
- Medications, biologicals, and solutions
- Operating, recovery, and treatment rooms and equipment for covered services
- Radiation therapy or chemotherapy
- Room and board in a semi-private room, or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Surgery and other invasive procedures

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

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

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

- A doctor or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- For EAR services, the patient must require 24-hour rehabilitation nursing and have the ability to meet rehabilitation goals;
- For SNF services, the patient must require 24-hour skilled care and have the ability to meet treatment goals. Skilled nursing services must be provided by and under the supervision of qualified and licensed professionals, such as an LPN or RN, and provided at a level of complexity and sophistication requiring assessment, observation, monitoring, and/or teaching or training to achieve the medically desired outcome;
- Room and board in a semi-private room, or a standard private room (not deluxe) is covered if the hospital only has private rooms or if a private room is medically necessary;
- The facility has 24/7 onsite RN coverage;
- The facility has enough professional staff to provide the needed treatment;
- The facility's designated medical director is a doctor or registered nurse practitioner, and provides direction for services provided at the facility; **and**
- The services meet the AZ Blue medical necessity criteria for inpatient level of care (see Medical necessity definition, guidelines, and criteria).

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

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

R. LONG-TERM ACUTE CARE—INPATIENT

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

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

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

S. MATERNITY

Your plan covers maternity benefits for services related to pregnancy. This includes certain screening tests, such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases, and others as determined by AZ Blue. Certain tests, including some genetic screening tests, may not be covered. For a complete listing of covered prenatal screening, please call Customer Service at the number on your ID card. Professional services provided in the member's home must be rendered by an eligible provider.

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

- Adopt the child within one year of birth;
- Be legally obligated to pay the costs of birth; **and**
- Notify AZ Blue within 60 days of their acceptability to adopt children.

This adopted-child maternity benefit is secondary to any other coverage available to the birth mother. Contact Customer Service at the number on your ID card to request an adoption packet.

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

Under federal law, health insurers may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the insurer may pay for a shorter stay if the attending provider (for example, the member's doctor, nurse midwife, or physician assistant), after speaking with the mother, sends the mother or newborn home early.

Also, under federal law, insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay (this means your cost share will not increase if you need to stay in the hospital longer than the 48 or 96 hours described above).

In addition, under federal law, a plan or insurer may not require that a doctor or other healthcare provider obtain prior authorization for prescribing a length of stay of up to 48 hours for the mother and newborn child following a normal vaginal delivery, or 96 hours for the mother and newborn child following a cesarean section delivery. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, prior authorization may be required. You will find additional details in the Prior Authorization section.

T. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

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

- The disorder is one of the diseases tested for under the newborn screening program required under Arizona law (A.R.S. § 36-694);

- The disorder requires the patient to consume medical foods throughout his or her life in order to avoid serious mental or physical impairment; **and**
- The disorder must involve amino acid, carbohydrate, or fat metabolism and have medically standard methods of diagnosis, treatment, and monitoring, including quantification of metabolites in blood, urine, or spinal fluid, or enzyme or DNA confirmation in tissues, as determined by AZ Blue.

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 AZ Blue. See the Medical Claims section for details and the address to submit claims.

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

U. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

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

V. OUTPATIENT SERVICES

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

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

W. PHARMACY AND MEDICATIONS BENEFITS

W.1 Pharmacy Benefit

Your plan covers prescription medications that:

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

Benefits are available for specialty medications obtained from a specialty pharmacy contracted with AZ Blue. Coverage of specialty medications and limitations on these medications are determined by current evidence-based criteria and may change at any time.

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

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

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

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

Coverage limits: Covered medications are subject to limitations, including, but not limited to, quantity, age, gender, dosage, and frequency of refills. AZ Blue 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.

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

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

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

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

Tip! You can find cost estimates for your prescription drugs in your AZ Blue portal account. After you log in, select "Pharmacy."

Not covered:

- Abortifacient (abortion-causing) medications
- All prescription and over-the-counter contraceptive medications and devices for male plan members
- Biologic serums
- Compounded medications obtained from a mail order pharmacy
- Designated medications prescribed by an ineligible provider or dispensed by an unapproved pharmacy or provider to members who are enrolled in the Designated Prescription Network program
- Except for emergencies or urgent care, medications obtained from an out-of-network pharmacy
- Medication delivery implants
- Medications designated as clinic packs
- Medications designed for weight gain or loss, regardless of the condition for which it is prescribed
- Medications for athletic performance
- Medications for lifestyle enhancement
- Medications for sexual dysfunction
- Medications for which the principal ingredient(s) are already available in greater and lesser strengths and/or combinations, as well as medications which modify the dosage form (tablet, capsule, liquid, suspension, extended release, tamper resistant) of drugs already available in a common dosage form, as described in the AZ Blue 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 AZ Blue and/or the PBM
- Medications obtained from an out-of-network mail order or specialty pharmacy, and out-of-network 90-day supply of drugs

- 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 AZ Blue 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
- Non-formulary medications, unless AZ Blue and/or the PBM authorizes a formulary exception
- Prescription medications dispensed in unit-dose packaging, unless that is the only form in which the medication is available
- Prescription refills for medications that are lost, stolen, spilled, spoiled, or damaged

W.2 Medications for the Treatment of Cancer

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

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

In administering claims for an off-label prescription medication, AZ Blue does not represent or warrant that the prescribed medication is safe or effective for the purpose for which your treating provider has prescribed 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 AZ Blue that they are requesting approval for this off-label use. After receiving your provider's request, AZ Blue will review the criteria and eligibility for benefits.

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

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

This benefit includes both habilitative and rehabilitative services and includes coverage for members diagnosed with autism spectrum disorder and developmental delays. 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.

- Cardiac and pulmonary habilitative and rehabilitative services are supervised programs that include exercise, education, counseling, and other lifestyle changes designed to regain strength and prevent or reverse the progression of cardiac and pulmonary diseases.

X.1 Habilitative Services

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

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

Not covered:

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

X.2 Rehabilitative Services

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

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

Not covered:

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

Y. PHYSICIAN SERVICES

Physician services are services provided by a doctor.

Services covered:

- Allergy testing, antigen administration, and desensitization treatment
- Foot care, including trimming of nails or treatment of corns or calluses, when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg
- Inpatient medical visits
- Medications and the administration of medications in a doctor’s office
- Office or home visits for the diagnosis and treatment of a sickness or injury
- 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 applicable prescription medication formulary 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 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.
- 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, AZ Blue will provide coverage in a manner determined in consultation between the attending physician and the member being treated. These benefits are subject to the same cost share generally applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Customer Service at the number on your ID card.

AA. PREVENTIVE SERVICES

Preventive services are those performed for screening purposes when you do not have active signs or symptoms of a condition. Your plan covers preventive services at no charge when obtained from a 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 schedules at cdc.gov/acip/vaccine-recommendations/index.html
- Health Resources and Services Administration (HRSA) guidelines for pediatric and adolescent preventive care and screening at mchb.hrsa.gov/programs-impact/bright-futures
- HRSA guidelines for women's healthcare services at hrsa.gov/womens-guidelines
- 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 a network provider:

- Breast cancer screening, in accordance with HRSA guidelines located at hrsa.gov/womens-guidelines and Arizona law
- Contraceptives and female sterilization as described in the Family Planning–Contraceptives and Sterilization section
- 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 applicable prescription medication formulary, 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 a network pharmacy. This is a request that either you or your provider can make that, if approved, could mean you would not have to pay your normal cost share for this medication. To make this request, either you or your provider can call the Pharmacy Benefit Customer Service number on your ID card anytime, 24 hours a day, seven days a week, 365 days a year. There is no guarantee that AZ Blue 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 AZ Blue, and you are undergoing or have undergone gender transition, please contact Customer Service at the number on your ID card for assistance. AZ Blue covers all gender-specific preventive services that are deemed medically necessary for a member, as determined by the member's attending provider, without regard to the member's gender identity, gender assigned at birth, or gender that is on file with AZ Blue.

Coverage limits:

- Coverage is limited to one preventive physical exam per member, per calendar year, unless additional visits are necessary for the member to obtain all covered preventive services. This limit does not apply to claims submitted with a primary behavioral health diagnosis.

- Preventive services do not include diagnostic tests performed because you have a condition or an active symptom of a condition. Active symptoms and conditions are determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.
- If you have a service or test that falls under this benefit, but the service or test is being done because of a specific diagnosis or because you are experiencing signs or symptoms of a condition or disease, the service or test may be covered through another benefit section of this plan. Certain maternity services covered under this benefit also are available through the Maternity benefit.

Not covered:

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

BB. RECONSTRUCTIVE SURGERY AND SERVICES

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

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

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

CC. SERVICES TO DIAGNOSE INFERTILITY

Your plan covers services to diagnose infertility.

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

DD. TELEHEALTH SERVICES—NETWORK PROVIDERS

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

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—Telehealth from AZ Blue benefit

EE. TELEHEALTH SERVICES—TELEHEALTH FROM AZ BLUE

Your plan covers remote medical and behavioral health consultations between a provider and a patient offered by the telehealth services administrator (TSA) through Telehealth from AZ Blue, 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 Telehealth from AZ Blue:

Log in to your AZ Blue portal account and click "Find Care," then "Telehealth." 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—Network Providers benefit

FF. TRANSPLANT TRAVEL AND LODGING

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

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

- AZ Blue has given prior authorization for the service;
- 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; bus, train, and air fare;
  - Room charges from hotels, motels, and hostels or apartment rental.

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

Not covered:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning, or valet services; telephone or Internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of the coverage limits
- All travel and lodging expenses incurred by a donor or the donor's caregiver
- Ambulance transportation (ground or air)
- Caregiver salary, stipend, and compensation for services

- Cleaning fees
- Expenses for travel or lodging incurred in connection with services that are not covered under this benefit plan
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Vehicle maintenance or services (such as tires, brakes, oil change)

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

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

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

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

Covered transplant services are available from plan network providers and from Blue Distinction Centers for Transplants in Arizona. 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 AZ Blue

- 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 AZ Blue
- Transplants that do not meet current evidence-based criteria

HH. TRAVEL REIMBURSEMENT—OUTSIDE SERVICE AREA

Your plan covers reimbursement for the following eligible travel expenses when a member who receives prior authorization to receive medically necessary covered services outside the member's service area because the services are not available in the member's service area from either a network or out-of-network provider. Services meeting these criteria must be provided in the United States to be covered.

Eligible travel expenses include:

- Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service in effect at the time of travel) from the member's home to the treating provider outside the member's service area; **or**
- The cost of a round-trip commercial airline coach-class ticket when a member's one-way travel exceeds 200 miles from the member's home to the treating provider outside the member's service area, and the member travels by air.

AZ Blue uses a standard Internet mapping tool to calculate mileage from the member's home address to the treating provider. AZ Blue will reimburse the member for eligible travel expenses for each round trip to receive covered services outside the member's service area. Reimbursement will not exceed actual expenses.

Coverage limits: AZ Blue will determine whether an expense is an eligible travel expense. The following are examples of items that are **not eligible** for reimbursement:

- Meals
- Travel expenses for a caregiver, parent, or other companion
- Travel-related expenses other than the mileage allowance noted above, and vehicle maintenance and services (such as tires, brakes, oil changes)

Travel expenses for members receiving a covered solid organ, bone marrow, or stem cell transplant outside the member's service area are covered under the Transplant Travel and Lodging benefit and are not eligible for reimbursement under this Travel Reimbursement provision.

Claims for Reimbursement: To request reimbursement for eligible travel expenses, you must submit a Travel Expense Reimbursement form to AZ Blue. See the Medical Claims section for details on how and where to submit a claim.

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 AZ Blue portal 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.

JJ. PEDIATRIC DENTAL SERVICES

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

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

JJ.1 Type I Services

Services covered:

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

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

JJ.2 Type II Services

Services covered:

- Emergency palliative treatment—Treatment of pain or discomfort in emergency situations.
- Endodontic pulpal therapy—Limited to one treatment per tooth, per member, per lifetime. Pulpal therapy for primary incisors is covered through age 5, and pulpal therapy for primary molars and cuspids is covered through age 10.
- Occlusal guards—Limited to one guard, per member, per calendar year, only for members age 13 and older. Occlusion analysis and adjustment of occlusal guards are also covered.
- Periodontal non-surgical services—Non-surgical procedures to treat diseases of the gums and bones, such as gingivitis or periodontitis. Periodontal scaling and root planing are limited to one procedure, per quadrant, every two calendar years. Full mouth debridement is limited to one procedure per member, per lifetime. Periodontal maintenance procedures are limited to four procedures per calendar year. If you receive any prophylaxis/cleanings, they will count toward the calendar-year limit for periodontal maintenance procedures.
- Restorative fillings—Restoration of fractured, chipped or decayed teeth, including amalgam and composite resin. Placement of infiltrating resin restorations for strengthening, stabilizing and/or limiting the progression of a smooth surface lesion is limited to one restoration per tooth, per member, per three calendar-year period.
- Simple extractions—Extraction of an erupted tooth, an exposed root, or parts of a crown (coronal remnants) that is falling off a tooth.

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

JJ.3 Type III Services

Services covered:

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

        - The bridge is damaged beyond repair while in the oral cavity due to injury the member received while covered under this benefit plan
    - Replacement of bridgework done before the member had coverage under this benefit plan is covered if the bridgework cannot be repaired.
  - Replacement of removable dentures obtained before the member had coverage under this benefit plan is covered if the dentures cannot be repaired.
- Veneers—Limited to the following circumstances:
  - Repair of an existing veneer is necessary due to restorative material failure.
  - The surface of the tooth is not restorable by an alternate, dentally appropriate means.
  - The surface of the tooth is not structurally sound to hold a filling or to be repaired using an alternate, dentally appropriate means.

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

JJ.4 Type IV Services

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

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

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

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

Coverage limits:

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

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

- Additional procedures to construct a new crown under existing partial denture framework
- **Alternative dentistry**—Non-traditional or alternative dental therapies, interventions, services and procedures; naturopathic and homeopathic dentistry; diet therapies; nutritional or lifestyle therapies
- Adjustment of a denture or bridgework that is made within six months after installation by the same dentist who installed it
- Appliances, procedures, devices, and services necessary to alter vertical dimension and/or restore an occlusion
- **Athletic mouth guards**, including, but not limited to, any procedures and services necessary to fabricate or create such mouth guards

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

tooth with a rubber dam; endodontic hemisection (including any root removal), not including root canal therapy; and endodontic canal preparation and fitting of preformed dowels or posts

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

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

KK. PEDIATRIC VISION BENEFITS

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

KK.1 Pediatric Vision Exams (Routine)

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

Coverage limits:

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

Not covered:

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

KK.2 Pediatric Contact Lens Fit and Follow Up

There are a few terms to know for this benefit:

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

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

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

Not covered:

- Office infection control charges
- Services not meeting accepted standards of optometric practice
- Services not provided through a plan provider
- State or territorial taxes on vision services performed

KK.3 Pediatric Eyewear (Eyeglasses or Contact Lenses)

Here are some terms to know for this benefit:

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

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

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

Coverage limits:

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

Not covered:

- Eyewear not provided through a plan provider
- Lens designs or coatings that are not listed in the benefit description
- Non-prescription (plano) lenses or contact lenses
- Non-prescription sunglasses

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

KK.4 Pediatric Low Vision Evaluation and Follow Up

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

Coverage limits:

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

Not covered: Services not provided through a plan provider.

KK.5 Pediatric Low Vision Hardware

Your plan covers pediatric low vision hardware.

Coverage limits:

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

Not covered: Hardware not provided through a plan provider.

What's Not Covered

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

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

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

Acupuncture

Alternative medicine—Non-traditional and alternative medical therapies and interventions, including naturopathic and homeopathic treatments, diet therapies, aromatherapy, and any services or procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices, regardless of who provides the service

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

Biofeedback, except for pain management

Blood administration for the purpose of general improvement in physical condition

Body art, piercing, and tattooing—Services related to body piercing, cosmetic implants, body art, tattooing, and any related complications, except for services included in the Post-Mastectomy Services and the Reconstructive Surgery and Services sections

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

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

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

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

Cosmetics and health and beauty aids

Counseling—Counseling and behavioral modification services, except as stated in the Behavioral Health Services, the Chronic Disease Education and Training, the Hospice Services, the Preventive Services, the Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac, and Pulmonary Services, and the Telehealth Services—Telehealth from AZ Blue sections of this book

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

Custodial care

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

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

Dietary and nutritional supplements—All dietary, caloric, and nutritional supplements, such as specialized formulas for infants, children, or adults or other special foods or diets, even if prescribed, except as stated in the Eosinophilic Gastrointestinal Disorder, the Medical Foods for Inherited Metabolic Disorders, and the Pharmacy and Medications Benefits sections of this book

Domiciliary care

Expenses for services that exceed benefit limitations

Experimental or investigational services or items

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

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

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

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

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

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

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

Growth hormone to treat idiopathic short stature (ISS)

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

Hypnotherapy

Inpatient or outpatient non-acute long-term care

IQ testing

Laboratory services provided without an order from an eligible provider

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

Lodging and meals, except as stated in the Transplant Travel and Lodging and the Travel Reimbursement—Outside Service Area sections of this book

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

Manipulation of the spine under anesthesia

Manipulation under anesthesia, except for reductions of fractures and/or dislocations done under anesthesia

Marijuana—Medical marijuana, marijuana and any derivatives not prescribed by an eligible provider and dispensed through a pharmacy, and any costs or fees associated with obtaining medical marijuana, such as obtaining an initial or renewal registry identification card, even when prescribed and obtained in compliance with state law(s)

Massage therapy

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

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

Medications that are:

- Not FDA approved
- Not on the formulary or are a non-formulary medication that AZ Blue and/or the PBM have not authorized a formulary exception
- Not required by the FDA to be obtained with a prescription
- Not used in accordance with current evidence-based criteria or Pharmacy Coverage Guidelines
- Off-label, unlabeled, and orphan medications, except as stated in the Pharmacy and Medications Benefits section of this book
- Prescribed by ineligible providers, such as naturopathic and homeopathic practitioners
- Used to treat a condition not covered by AZ Blue

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

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

Non-medically necessary services—Services that AZ Blue determines are not medically necessary

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

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

Payments for exclusions imposed by any certification requirement

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

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

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

Phase 3 cardiac rehabilitation

Private-duty nursing

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

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

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

Respite care

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

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

Sensory integration, LOVAAS therapy, and music therapy

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

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

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

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

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

Services for weight loss and gain, except as stated in the Chronic Disease Education and Training, the Inpatient Hospital and the Outpatient Services sections of this book related to bariatric surgeries, and the Preventive Services section of this book

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

Services performed by out-of-network providers, except services that have received prior authorization, emergencies, urgent telehealth services, eosinophilic gastrointestinal disorder formula, and medical foods

Services provided after the member's coverage termination date, except a) covered pediatric eyewear ordered before coverage ended that is delivered, and services are rendered to the former member within 31 days of the date of such order, and b) continuing coverage for 31 days for certain covered pediatric dental benefits if a dentist made a dental impression (such as a mold of the teeth) before coverage terminated; a dentist opened a pulp chamber before coverage terminated, and a device is installed or treatment is finished within 31 days after coverage terminated; a dentist prepared a tooth for cast restoration before coverage terminated; or a dentist prepared abutment teeth for the completion of installation of prosthetic devices before coverage terminated

Services provided prior to member's coverage effective date

Services related to or associated with noncovered services

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

Sex-trait modification procedures

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

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

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

Surgical treatment of hyperhidrosis

Telephonic and electronic consultations, except as stated in the Telehealth Services—Network Providers and the Telehealth Services—Telehealth from AZ Blue sections of this book

Therapy services, except as stated in this benefit plan

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

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

Transportation—Transport services and travel expenses, except as stated in the Ambulance Services, the Transplant Travel and Lodging, and the Travel Reimbursement—Outside Service Area sections of this book

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

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

Vocational therapy—Services related to employability

Voluntary abortions

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

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

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

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

USING YOUR PHARMACY BENEFITS

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

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

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

Covered Medications — the Formulary

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

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

If AZ Blue makes a formulary change that limits or excludes coverage for a prescription drug that you are currently taking, AZ Blue will provide 60 days' advance notice to you and your provider. The notice will describe the process your provider can use to request your continued use of the non-formulary prescription drug for the remainder of the policy year at the same coverage level. Your provider may need to request a new formulary exception for your continued use of the prescription drug for the following policy year.

Getting Your Prescriptions

You may fill prescription medications at either a network retail pharmacy, the network mail order pharmacy, or a network specialty pharmacy. If you currently get your covered medication through the network mail order pharmacy, you have the option to get that medication from a network retail pharmacy. If you currently get a specialty medication from a specialty pharmacy and need to get that medication from a retail pharmacy instead, contact AZ Blue. We will need to determine if you are eligible to receive the specialty medication from a retail pharmacy. Compounded medications must be filled by network retail pharmacies that have been credentialed (approved) by AZ Blue 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 AZ Blue/PBM will authorize an exception. Reasons for requesting an exception include, but are not limited to: quantity, age, gender, dosage and/or frequency of refill limitations, requests for a formulary exception, and requests for waiver of cost share for medications or devices taken or used for a preventive purpose.

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

- Call the Pharmacy Benefit Customer Service number on your ID card for assistance, **or**
- Pay the pharmacy for the medication, and then submit a claim to AZ Blue 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 AZ Blue medication synchronization program. If you are enrolled in the AZ Blue medication synchronization program, your cost share for eligible covered medications will be adjusted for any early or short refills of those medications.

Specialty Medications

If you get a specialty medication from a network pharmacy that is not contracted with AZ Blue 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 your AZ Blue portal account 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 AZ Blue has assigned the medication at the time the prescription is filled. No exceptions will be made regarding the assigned tier of a medication. AZ Blue may change the tier of a medication at any time. Go to azblue.com to view the lists of prescription drug tiers. To confirm the tier of a particular medication, you may also call Pharmacy Benefit Customer Service at the number on your ID card.

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

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

Requests for Formulary Exceptions

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

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

A copy of AZ Blue's written decision will be provided to you and your provider. If your request is denied, the written denial will include an explanation of the medical or pharmacological reasons for the denial. You will have the right to appeal the decision and detailed instructions regarding the appeals process will be provided in your denial notice. If your request is approved, the formulary exception will remain in place through the end of the policy year. Your provider may need to request a new formulary exception for your continued use of the prescription drug for the following policy year.

Submission of Claims and Cost Adjustments

If you submit a claim for a medication to AZ Blue, AZ Blue will review your request to determine if you should be reimbursed for some or all of the money you paid to the pharmacy, and will send you an Explanation of Benefits (EOB). If AZ Blue denies your claim, you will receive a document describing your appeal rights along with the EOB. Submitting a prescription to a pharmacy is not considered 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 AZ Blue Pharmacy benefit, the amount of the discount (the dollar value) will be applied to your deductible and out-of-pocket maximum if the medication is:

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

FINDING & WORKING WITH HEALTHCARE PROVIDERS

Your health plan is an HMO and comes with a network of providers who you see when you need care. This section explains the role of your primary care provider (PCP) and how to find network providers. There is also important information about what to do if you need urgent or emergency care and your network providers are not available or when you're out of the area.

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.

Consider choosing a primary doctor

With your plan, you don't need to select a 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 AZ Blue
- 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)
- Tell AZ Blue if you see any differences between the member cost share listed on your claims documents and what you actually paid.

Network Providers

Plan network

AZ Blue works with a network of healthcare providers who have a plan-network contract with AZ Blue, or with a vendor that has contracted with AZ Blue to provide or administer services for AZ Blue HMO members. **Services are covered only if you receive them from network providers** except for services from an out-of-network provider that have received prior authorization, emergencies, urgent telehealth services, eosinophilic gastrointestinal disorder (EGID) formula, and medical foods.

To be covered, a service must *also* be:

- Performed by a provider acting within his or her scope of practice*;* **and**
- Performed at a 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 you receive a service from a network provider does not guarantee that the service will be covered. That's because network providers may offer services that are not covered by your plan. Provider contracts allow providers to charge you up to billed charges for noncovered services. We recommend that you discuss costs with your provider before you receive a noncovered service.

Network providers will file your claims with AZ Blue or the host Blue plan with which they are contracted. 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 from this other source (a third-party insurer), or from proceeds received from the other source, for covered services.

AZ Blue pays network providers for our portion of the allowed amount of a claim. You are responsible for paying your portion (the member cost share) directly to your provider. You are not responsible for any charge over and above your cost share.

Finding a network provider in Arizona

You can find a list of network providers online using the "Find a Doctor" tool in your AZ Blue portal 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 a network provider, or are unable to make an appointment with one, you can either:

- Call AZ Blue 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 network provider who can treat you. See Prior Authorization for more information.

Finding network providers when you travel outside of Arizona

You also have limited coverage outside Arizona for urgent care and authorized (approved) follow-up care. Urgent care and authorized follow-up care are covered only when provided by host Blue network providers. Services from an out-of-network provider that have received prior authorization, emergency services, urgent telehealth services, EGID formula, and medical foods are covered when provided by host Blue network providers as well as noncontracted providers. Coverage for pediatric dental or vision services is not available through the Inter-Plan Programs.

Provider treatment decisions and disclaimer of liability

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

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

Out-of-Network Providers

You have coverage for services from out-of-network providers only for services that have received prior authorization, emergencies, urgent telehealth services, EGID formula, and medical foods. An out-of-network provider in or outside of Arizona is not required to file a claim for you, and may require payment from you. If the provider does not file your claim, send a copy of the itemized bill and a completed claim form to AZ Blue. When you do, your payment will be applied toward your deductible. If you've already met your calendar-year deductible, you may receive money back after we process your claim.

AZ Blue generally does not send claim payments to out-of-network providers. Except for claims covered by the No Surprises Act, or unless AZ Blue agrees to pay the provider directly, AZ Blue will send payment to you for whatever benefits are covered under your plan, and you will be responsible for paying the out-of-network provider.

Save money by staying in the network

The following example shows how your out-of-pocket costs can change depending on whether or not your provider is in the network. In this example, the member has a $250 copay for a specific service when using a network provider, and no benefits when using an out-of-network provider.

Billed Charges	**Allowed Amount**	**Costs with Network Providers**		**Costs with Out-of-Network Providers**	
$1,000	$800	**You pay:**	**$250**	**You pay:**	**$1,000**
		AZ Blue pays:	$550 ($800 *minus* $250)	**AZ Blue pays:**	$0

Continuing care from an out-of-network provider

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

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 90 days from the effective date of coverage; **or**

   Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered provider services for the delivery and any care related to the delivery for up to 6 weeks from the delivery date; **and**

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

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

Current members

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

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

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

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

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

Out-of-Area Services

Overview

AZ Blue has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” These Inter-Plan Programs work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you obtain healthcare services outside of AZ Blue’s service area, the claim for those services may be processed through one of these Inter-Plan Programs.

When you receive care outside of AZ Blue’s service area, you will receive it from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield plan in that geographic area (“host Blue”). Some providers (“nonparticipating providers”) don’t contract with the host Blue. We explain below how AZ Blue pays both kinds of providers.

Your plan covers only limited healthcare services received outside of our service area. As used in this section, out-of-area covered healthcare services include services from an out-of-network provider that have received prior authorization, emergency care, urgent care, follow-up care, EGID formula, and medical foods obtained outside the geographic area we serve. Services from an out-of-network provider that have received prior authorization, emergency services, EGID formula, and medical foods are covered when provided by providers contracted with a host Blue and when provided by noncontracted providers. Urgent care and authorized follow-up care is covered only when provided by providers contracted with a host Blue. Any other services will not be covered when processed through any Inter-Plan Programs unless authorized by AZ Blue.

Inter-Plan Programs eligibility—claim types

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

Inter-Plan Programs

Under the Inter-Plan Programs, when you receive out-of-area covered healthcare services within the geographic area served by a host Blue, AZ Blue will remain responsible for doing what we agreed to in the contract. However, the host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

The Inter-Plan Programs enables you to obtain out-of-area covered healthcare services, as defined above, from a healthcare provider participating with a host Blue, where available. The participating provider will automatically file a claim for the out-of-area covered healthcare services provided to you, so there are no claim forms for you to fill out. You will be responsible for your cost-share amount, as stated in your plan documents.

When you receive out-of-area covered healthcare services outside our service area and the claim is processed through the Inter-Plan Programs, the amount you pay for the out-of-area covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

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

Often, this “negotiated price” will be a simple discount that reflects an actual price that the host Blue pays to your healthcare provider. Sometimes, it is an estimated price that considers 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 considering the same types of transactions as with an estimated price.

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

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

Emergency care services: If you experience an emergency medical condition while traveling outside AZ Blue's service area, go to the nearest emergency care facility (see the No Surprises Act section).

Nonparticipating providers outside AZ Blue's service area

Your liability calculation:

When out-of-area covered healthcare services are provided outside of AZ Blue's service area by nonparticipating providers, the amount you pay for such services will normally be based on either the host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law.

Exceptions:

In certain situations, AZ Blue may use other payment methods, such as billed charges for out-of-area covered healthcare services, the payment we would make if the healthcare services had been obtained within our service area, **or** a special negotiated payment to determine the amount we will pay for services provided by nonparticipating providers.

Federal or state law, as applicable, will govern payments for out-of-network emergency services (see the No Surprises Act section).

Blue Cross Blue Shield Global® Core program

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

If you need medical assistance services (including locating a doctor or hospital) outside the United States, you should call the Service Center at **1-800-810-BLUE (2583),** or call collect at **804-673-1177,** 24 hours a day, 7 days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

- **Inpatient services:** In most cases, if you contact the Service Center for assistance, hospitals, outside the domestic service area, 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 initiate claims processing. However, if you paid in full at the time of service, you must submit a claim to obtain reimbursement for covered services. You must contact AZ Blue to obtain prior authorization for non-emergency inpatient services.
- **Outpatient services:** Physicians, urgent care centers, and other outpatient providers located outside the domestic 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 domestic service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the Service Center (the

address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from AZ Blue, the Service Center, or online at bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Service Center at **1-800-810-BLUE (2583)** or call collect at **804-673-1177,** 24 hours a day, 7 days a week.

Services received on cruise ships

If you receive healthcare services while on a cruise ship, you will pay your network cost share, and the allowed amount will be based on billed charges. A cruise ship claim is not considered an out-of-country claim. Claims should be submitted and processed through AZ Blue, not through the Blue Cross Blue Shield Global Core program. Please call the AZ Blue Customer Service department at the phone number listed on your ID card for more information, or mail copies of your receipts to the AZ Blue 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 AZ Blue 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 AZ Blue 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 AZ Blue website, you'll find a list of services that need prior authorization at azblue.com/priorauthorizationlist 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 AZ Blue for prior authorization before you receive services and medications that require it. Your provider is the one who must contact AZ Blue because they have the information and medical records we need to make a benefit determination. AZ Blue 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.

AZ Blue 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, AZ Blue 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 a network provider
- 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.

Prescription medication exception

If a covered medication requires prior authorization, but you must get the medication outside of AZ Blue'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 AZ Blue.

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

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

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

Concurrent care decisions

AZ Blue may require that your provider submit a plan of care. Based on that plan, AZ Blue may provide prior authorization for a certain number of visits 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, AZ Blue 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, AZ Blue 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 AZ Blue Provides Prior Authorization for Your Service

You and your provider will receive a notice from AZ Blue 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 AZ Blue denies your prior authorization request

If AZ Blue 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 in your AZ Blue portal account.

If your request for prior authorization for a service is denied because AZ Blue 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 AZ Blue denies prior authorization, you and your provider should decide whether to proceed with the service or procedure based on what is best for you and your health.

Urgent requests for prior authorization

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

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

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

MEDICAL CLAIMS

This section tells you when, how, and where to submit medical claims. A claim is a request for payment. In most cases, 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 AZ Blue can track your covered expenses and properly credit your applicable deductibles, coinsurance, out-of-pocket maximums, and coverage limits.

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

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

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

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

AZ Blue claim forms are available at azblue.com/individualsandfamilies/resources/forms. 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 birth date
- Patient name
- Place of service
- Procedure code
- Provider ID number
- Area of oral cavity or tooth treated, as applicable (dental claims only)
- Description of service (dental claims only)

Time limit for claim filing

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

- When Medicare or another carrier was the primary payer on a claim where AZ Blue was secondary payer, and the delay was caused by the need to coordinate benefits with the primary payer
- When the member can show good cause for delay. Examples of good cause:

- AZ Blue gave the member wrong information about the filing date
- The member did not have legal capacity
- The member had an extended illness that prevented 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, AZ Blue may need to request medical or dental records to make a coverage determination. If AZ Blue has requested medical records or other information from a third party, AZ Blue will stop processing the claim while the request is pending. AZ Blue 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 52033 Phoenix, AZ 85072-2033
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

Explanation of Benefits

After your claim is processed, AZ Blue will send you an Explanation of Benefits (EOB). You can see all of your AZ Blue EOBs in your AZ Blue portal account.

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. AZ Blue will also send your 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. AZ Blue 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 will include the notice, and will:

- Describe additional material or information we need in order to process the claim, if any, and the reasons we need the material or information;
- Explain the specific reason(s) for the denial (for example, it might say that a service is not covered because the provider is ineligible, or because the services are not covered under your plan);

- Explain any business rule, guideline, or protocol that we relied on in making the adverse determination (or explain that this information is available free of charge upon request);
- Explain the scientific or clinical judgment for the determination (or explain that the information is available free of charge upon request), if the denial is based on medical necessity, experimental treatment, or similar limit;
- Let you know the specific plan provision that we referenced in making the determination; **and**
- Describe applicable grievance/appeal procedures.

Time period for claim decisions

Within 30 days of receiving your claim for a service that was already rendered, AZ Blue will send you either an EOB explaining how the claim was processed and what was paid (or not), or a notice that AZ Blue 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 AZ Blue cannot make a decision on your claim within 30 days, AZ Blue 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 grace period details so you don't risk losing your health coverage.

Eligibility Overview

Effective date of coverage

AZ Blue must approve your application before your coverage will take effect. Your coverage will take effect on the earliest available effective date, as determined by AZ Blue. You are the contract holder. We will let you know your effective date of coverage.

	Effective date of coverage
Contract holder	Determined by AZ Blue
Dependent	Determined by AZ Blue
Spouse	The first day of the month following application submission. Applications must be submitted within 60 days of marriage.
Newborn/adopted child/ child placed for adoption or placement in foster care	The first day of the month following application submission. Applications must be submitted within 60 days of birth, adoption, placement for adoption, or placement in foster care.

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 26, 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
- Foster children
- 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.

Eligibility to enroll for coverage

Contract holder—A contract holder becomes eligible to enroll for coverage after meeting the eligibility requirements of AZ Blue.

Child—A child is eligible for dependent coverage until the end of the policy year in which the child turns 26.

A child is automatically eligible for coverage for the first 31 days beginning on the date of birth, adoption, placement for adoption, or placement in foster care (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. To continue coverage for the child after the 31-day period, you must add the child to your policy (see Special Enrollment Period). You will be responsible for any additional premium, which will be prorated.

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

- Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;
- Is totally disabled due to a continuous physical or intellectual disability or condition as defined by current evidence-based criteria on the date the dependent reaches age 26; **and**
- Is dependent on the contract holder for maintenance and support, as determined by AZ Blue criteria.

Medical reports, acceptable to AZ Blue, must substantiate the incapacity and must be submitted by the contract holder within 31 days of the date such dependent child reaches age 26. The child's eligibility to continue this coverage as a dependent under this plan is subject to periodic, but not more than annual, review by AZ Blue.

AZ Blue 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 AZ Blue if the child's disability ceases. Cessation of the child's disability or dependency will terminate the child's coverage as a dependent under this plan.

AZ Blue may decline to renew current coverage or to issue new coverage to you in the future if all outstanding premiums are not paid in full.

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 an AZ Blue member, the donor may be eligible for limited benefits (see benefit descriptions for Transplants—Organ, Tissue, and Bone Marrow and Stem Cell Procedures).

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

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

Pediatric dental and vision benefit eligibility

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

Loss of eligibility

AZ Blue will notify the contract holder if the contract holder and/or any dependents lose eligibility for coverage under this benefit plan.

New policy required for individuals who relocate outside of service area

If you move outside the service area associated with your benefit plan, AZ Blue will not reissue your policy at the end of its term. To determine the service area associated with your benefit plan, call Customer Service at the number on your ID card.

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 AZ Blue 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 AZ Blue for collection of claims payments made after you or your dependents became ineligible.

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

- A disabled dependent age 26 or older who is no longer disabled;
- Eligibility of you or your dependents for the Arizona Health Care Cost Containment System (AHCCCS) or other Medicaid coverage during the term of this contract;
- Eligibility of you or your dependents for Basic Health Program (BHP) coverage during the term of this contract;
- Eligibility of you or your dependents for individual coverage through the Marketplace;
- Eligibility of you or your dependents for Medicare during the term of this contract;
- Eligibility of you or your dependents for the Children's Health Insurance Program (CHIP) coverage during the term of this contract;
- Individuals being added to the benefit plan: spouse, newborns, adopted children, children placed for adoption, stepchildren;
- Individuals removed from the benefit plan due to divorce or death;

- Other medical coverage that you or your dependents add or lose, including changes in benefits; **or**
- Your mailing address or phone number.

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.

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, AZ Blue 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, AZ Blue will process the claim as if it were the primary payer, subject to all of the terms of this plan. We do not coordinate benefits with Medicare Part D. The combined total payments by Medicare and AZ Blue will never exceed the amount a provider is permitted to bill the member under applicable Medicare law.

With secondary coverage under an AZ Blue group plan

If you have coverage under this plan and also under an AZ Blue 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 AZ Blue individual plan

If a member has coverage under this plan and also under one or more additional AZ Blue 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 AZ Blue plan and the parents are married, living together, or share custody of the child, then the plan of the parent whose birthday occurs earlier in the calendar year covers the child first. If both parents have the same birthday, the benefits of the plan that has covered a parent longer covers the dependent child first.
- If the dependent child's parents are legally separated or divorced and do not share custody, the following applies when the parents or stepparents are covered under an AZ Blue individual plan:
  - 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.

AZ Blue does not coordinate benefits for pharmacy services. Pharmacy claims are payable only when the member chooses to use AZ Blue coverage as their pharmacy coverage. If the member has pharmacy coverage with another carrier and chooses to use those benefits for pharmacy coverage, AZ Blue will not provide any payment.

With coverage under a non-AZ Blue plan including other BCBS plans

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

Open Enrollment

Other than as described in this benefit plan, AZ Blue will permit individuals to enroll in or change benefit plans only during initial, limited, and annual open enrollment periods. After the initial open enrollment period, AZ Blue will provide each member with a written annual open enrollment notice.

Benefits and premiums are subject to change upon providing notice as required by federal and state law.

Special Enrollment Period

There are certain qualifying events that make you or others in your household eligible for a special enrollment period. That's a time you (and sometimes others) can enroll in or change a health plan outside of the normal open enrollment period.

AZ Blue may require that you submit documents to show that you qualify for a special enrollment period. For more information, please visit the special enrollment period web page on HealthCare.gov at healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/. Certain special enrollment periods are only available on the Marketplace while some apply to plans sold both on and off the Marketplace.

Rescission of Coverage

AZ Blue 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, AZ Blue may rescind (declare null and void) any plan issued to the member as of the effective date of the plan. AZ Blue will give a 30-day written notice of its intent to rescind, during which time the member may protest the decision by writing to AZ Blue at the address indicated in the notice and explaining why a rescission is not appropriate or allowable.

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 AZ Blue 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, AZ Blue will convert the policy to a child-only plan as of the effective date for the rescinded policy. You must pay any required premium for the child-only policy.

Retroactive adjustment of premium

If you made a false statement or material omission on your application that enabled you to receive a lower premium than you should have received if you had truthfully and fully disclosed all information,

AZ Blue may, in lieu of rescinding your policy, permit you to retain your coverage at the correct premium. In this case, you must pay all difference in premium owed since the start of coverage and be otherwise current on premium payments in accordance with this plan.

Termination of Coverage

Reasons for termination

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

- Coverage for the contract holder and/or dependents is rescinded
- Non-payment of premiums by the contract holder, after expiration of any grace period available under applicable law
- The contract holder and/or any dependent(s) die
- The contract holder and/or dependent(s) request termination of coverage

Unless coverage is earlier terminated by request of the contract holder and/or any dependent(s) or due to the death of the contract holder and/or or any dependents, AZ Blue will notify the contract holder and dependent(s) of any termination dates of coverage for the contract holder and/or any dependent(s) a minimum of 30 days prior to the last day of coverage.

Except as explained in this section for dependents subject to court order or administrative order, the contract holder may voluntarily cancel coverage at any time for the contract holder and all dependents by notifying AZ Blue. AZ Blue will terminate the plan on the first day of the month following AZ Blue's receipt of the request.

Termination date

Termination dates are generally the following, subject to changes in applicable federal and state law:

- If the contract holder gets divorced, the termination date for the contract holder's spouse is the date of the final divorce decree.
- The last day of coverage allowed by applicable law for a grace period for non-payment of premium.
- When a contract holder dies, AZ Blue terminates the contract holder's policy on the date of death and transfers any dependents to a new policy on the date of death.
- When a dependent child covered by a qualified medical support order is no longer eligible under the court order or administrative order, the termination date is the last day of the time period specified in the court order or administrative order.
- When an adult dependent turns age 26 and does not qualify as a disabled dependent, the termination date is the end of the policy year in which the adult dependent turns 26.
- When an adult dependent's disability ends, the termination date is the date disability or incapacity ends.

AZ Blue does not automatically terminate a contract holder or dependent when that person turns age 65 or becomes eligible for Medicare for some other reason. If you are eligible for Medicare and/or age 65 or older, you may have other AZ Blue plan options that have lower premiums. Visit your AZ Blue portal account or contact Customer Service if you'd like to explore other options.

If you continue your coverage under this plan, AZ Blue will not duplicate benefits for covered services paid by Medicare as primary payer (see Non-Duplication of Benefits).

Benefits after termination

You have no coverage on and after the date coverage ends no matter the reason for termination. This applies even if the expense was incurred because of an accident, injury, or illness that occurred, or existed while this coverage was in effect. There are two exceptions:

Continuing coverage for terminated dependents

Eligible dependents whose coverage has been terminated may be able to continue coverage on a separate plan.

Continuing coverage for certain pediatric dental benefits

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

- Your dentist made a dental impression (such as a mold of your teeth) before your coverage terminated;
- Your dentist opened a pulp chamber before your coverage terminated, and a device is installed or treatment is finished within 31 days after your coverage terminated;
- Your dentist prepared a tooth for cast restoration before your coverage terminated; **or**
- Your dentist prepared abutment teeth for the completion of installation of prosthetic devices before your coverage terminated.

Wellness Incentives

AZ Blue believes in inspiring health. Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs, making it easier and more affordable for you to make healthy lifestyle choices. The decision to participate in wellness program activities is voluntary, and we recommend that you discuss participation with your physician.

Successful completion of a recommended wellness program may earn rewards such as gift cards, debit cards, and discounts. These incentives are not benefits and do not alter or affect your benefits. The rewards may be taxable income. You may consult a tax advisor for further guidance. Contact us at the number listed on your ID card for more information.

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 AZ Blue, with some limited exceptions required by law. If you choose to review your medical records in person, AZ Blue will require a reasonable amount of time to research and retrieve the records before scheduling a time with you to review the records.

The AZ Blue Notice of Privacy Practices describes how AZ Blue may use and disclose your information to administer your health plan. It also describes some of your individual rights and AZ Blue's responsibilities under federal privacy regulations. You can view the Notice of Privacy Practices by visiting the AZ Blue website, azblue.com, and clicking on the Privacy & Legal link under the Resources heading at the bottom of the home page. If you would like AZ Blue to mail you a copy of the Notice of Privacy Practices, please call the Customer Service number 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 AZ Blue payment and your cost share (see definition). AZ Blue calculates your coinsurance amount and how much applies toward your deductible based on the allowed amount. The allowed amount isn't tied to the amounts providers in a given area usually charge for their services. If the allowed amount is based on a fee schedule (see table below), a change to the fee schedule may result in a higher member cost share. Allowed Amount for Pediatric Dental Benefits: AZ Blue or its contracted vendor bases the Allowed Amount on the lesser of the dental provider's billed charges or the applicable fee schedule, with adjustments for any negotiated contractual arrangements and certain operational guidelines.

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

Type of Provider	Type of Claim	How We Determine the Allowed Amount
Providers contracted as AZ Blue 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, excluding air ambulance, in and outside Arizona, including providers contracted with AZ Blue as PPO or HMO providers but who are not in your plan's network	Emergency	The Qualifying Payment Amount, as defined by federal law, is the allowed amount.
Noncontracted ground ambulance in and outside Arizona	Emergency	The billed charges from the provider are the allowed amount.
Noncontracted air ambulance in and outside Arizona	Emergency and non-emergency	We compare the provider's billed charges to the applicable AZ Blue fee schedule (with adjustments for certain operational guidelines). The allowed amount will be the lower of the two amounts. The member's cost share will be based on the lesser of the provider's billed charges or the Qualifying Payment Amount, as defined by federal law.
Noncontracted providers in a network facility in and outside Arizona, including providers contracted with AZ Blue as PPO or HMO providers but who are not in your plan's network	Non-emergency and non-ancillary	The Qualifying Payment Amount, as defined by federal law, is the allowed amount. If you sign a consent for a noncontracted provider to perform services at a network facility, you are responsible for the difference between the Qualifying Payment Amount and the provider's billed charges.

Ancillary services	Ancillary services include emergency medicine, anesthesiology, pathology, radiology, neonatology, certain laboratory services, or as otherwise required by law.
AZ Blue	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, AZ Blue also may include contracted vendors, when a contracted vendor is performing functions on behalf of AZ Blue. Blue Cross Blue Shield of Arizona is an independent licensee of the Blue Cross Blue Shield Association. AZ Blue is a not-for-profit corporation organized under the laws of the state of Arizona as a hospital, medical, dental, and optometric services corporation, and is authorized to operate a healthcare services organization as a line of business.
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).
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 AZ Blue. 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.
Billed charges	For a provider that has a participation agreement governing the amount of reimbursement, the term billed charges refers to the amount the provider normally charges for a service. For a provider that does not have a participation agreement governing the amount of reimbursement, billed charges refers to the lowest amount that the provider is willing to accept as payment for a service.
Blue Distinction	A national designation awarded by Blue Cross Blue Shield (BCBS) plans to recognize providers that demonstrate expertise in delivering quality specialty care that is safe, effective, and cost-efficient.
Cancer treatment medication	Prescription drugs and biologicals that are used to kill, slow, or prevent the growth of cancerous cells.
Cardiac and pulmonary services	Cardiac and pulmonary habilitative and rehabilitative services are supervised programs that include exercise, education, counseling, and other lifestyle changes designed to regain strength and prevent or reverse the progression of cardiac and pulmonary diseases.
Caregiver	The person primarily responsible for providing daily care, basic assistance, and support to a member who is eligible for transport, lodging, and reimbursement.
Chiropractic Benefits Administrator (CBA)	The CBA is an independent company that develops and manages the AZ Blue network of chiropractic providers, processes chiropractic claims, determines medical necessity, and handles utilization management, grievances, and appeals related to chiropractic services. The CBA for AZ Blue 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). Coinsurance applies to every covered service unless the specific benefit section says it does not apply. While AZ Blue 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, AZ Blue will calculate your coinsurance based on the lesser billed charge.
Compounded medications	Medications that contain at least one FDA-approved component and that are custom-mixed by a pharmacist.
Contract holder	The person to whom a benefit plan is issued. Any other person approved for coverage under the plan along with the contract holder is a dependent.
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, or coinsurance.
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 **or** **Calendar-year deductible**	The amount you pay toward covered healthcare services each calendar year before AZ Blue 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 do not count toward the deductible. Your deductible amount is listed in the enclosed Plan Attachment, as well as in your SBC document.
Dentist	A properly licensed DDS or DMD.
Dependents	The contract holder's spouse, under a legally valid, existing marriage; **and** The contract holder's children or the children of the contract holder's spouse, including natural children, legally adopted children, stepchildren, children placed for adoption, children under legal guardianship substantiated by a court order, children who are entitled to coverage under a medical support order, and foster children.

Designated prescription network program	A program that requires certain members who take certain medications to get prescriptions for those covered medications from one designated eligible provider, and to get all medications designated by AZ Blue or the PBM from one network pharmacy or provider. AZ Blue or the PBM determines which members are required to participate in this program.
Disabled dependent child	A child who has reached age 26 and who meets criteria for coverage under this plan as described in the eligibility overview.
Doctor or physician	For purposes of classifying benefits and member cost shares in your plan, we use the terms doctor and physician to mean a properly licensed MD, DO, DPM, or DC.
Domiciliary care	A supervised living arrangement in a home-like environment for people who are unable to live on their own because they need assistance with the activities of daily living, such as bathing, dressing, and food preparation.
Eligible providers	Properly licensed, certified, or registered providers acting within the scope of their practice and license, and contracted with your plan network, and out-of-network providers when providing services that have received prior authorization, emergency services, urgent telehealth services, eosinophilic gastrointestinal disorder (EGID) formula, and medical foods. All other providers are ineligible.
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 AZ Blue determine whether a service, procedure, device, or drug meets the industry standard for medical necessity and/or is a covered benefit. Criteria may include prescription medication or service limitations. AZ Blue ensures that evidence-based criteria 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. An AZ Blue contracted vendor may establish evidence-based criteria for services they provide or administer as stated in the vendor's contract with AZ Blue. 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 AZ Blue. AZ Blue 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) • AZ Blue's past claims experience • Other pricing information that may be available to AZ Blue • Information and comments from providers • Negotiated contractual arrangements with providers AZ Blue may change its fee schedule at any time without prior notice to members. If the allowed amount for a service is based on a fee schedule, a change to the fee schedule may result in higher member cost share for that service.

Formulary	A formulary is a list of drugs that are covered by your health plan. It also helps you figure out how much you can expect to pay when you have a prescription filled at a pharmacy in your plan network. AZ Blue and/or the PBM decide which medications are on the formulary.
Formulary exception	When AZ Blue and/or the PBM has authorized coverage of a non-formulary medication for a member. AZ Blue and/or the PBM decide whether to authorize formulary exceptions for coverage of non-formulary medications.
Generic medications	Medications defined as generic by the national database system used by AZ Blue to pay prescription claims.
Habilitative services	Healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health Insurance Marketplace (the Marketplace)	The health insurance marketplace run by the federal government. It provides a service via HealthCare.gov to help individuals and small businesses shop for and enroll in health coverage. The term also refers to state exchanges, regional exchanges, subsidiary exchanges, as well as the federally-facilitated exchange.
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 AZ Blue or the PBM. AZ Blue and/or the PBM ("AZ Blue/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 AZ Blue approve what is called a short refill.
Member	An individual, employee, participant, or dependent covered under a benefit plan.
Network provider	A doctor, clinic, hospital, or other healthcare provider that has contracted with AZ Blue to serve plan members.
Non-formulary medication	A medication that is not on the formulary. You can ask your prescribing provider to request that AZ Blue make a formulary exception for a non-formulary medication. AZ Blue and/or the PBM decide which medications are non-formulary medications and whether to authorize formulary exceptions for non-formulary medications.
Occupational therapy	Treatment of *neuromusculoskeletal dysfunction* (injuries or disorders of the musculoskeletal system, such as muscles, tendons, ligaments, nerves, discs, and blood vessels) using specific tasks or goal-directed activities to improve functional performance.
Open enrollment period	The yearly period where individuals and families can enroll in a health insurance plan offered through the Marketplace, or enroll in an AZ Blue plan not sold through the Marketplace.
Out-of-network provider	A doctor, clinic, hospital, or other healthcare provider that is not a part of any AZ Blue plan network. Services from an out-of-network provider are not covered, except in a few limited situations, such as in the case of a medical emergency.
Out-of-pocket maximum	The most you pay in cost share for covered services in a calendar year before your health insurance begins paying 100% of the cost of covered services. AZ Blue applies deductible, coinsurance, and copays toward any out-of-pocket maximum that applies to your benefit plan. Any payments you make for either 1) noncovered services or 2) an amount above the maximum allowed for a specific benefit will not count toward your out-of-pocket maximum.

	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 AZ Blue 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 network providers. See your ID card for the name of your plan network.
PPACA	The Patient Protection and Affordable Care Act of 2010, as amended.
Preventive services	Services provided for screening purposes when a member does not have active signs or symptoms of a condition.
Primary Care Provider (PCP)	A healthcare professional who is contracted with AZ Blue as a PCP and generally specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, pediatrics, or any other classification of provider approved as a PCP by AZ Blue. Your benefit plan does not require you to see a PCP for a referral before seeing a specialist.
Prior authorization	A review done by AZ Blue to approve a service, treatment plan, doctor visit, or medication before you make the appointment or fill the prescription. Some services and medications require this review in order for the service or medication to be covered under your plan.
Provider	Any properly licensed, certified, or registered person or facility furnishing medical care to you, such as a doctor, hospital, laboratory, or other health professional. A provider can be related to a member.
Qualified Health Plan (QHP)	A health plan that's been certified by the Marketplace, provides all 10 essential health benefits, follows limits on cost sharing, and meets other requirements of the Affordable Care Act.
Rehabilitative services	Services that help a person restore skills and functioning for daily living that have been lost due to injury or illness.
Respite care	The provision of short-term, temporary relief of the daily routine and stress to provide those who are caring for family members a personal break from their role as caregiver.
Service	A generic term referencing any type of healthcare treatment, test, procedure, supply, medication, technology, device, or equipment.

Sex-trait modification procedure	Any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by: • Intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; **or** • Intentionally altering an individual's physical appearance or body, including amputating, minimizing, or destroying primary or secondary sex-based traits, such as the sexual and reproductive organs. This term does not include procedures undertaken to treat a person with a medically verifiable disorder of sexual development or for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.
Short refill	A prescription refilled with less medication than usual.
Special enrollment period	A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Marketplace outside of the initial and annual open enrollment periods.
Specialist	A doctor or other healthcare professional who practices in a specific area other than those practiced in by PCPs, family doctors, and other general practitioners; **or** a properly licensed, certified, or registered individual healthcare provider whose practice is limited to rendering behavioral health services. For purposes of cost share, this definition of the term specialist does not apply to dentists. Your benefit plan does not require you to get a referral from a PCP before you see a specialist.
Specialty medications	Medications that treat chronic or complex conditions. AZ Blue/PBM determine which medications are specialty medications.
Specialty pharmacy	A pharmacy contracted with AZ Blue/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 AZ Blue or the PBM will consider covering the brand-name version of that medication. The step therapy program also requires members to take certain medications on the formulary before AZ Blue or the PBM will consider approval of a formulary exception for a non-formulary medication. AZ Blue/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 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 AZ Blue to offer members the services of contracted healthcare providers over an interactive web platform. Amwell also provides technical support for the telehealth services (i.e., Telehealth from AZ Blue) covered under this plan.
Telehealth from AZ Blue	Medical and behavioral health services provided online via video using a computer, tablet, smartphone, or other mobile device through the telehealth services administrator.
Telehealth services from 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 AZ Blue 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

AZ Blue 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, AZ Blue provides equal parental access to information.

Appeal and grievance process

Members may participate in AZ Blue's appeal and grievance processes, which are described in detail in the AZ Blue Appeal and Grievance Guidelines. You can find these guidelines in your AZ Blue portal 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 AZ Blue.

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

Basis of operational guidelines

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

Billing limitations and exceptions

When there is another source of payment, such as a liability insurer, network providers may be entitled to collect any difference between the allowed amount and the provider's billed charges from the other source or from proceeds received from the other source, pursuant to A.R.S. (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 AZ Blue. AZ Blue 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). AZ Blue does not subrogate. If you are represented by an attorney in a dispute concerning recovery for injuries or illness, please show this section of your book to your attorney.

Blue Cross Blue Shield Association

This paragraph shall not create any additional obligations whatsoever on the part of AZ Blue other than those obligations created under other provisions of this agreement. 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 AZ Blue, 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 AZ Blue to use the Blue Cross and/or Blue Shield service marks in the state of Arizona;
- AZ Blue 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 AZ Blue; **and**
- Contract holder and members shall not seek to hold the Association or any Blue Cross or Blue Shield plan other than AZ Blue accountable or liable for AZ Blue's obligations created under this agreement.

Broker commissions

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

Cost of records

In order to process your claims, AZ Blue may need to ask your provider for copies of your health records. Network providers generally cannot charge you for providing AZ Blue with health records. Noncontracted providers have no contractual obligation to provide records to AZ Blue 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 AZ Blue, 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 AZ Blue eligibility requirements. The order must clearly specify the name of the contract holder, the name and birth date of each child covered by the order, and the time period to which the order applies. The court's order applies to the contract holder. It does not bind AZ Blue.

To obtain coverage for the child, the contract holder must submit an application. After receiving the contract holder's application for the child, AZ Blue will assign a rate for the child based on location, age, and applicable plan network. Coverage will not be effective until the date assigned by AZ Blue. 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 AZ Blue with satisfactory evidence that the child is enrolled or will be enrolled in other health coverage, effective on the date this coverage terminates or that the requirements of the order have been otherwise satisfied or terminated.

Dental necessity guidelines and criteria

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

- It is consistent with the diagnosis or treatment of a symptom, illness, disease, or injury;
- It is not primarily for the convenience of a member or a provider;
- It is rendered by an eligible provider acting within the provider's scope of practice, as determined by AZ Blue or its contracted vendor; **and**

- It meets AZ Blue's or its contracted vendor's dental necessity guidelines and criteria in effect when the service is rendered. If AZ Blue or its contracted vendor does not have formal dental necessity guidelines or criteria for a dental service, AZ Blue or its contracted vendor will base its decision on the judgment and expertise of an AZ Blue healthcare professional or dental consultant retained by AZ Blue or its contracted vendor.

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

Decisions about dental necessity may differ from your provider's opinion. A provider may prescribe, order, recommend, or approve a service that AZ Blue or its contracted vendor decides is not dentally necessary and, therefore, is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered. If you have an adverse determination, refer to the Explanation of Benefits and the Appeal and grievance process sections.

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

Discretionary authority

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

Experimental or investigational services

AZ Blue or AZ Blue's contracted vendor, in its sole and absolute discretion, decides whether a service or item is experimental or investigational. 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.

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

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

Identity protection services

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

Lawsuits against AZ Blue

AZ Blue has an appeal process for resolving certain types of disputes with members. AZ Blue encourages you to use the appeal process before filing a lawsuit, as 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 AZ Blue, a member must first either:

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

The written notice must 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 AZ Blue's administrative remedies (that is, for not using all of our available solutions). By providing this notice, AZ Blue does not waive but expressly reserves all applicable defenses available under federal and Arizona law.

Legal action and applicable law

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

Medicaid reimbursement

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

Medical necessity definition, guidelines, and criteria

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

AZ Blue 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.

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

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

AZ Blue sends most notices and communications electronically. By providing your email address to AZ Blue, you consent to receive notices and communications in electronic form. You can change your communication preference anytime at azblue.com/member or call AZ Blue Customer Service. If you have not consented to electronic delivery, AZ Blue will send these communications by U.S. mail to the most recent mailing address on file with AZ Blue Customer Service. 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 AZ Blue and imposes no duty or obligation on AZ Blue. If you receive covered services from an out-of-network provider and wish to assign your right to payment to the provider, you or the provider may submit the documents requesting assignment to AZ Blue. AZ Blue, at our sole discretion, will determine whether to honor the assignment and, if approved, remit any payment due directly to the provider.

No Surprises Act

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

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

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

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

Pediatric dental services predetermination of benefits

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

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

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

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

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

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

Plan amendments/changes

There is no guarantee that the benefits listed here will not change. Benefits, limitations, cost-share amounts, and all other provisions may be added, deleted, or changed upon notice to the contract holder and/or participant or as required according to federal or state laws.

AZ Blue 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

AZ Blue 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 AZ Blue 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 and due date

AZ Blue determines premiums as follows:

- Applicants will not be denied coverage due to a medical condition.
- Premiums vary based upon age, family composition, and whether any applicants are tobacco users.
- Premiums also vary based upon deductible amount and geographic rating area.
- When a child covered by a child-only policy reaches age 19, the child is automatically considered an adult contract holder.

Premium payments must be made to AZ Blue on or before the due date. If premiums are paid by check, premiums must be paid in U.S. dollars and drawn from a bank located and based in the United States. If you believe you have paid too much for your premium and should receive a refund, please call the Customer Service number on the back of your ID card.

Premium payment grace period

If you do not pay your premium by the premium due date, AZ Blue allows you a 31-day grace period to make the payment. AZ Blue is not responsible or liable for claims incurred during the grace period, unless AZ Blue receives payment before the end of the grace period.

- A premium not paid when due and not paid within the grace period is in default.
- 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 AZ Blue provided prior authorization for a service during the grace period, that prior authorization is null and void if the plan is later retroactively terminated for non-payment of premium.

The member is responsible for all medical expenses incurred during the grace period if the plan is later retroactively terminated for non-payment of premium. Please be aware that AZ Blue may decline to renew current coverage or to issue new coverage to you in the future if all outstanding premiums are not paid in full.

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

Premium payments by third parties

You are responsible for your premium payment. In accordance with guidance from Centers for Medicare and Medicaid Services (CMS), AZ Blue only accepts premium payments from the following third parties: Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services Act; Indian tribes, tribal organizations or urban Indian organizations; federal and state government programs; **or** family members.

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

Prescription medication rebates

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

The rebates AZ Blue receives on your prescription drug utilization are not reimbursable to you, including prescription costs applied to any copay, deductible, coinsurance calculation, or out-of-pocket maximum that may apply under your plan. You acknowledge and agree that AZ Blue will keep all rebates. Pharmacy rebates may cause the overall cost of a 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 AZ Blue allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors. For that reason, AZ Blue network providers have varying compensation levels based on the provider’s agreement to accept a certain reimbursement rate. This means that your network cost share for a particular service can vary based on the network provider you choose because not all providers have the same negotiated reimbursement rate for the same service.

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

Retroactive changes

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

APPENDIX C: PEDIATRIC DENTAL CODES

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

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

Type I

Procedure Code	Procedure Description
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT
D0170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT
D0191	ASSESSMENT OF A PATIENT
D0210	INTRAORAL - COMPLETE SERIES (RADIOGRAPHIC IMAGE)
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE
D0250	EXTRAORAL - 2D PROJECTION RADIOGRAPHIC IMAGE CREATED USING A STATIONARY RADIATION SOURCE, AND DETECTOR
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES
D0330	PANORAMIC RADIOGRAPHIC IMAGE
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS
D0372	INTRAORAL TOMOSYNTHESIS COMP SERIES OF RADIOGRAPHIC IMAGES
D0373	INTRAORAL TOMOSYNTHESIS BITEWING RADIOGRAPHIC IMAGE
D0374	INTRAORAL TOMOSYNTHESIS PERIAPICAL RADIOGRAPHIC IMAGE
D0387	INTRAORAL TOMOSYNTHESIS COMP SERIES RADIOGRAPHIC IMAGES CAPTURE ONLY
D0388	INTRAORAL TOMOSYNTHESIS BITEWING RADIOGRAPHIC IMAGE CAPTURE ONLY
D0389	INTRAORAL TOMOSYNTHESIS PERIAPICAL RADIOGRAPHIC IMAGE CAPTURE ONLY
D0414	LAB PROCESSING OF SPECIMEN
D0419	ASSESSMENT OF SALIVARY FLOW BY MEASUREMENT
D0460	PULP VITALITY TESTS
D0461	TESTING FOR CRACKED TOOTH

D0470	DIAGNOSTIC CASTS
D0600	DIAGNOSTIC PROCEDURE
D0705	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY
D0706	INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY
D0707	INTRAORAL – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY
D0708	INTRAORAL – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY
D0709	INTRAORAL – COMPLETE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CAPTURE ONLY
D0801	3D DENTAL SURFACE SCAN DIRECT
D0802	3D DENTAL SURFACE SCAN INDIRECT
D0803	3D FACIAL SURFACE SCAN DIRECT
D0804	3D FACIAL SURFACE SCAN INDIRECT
D1110	PROPHYLAXIS - ADULT
D1120	PROPHYLAXIS - CHILD
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH
D1351	SEALANT - PER TOOTH
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION
D1355	CARIES PREVENTIVE MEDICAMENT APPLICATION – PER TOOTH
D1510	SPACE MAINTAINER-FIXED UNILATERAL
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR
D1520	SPACE MAINTAINER-REMOVABLE UNILATERAL
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MAXILLARY
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MANDIBULAR
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER – PER QUADRANT
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER – PER QUADRANT
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MAXILLARY
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MANDIBULAR
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN
D9311	CONSULTATION WITH A MEDICAL HEALTH CARE PROFESSIONAL
D9912	PRE-VISIT DENTAL PATIENT SCREENING
D9994	DENTAL CASE MANAGEMENT - PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL-TIME ENCOUNTER
D9997	DENTAL CASE MANAGEMENT – PATIENTS WITH SPECIAL HEALTH CARE NEEDS

Type II

Procedure Code	Procedure Description
D2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT
D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT
D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT
D2161	AMALGAM - FOUR OR MORE SURFACES PRIMARY OR PERMANENT
D2330	RESIN, ONE SURFACE, ANTERIOR
D2331	RESIN, TWO SURFACES, ANTERIOR
D2332	RESIN, THREE SURFACES, ANTERIOR
D2335	RESIN- FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR
D3110	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)

D3120	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT
D3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)
D3240	PULPAL THERAPY (RESORBABLE FILLING)- POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)
D3355	PULPAL REGENERATION - INITIAL VISIT
D3356	PULPAL REGENERATION - INTERIM MEDICATION REPLACEMENT
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT
D4346	SCALING IN PRESENCE OF MODERATE OR SEVERE GINGIVAL INFLAMMATION
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS
D4910	PERIODONTAL MAINTENANCE
D7111	EXTRACTION, CORONAL REMNANTS - DECIDUOUS TOOTH
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)
D7880	OCCLUSAL ORTHOTIC APPLIANCE
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURES
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION
D9612	THERAPEUTIC PARENTERAL DRUGS, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS
D9613	INFILTRATION OF SUSTAINED RELEASE THERAPEUTIC DRUG - SINGLE OR MULTIPLE SITES
D9910	APPLICATION OF DESENSITIZING MEDICAMENT
D9911	APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH
D9936	CLEANING AND INSPECTION OF OCCLUSAL GUARD - PER APPLIANCE
D9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH
D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH

Type III

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

D2722	CROWN-RESIN WITH NOBLE METAL
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL
D2751	CROWN-PROCELAIN FUSED TO PREDOMINANTLY BASE METAL
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL
D2753	CROWN PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL
D2781	CROWN - 3/4 CAST PREDOMINATELY BASE METAL
D2782	CROWN - 3/4 CAST NOBLE METAL
D2783	CROWN - 3/4 PORCELAIN/CERAMIC
D2790	CROWN - FULL CAST HIGH NOBLE METAL
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL
D2792	CROWN-FULL CAST NOBLE METAL
D2794	CROWN-TITANIUM
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED CAST OR PREFABRICATED POST AND CORE
D2920	RE-CEMENT OR RE-BOND CROWN
D2928	PREFABRICATED PORCELAIN/CERAMIC CROWN – PERMANENT TOOTH
D2929	PREFABRICATED PORCELAIN/CERAMIC CROWN - PRIMARY TOOTH
D2930	PREFABRICATED STAINLESS STEEL CROWN -PRIMARY TOOTH
D2931	PREFABRICATED STAINLESS STEEL CROWN -PERMANENT TOOTH
D2932	PREFABRICATED RESIN CROWN
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH
D2940	PROTECTIVE RESTORATION
D2941	INTERIM THERAPEUTIC RESTORATION - PRIMARY DENTITION
D2949	RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION
D2950	CORE BUILD-UP, INCLUDING ANY PINS WHEN REQUIRED
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN
D2956	REMOVAL OF AN INDIRECT RESTORATION ON A NATURAL TOOTH
D2980	CROWN REPAIR, NECESSITATED BY RESTORATIVE MATERIAL FAILURE
D2981	INLAY REPAIR
D2982	ONLAY REPAIR
D2983	VENEER REPAIR
D2990	RESIN INFILTRATION/SMOOTH SURFACE
D3310	ENDODONTIC THERAPY, ANTERIOR (EXCLUDING FINAL RESTORATION)
D3320	ENDODONTIC THERAPY BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)
D3330	ENDODONTIC THERAPY MOLAR (EXCLUDING FINAL RESTORATION)
D3331	TREATMENT OF ROOT CANAL OBSTRUCTION; NON SURGICAL ACCESS
D3332	INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR
D3351	APEXIFICATION/RECALCIFICATION- INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)
D3352	APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.)
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)
D3410	APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR
D3421	APICOECTOMY - BICUSPID (FIRST ROOT)
D3425	APICOECTOMY - MOLAR (FIRST ROOT)
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)

D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY
D3428	BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY - PER TOOTH, SINGLE SITE
D3430	RETROGRADE FILLING-PER ROOT
D3432	GUIDED TISSUE REGENERATION RESORBABLE BARRIER, PER SITE IN CONJUNCTION WITH PERIRADICULAR SURGERY
D3450	ROOT AMPUTATION-PER ROOT
D3471	SURGICAL REPAIR OF ROOT RESORPTION – ANTERIOR
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR
D3501	SURG EXPOSURE OF ROOT SURFACE W/O APICOECTOMY OR REPAIR OF ROOT RESORPTION – ANTERIOR
D3502	SURG EXPOSURE OF ROOT SURFACE W/O APICOECTOMY OR REPAIR OF ROOT RESORPTION – PREMOLAR
D3503	SURG EXPOSURE OF ROOT SURFACE W/O APICOECTOMY OR REPAIR OF ROOT RESORPTION – MOLAR
D3911	INTRAORVICE BARRIER
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL) - NOT INCLUDING ROOT CANAL THERAPY
D3921	DECORONATION OR SUBMERGENCE OF ERUPTED TOOTH
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGIOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4212	GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4245	APICALLY POSITIONED FLAP
D4249	CLINICAL CROWN LENGTHENING-HARD TISSUE
D4260	OSSEOUS SURGERGY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4261	OSSEOUS SURGERGY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)- ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT
D4263	BONE REPLACEMENT GRAFT -FIRST SITE IN QUADRANT
D4264	BONE REPLACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT
D4266	GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE
D4267	GUIDED TISSUE REGENERATION - NON-RESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL)
D4268	SURGICAL REVISION PROCEDURE, PER TOOTH
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES), FIRST TOOTH OR EDENTULOUS TOOTH, IMPLANT, POSITION IN SAME GRAFT SITE
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES), EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE
D4286	REMOVAL OF NON-RESORBABLE BARRIER
D4322	SPLINT INTRA-CORONAL; NATURAL TEETH OR PROSTH CROWNS
D4323	SPLINT EXTRA-CORONAL; NATURAL TEETH OR PROSTH CROWNS
D5110	COMPLETE DENTURE - MAXILLARY
D5120	COMPLETE DENTURE - MANDIBULAR
D5130	IMMEDIATE DENTURE -MAXILLARY
D5140	IMMEDIATE DENTURE - MANDIBULAR
D5211	UPPER PARTIAL - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5212	LOWER PARTIAL - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5214	MANDIBULAR PARTIAL DENTURE, CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)
D5225	MAXILLARY PARTIAL DENTURE-FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)
D5226	MANDIBULAR PARTIAL DENTURE-FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)
D5228	IMMEDIATE MANDIBULAR PARTIAL DENTURE FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE, ONE PIECE CAST METAL, MAXILLARY
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE, ONE PIECE CAST METAL, MANDIBULAR
D5410	ADJUST COMPLETE DENTURE, MAXILLARY
D5411	ADJUST COMPLETE DENTURE, MANDIBULAR
D5421	ADJUST PARTIAL DENTURE-MAXILLARY
D5422	ADJUST PARTIAL DENTURE-MANDIBULAR
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH)
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH
D5640	REPLACE BROKEN TEETH-PER TOOTH
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE - PER TOOTH
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)
D5671	REPLACE TEETH AND ACRYLIC ON METAL FRAMEWORK (MANDIBULAR)
D5710	REBASE COMPLETE MAXILLARY DENTURE
D5711	REBASE COMPLETE MANDIBULAR DENTURE
D5720	REBASE MAXILLARY PARTIAL DENTURE
D5721	REBASE MANDIBULAR PARTIAL DENTURE
D5725	REBASE HYBRID PROSTHESIS
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)
D5731	RELINE LOWER COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)
D5765	SOFT LINER FOR COMPLETE OR PARTIAL REMOVABLE DENTURE INDIRECT
D5850	TISSUE CONDITIONING, MAXILLARY
D5851	TISSUE CONDITIONING, MANDIBULAR
D5863	OVERDENTURE - COMPLETE MAXILLARY
D5865	OVERDENTURE - COMPLETE MANDIBULAR
D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH)
D6010	SURGICAL PLACEMENT OF IMPLANT BODY; ENDOSTEAL IMPLANT
D6011	SECOND STAGE IMPLANT SURGERY
D6012	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT
D6013	SURGICAL PLACEMENT OF MINI IMPLANT
D6040	SURGICAL PLACEMENT: EPOSTEAL IMPLANT
D6049	SCALING AND DEBRIDEMENT OF A SINGLE IMPLANT IN THE PRESENCE OF PERI-IMPLANTITIS
D6050	SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT

D6051	INTERIM ABUTMENT - INCLUDES PLACEMENT AND REMOVAL
D6055	CONNECTING BAR -IMPLANT SUPPORTED OR ABUTMENT SUPPORTED
D6056	PREFABRICATED ABUTMENT - INCLUDES MODIFICATION AND PLACEMENT
D6057	CUSTOM FABRICATED ABUTMENT - INCLUDES PLACEMENT
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN
D6066	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS
D6067	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FIXED PARTIAL DENTURE
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FIXED PARTIAL DENTURE (HIGH NOBLE METAL)
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FIXED PARTIAL DENTURE (PREDOMINANTLY BASE METAL)
D6071	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FIXED PARTIAL DENTURE (NOBLE METAL)
D6072	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FIXED PARTIAL DENTURE (HIGH NOBLE METAL)
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FIXED PARTIAL DENTURE (PREDOMINATELY BASE METAL)
D6074	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FIXED PARTIAL DENTURE (NOBLE METAL)
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FIXED PARTIAL DENTURE
D6076	IMPLANT SUPPORTED RETAINER FOR FIXED PARTIAL DENTURE - PORCELAIN FUSED TO HIGH NOBLE ALLOYS
D6077	IMPLANT SUPPORTED RETAINER FOR METAL FIXED PARTIAL DENTURE - HIGH NOBLE ALLOYS
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH FIXED HYBRID PROSTHESIS IS REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIS AND ABUTMENTS
D6081	SCALING AND DEBRIDEMENT IN PRESENCE OF INFLAMMATION OF SINGLE IMPLANT
D6082	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS
D6083	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS
D6084	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM OR TITANIUM ALLOYS
D6085	PROVISIONAL CROWN
D6086	IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS
D6087	IMPLANT SUPPORTED CROWN - NOBLE ALLOYS
D6088	IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS
D6089	ACCESSING AND RETORQUING LOOSE IMPL SCREW - PER SCREW
D6090	REPAIR OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS
D6091	REPLACEMENT OF REPLACEABLE PART OF SEMI-PRECISION OR PRECISION ATTACHMENT OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT
D6092	RE-CEMENT OR RE-BONDED IMPLANT/ABUTMENT SUPPORTED CROWN
D6093	RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW
D6097	ABUTMENT SUPPORTED CROWN – PORCELAIN FUSED TO TITANIUM OR TITANIUM ALLOYS
D6098	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS
D6099	IMPLANT SUPPORTED RETAINER FOR FIXED PARTIAL DENTURE - PORCELAIN FUSED TO NOBLE ALLOYS
D6100	SURGICAL REMOVAL OF IMPLANT BODY
D6101	DEBRIDEMENT OF A PERI-IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT, AND SURFACE CLEANING OF THE EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE
D6102	DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERI-IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT AND INCLUDES SURFACE CLEANING OF THE EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE
D6103	BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT - DOES NOT INCLUDE FLAP ENTRY AND CLOSURE
D6104	BONE GRAFT AT TIME OF IMPLANT PLACEMENT
D6110	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY
D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR
D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY

D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR
D6114	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY
D6115	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR
D6116	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY
D6117	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY
D6120	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS
D6121	IMPLANT SUPPORTED RETAINER FOR METAL FIXED PARTIAL DENTURE - PREDOMINANTLY BASE ALLOYS
D6122	IMPLANT SUPPORTED RETAINER FOR FIXED PARTIAL DENTURE METAL - NOBLE ALLOYS
D6123	IMPLANT SUPPORTED RETAINER FOR METAL FIXED PARTIAL DENTURE – TITANIUM AND TITANIUM ALLOYS
D6180	IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH FIXED HYBRID PROSTHESIS IS NOT REMOVED, INCLUDING CLEANSING OF PROSTHESIS AND ABUTMENTS
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT
D6191	SEMI-PRECISION ABUTMENT – PLACEMENT
D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT
D6193	REPLACEMENT OF AN IMPLANT SCREW
D6195	ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS
D6198	REMOVE INTERIM IMPLANT COMPONENT
D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE
D6210	PONTIC - CAST HIGH NOBLE METAL
D6211	PONTIC - CAST PREDOMINANTLY BASE METAL
D6212	PONTIC - CAST NOBLE METAL
D6214	PONTIC – TITANIUM
D6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL
D6241	PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL
D6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL
D6243	PONTIC – PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS
D6245	PONTIC-PORCELAIN/CERAMIC
D6250	PONTIC-RESIN WITH HIGH NOBLE METAL
D6251	PONTIC-RESIN WITH PREDOMINANTLY BASE METAL
D6252	PONTIC-RESIN WITH NOBLE METAL
D6253	PROVISIONAL PONTIC
D6519	INLAY/ONLAY – PORCELAIN/CERAMIC
D6520	INLAY – METALLIC – TWO SURFACES
D6530	INLAY – METALLIC – THREE OR MORE SURFACES
D6543	ONLAY – METALLIC – THREE SURFACES
D6544	ONLAY – METALLIC – FOUR OR MORE SURFACES
D6545	RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTHESIS
D6548	RETAINER - PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS
D6600	RETAINER INLAY - PORCELAIN/CERAMIC, TWO SURFACES
D6601	RETAINER INLAY - PORCELIAN/CERAMIC, THREE OR MORE SURFACES
D6602	RETAINER INLAY - CAST HIGH NOBLE METAL, TWO SURFACES
D6603	RETAINER INLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES
D6604	RETAINER INLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES
D6605	RETAINER INLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES
D6606	RETAINER INLAY - CAST NOBLE METAL, TWO SURFACES
D6607	RETAINER INLAY - CAST NOBLE METAL THREE OR MORE SURFACES
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC, TWO SURFACES
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC, THREE OR MORE SURFACES
D6610	RETAINER ONLAY - CAST HIGH NOBLE METAL, TWO SURFACES
D6611	RETAINER ONLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES
D6612	RETAINER ONLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES
D6613	RETAINER ONLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES
D6614	RETAINER ONLAY - CAST NOBLE METAL, TWO SURFACES

D6615	RETAINER ONLAY - CAST NOBLE METAL, THREE OR MORE SURFACES
D6624	RETAINER INLAY - TITANIUM
D6634	RETAINER ONLAY - TITANIUM
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE
D6720	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL
D6721	RETAINER CROWN - RESIN WITH PREDOMINANTLY BASE METAL
D6722	RETAINER CROWN - RESIN WITH NOBLE METAL
D6740	RETAINER CROWN - PORCELAIN/CERAMIC
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL
D6753	RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL
D6781	CROWN - 3/4 CAST PREDOMINATELY BASE METAL
D6782	CROWN - 3/4 CAST NOBLE METAL
D6783	RETAINER CROWN - 3/4 CAST PORCELAIN/CERAMIC
D6784	RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL
D6792	RETAINER CROWN - FULL CAST NOBLE METAL
D6794	RETAINER CROWN - TITANIUM
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE
D6980	BRIDGE REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTION OF TOOTH, AND ELEVATION OF MUCOPERIOSTEAL FLAP
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY
D7241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL
D7252	PARTIAL EXTRACTION FOR IMMEDIATE IMPLANT PLACEMENT
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH
D7280	SURGICAL ACCESS OF UNERUPTED TOOTH
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION
D7297	CORTICOTOMY - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT
D7298	REMOVAL OF TEMPORARY ANCHORAGE DEVICE (SCREW RETAINED PLATE) REQ FLAP
D7299	REMOVAL OF TEMPORARY ANCHORAGE DEVICE REQ FLAP
D7300	REMOVAL OF TEMPORARY ANCHORAGE DEVICE WITHOUT FLAP
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY
D7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)
D7520	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE
D7521	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)
D7720	MAXILLA - CLOSED REDUCTION
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM
D7921	COLLECT - APPLY AUTOLOGOUS PRODUCT

D7922	PLACEMENT INTRA-SOCKET BIOLOG DRESSING TO AID HEMOSTASIS/CLOT STABILIZATION, PER SITE
D7953	BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION-PER SITE
D7960	FRENULECTOMY ALSO KNOWN AS FRENECTOMY OR FRENOTOMY-SEPARATE PROCEDURE NOT INCIDENTAL TO ANOTHER PROCEDURE
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)
D7971	EXCISION OF PERICORONAL GINGIVAL
D7979	NON-SURGICAL SILAOLITHOTOMY
D9120	FIXED PARTIAL DENTURE SECTIONING
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT
D9224	ADMINISTRATION OF GENERAL ANESTHESIA WITH ADVANCED AIRWAY - FIRST 15-MINUTE INCREMENT OR ANY PORTION THEREOF
D9225	ADMINISTRATION OF GENERAL ANESTHESIA WITH ADVANCED AIRWAY - EACH SUBSEQUENT 15-MINUTE INCREMENT, OR ANY PORTION THEREOF
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT
D9930	TREATMENT OF COMPLICATIONS (POSTSURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT

Type IV

Procedure Code	Procedure Description
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE
D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION
D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION
D8040	LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION
D8091	COMPREHENSIVE ORTHODONTIC TREATMENT WITH ORTHOGNATHIC SURGERY
D8210	REMOVABLE APPLIANCE THERAPY
D8220	FIXED APPLIANCE THERAPY
D8660	PRE-ORTHODONTIC EXAMINATION TO MONITOR GROWTH AND DEVELOPMENT
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT
D8671	PERIODIC ORTHODONTIC TREATMENT VISIT ASSOCIATED WITH ORTHOGNATHIC SURGERY
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S))
D8681	REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT
D8696	REPAIR OF ORTHODONTIC APPLIANCE – MANDIBULAR
D8697	REPAIR OF ORTHODONTIC APPLIANCE – MANDIBULAR
D8698	RE-CEMENT OR RE-BOND FIXED RETAINER – MAXILLARY
D8699	RE-CEMENT OR RE-BOND FIXED RETAINER – MANDIBULAR
D8701	REPAIR OF FIXED RETAINER, INCLUDES REATTACHMENT – MAXILLARY
D8702	REPAIR OF FIXED RETAINER, INCLUDES REATTACHMENT – MANDIBULAR
D8703	REPLACEMENT OF LOST OR BROKEN RETAINER – MAXILLARY
D8704	REPLACEMENT OF LOST OR BROKEN RETAINER – MANDIBULAR
D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCE(S) – OTHER THAN AT CONCLUSION OF TREATMENT

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