#31

SEP 11 2014

MEMORANDUM

DATE: September 11, 2014

TO: Mayor and Council

THRU: Rich Dlugas, City Manager RD
Debra Stapleton, Director of Human Resources Division DAS

FROM: Rae Lynn Nielsen, Benefits & Labor Relations Administrator RN

SUBJECT: Recommendation for Approval of Blue Cross Blue Shield of Arizona Agreement, 2015 Healthcare Plan Design and Monthly Premium Contribution

RECOMMENDATION: Approve and authorize the Mayor and Council to approve the one (1) year extension to the agreement between the City of Chandler and Blue Cross Blue Shield of Arizona for benefit plan year 2015, effective January 1, 2015.

Approve and authorize the Mayor and Council to approve benefit plan year 2015 healthcare plan design.

Approve and authorize the Mayor and Council to approve benefit plan year 2015 healthcare monthly premiums.

BACKGROUND: The City's medical benefit is reviewed throughout the year by staff and in collaboration and input from the city-wide Healthcare Task Force (Task Force) with assistance from a benefits consulting firm.

In 2014 the City introduced the Red and Blue benefit plans. Both benefit plans include well established benefit designs of co-insurance, deductibles and out of pocket maximums. The Red Plan best mirrors the City's 2013 benefit design for it maintains the "co-pay" feature for basic services such as primary care and specialist doctor visits, of which the member pays a flat fee for a service. The Blue Plan best mirrors that of a true deductible/co-insurance benefit plan. The introduction of these plans was part of two year strategy with the final piece being the introduction of a High Deductible Health Plan (HDHP)-known as the "White Plan", with a Health Savings Account (HSA) in the 2015 benefit year.

The City's Human Resources benefits staff, the benefits consultant, and the Task Force have engaged in discussions since 2011 about the possibility of a HDHP. The goal was to design a plan that follows the City's strategic benefit plan offering principles. Those principles include; compliance with the Patient Protection and Affordable Care Act, commonly referred to as the Affordable Care Act (ACA), provide employee/dependent choice both in coverage options and financially, engage membership in their personal health, educate membership on the cost of medical and pharmacy services, and ensure sustainability of health insurance benefit plans. The City's benefit consultant facilitated the Task Force meetings where significant discussion, education, and evaluation occurred. The Task Force outlined several key components they felt would be important to implement a successful HDHP for City employees. The City's Human Resources benefits staff along with the benefits consultant worked with the City's healthcare actuary to establish a plan that met the principals. As a result, the proposal of adding the White benefit plan to the existing Red and Blue benefit plans is being presented before Mayor and Council.

No benefit plan design changes will be made to the Red and Blue plans in 2015. The White plan is a HDHP that features higher deductibles than traditional insurance plans including the existing Red and Blue plans. HDHPs include federally determined minimum deductible levels that may be adjusted annually by the Internal Revenue Service (IRS). The plan cannot include "first dollar" benefits, with the exception of preventative care, for services covered under the deductible. A high-deductible, health savings account qualified plan is required to open an (HSA) account. The White plan meets these qualifications. An HSA is an employee owned tax-advantaged savings and spending account that can be used to pay for qualified medical expenses. Employers and employees may contribute to the HSA but there are contribution limits required by the IRS. The HSA provides the opportunity to use tax-free dollars to pay for qualified medical expenses, and unlike a Flexible Spending Account (FSA), allows the money to be carried forward year after year.

In 2015, the City will contribute $1,000 into the HSA accounts of employees that select the White Plan. This contribution will be deposited into each account the first pay period of the plan year. The City's contribution, coupled with voluntary contributions made by the employee, will help provide a balance in the HSA that will help mitigate initial out-of-pocket medical expenses that may occur.

All plans will continue to provide for preventative services at 100% such as well women and well man visits, along with well-baby visits. The contracted network and network discounts apply to all plans as well.

The pharmacy benefit will continue to operate with a co-pay feature immediately in the Red and Blue Plan. The same co-pay structure was established in the White Plan, but is not applicable until the employee has reached their deductible based on the legal requirements of a HDHP. The Task Force was cognizant of the fact that the city's pharmacy benefit is highly utilized; therefore, they wanted to ensure that regardless of what benefit plan the employee selected, the benefit would be administered the same for all plans with the noted exception on the White Plan.

The City will continue to contract with Blue Cross Blue Shield of Arizona to provide the administration of the City's group medical and pharmacy program, to include customer service support, administrative services, network contracts, clinical programs, pharmacy benefit management service, and stop-loss coverage.

On August 28, 2014, after review and consideration of the financial attestation provided by the City's healthcare actuary and in accordance with the City of Chandler Health Care Benefits Trust Agreement, the City's Health Benefits Trust Board approved benefit plan year 2015 healthcare benefit premiums and requested that said premiums be presented to City Council for review and approval.

As previously noted in the City's budget proceedings and subsequently approved by the Mayor and Council the contribution strategy will remain at an 80/20 split of which the City pays 80% and the employee 20% for the Red and Blue Plan.

The White Plan premium will be paid 100% by the City. This strategy will provide employees with an opportunity to deposit a portion or all of what they would have normally paid in premiums, into their HSA in order to cover expenses subject to the deductible.

The proposed 2015 proposed premiums have been provided in the following chart.

MEDICAL	RED PLAN				BLUE PLAN				WHITE PLAN			
	Monthly			Employee per pay period	Monthly			Employee per pay period	Monthly			Employee per pay period
	Total premium	Employer 80%	Employee 20%		Total premium	Employer 80%	Employee 20%		Total premium	Employer 100%	Employee 0%	
Employee only	$733.10	$586.48	$146.62	$73.31	$616.12	$492.90	$123.22	$61.61	$492.90	$492.90	$0.00	$0.00
Employee + spouse	$1,224.20	$979.36	$244.84	$122.42	$1,028.86	$823.10	$205.76	$102.88	$823.10	$823.10	$0.00	$0.00
Employee + child(ren)	$1,084.88	$867.90	$216.98	$108.49	$911.76	$729.42	$182.34	$91.17	$729.42	$729.42	$0.00	$0.00
Employee + family	$1,781.30	$1,425.04	$356.26	$178.13	$1,497.06	$1,197.64	$299.42	$149.71	$1,197.66	$1,197.66	$0.00	$0.00

The HR Benefits staff developed and will be presenting various forms and venues of communication regarding the White Plan to City employees, dependents and retirees. This will be done in order to ensure they have an adequate understanding of the plan choices for 2015 and the differences of how a HDHP plan operates as well as an HSA.

Exhibit (H)-Benefit Plan Booklets in the amendment is on file in the City Clerk's office.

PROPOSED MOTION: Move to approve and authorize the Mayor and Council to approve the one (1) year extension to the agreement between the City of Chandler and Blue Cross Blue Shield of Arizona for benefit plan year 2015, effective January 1, 2015.

Move to approve and authorize the Mayor and Council to approve 2015 healthcare plan design.

Move to approve and authorize the Mayor and Council to approve benefit plan year 2015 healthcare monthly premiums.

CALENDAR YEAR 2015 AMENDMENT
TO THE ADMINISTRATIVE SERVICES AGREEMENT
BETWEEN THE CITY OF CHANDLER AND
BLUE CROSS BLUE SHIELD OF ARIZONA, INC.

This Amendment ("Calendar Year 2015 Amendment") is made and entered into this _____ day of _____, 2014 to the *Administrative Services Agreement Between the City of Chandler and Blue Cross Blue Shield of Arizona, Inc.* Group Contract Number 28399 ("Administrative Services Agreement") and the Maximum Aggregate and Specific Liability Agreement Group Contract Number 28399 ("Stop Loss Agreement").

WHEREAS, the City and BCBSAZ executed the Administrative Services Agreement effective January 1, 2011 through December 31, 2011, and

WHEREAS, the City and BCBSAZ executed Stop Loss Agreement effective January 1, 2011 through December 31, 2011; and

WHEREAS, the City of Chandler, hereinafter called the "City", and Blue Cross Blue Shield of Arizona, Inc., an independent licensee of the Blue Cross and Blue Shield Association hereinafter called "BCBSAZ", entered into an Agreement with an initial term from January 1, 2011 through December 31, 2011; and subsequently the Agreement was amended to extend the term though December 31, 2012 and for certain other changes through the *Calendar Year 2012 Amendment to the Memorandum of Agreement Between the City of Chandler and Blue Cross Blue Shield of Arizona, Inc.;* and

WHEREAS, the City and BCBSAZ through *Calendar Year 2013 Amendment to the Memorandum of Agreement Between the City of Chandler and Blue Cross and Blue Shield of Arizona* amended the Agreement and the 1) to extend the term to include the period from January 1, 2013 through December 31, 2013; and 2) amend the renewal rates for that calendar year.

WHEREAS, the City and BCBSAZ through *Calendar Year 2014 Amendment to the Memorandum of Agreement Between the City of Chandler and Blue Cross and Blue Shield of Arizona* amended the Agreement to: 1) extend the term to include the period from January 1, 2014 through December 31, 2014; 2) amend the grace period; and 3) amend the Health Insurance Portability and Accountability Act of 1996 section.

WHEREAS, the City and BCBSAZ now want to amend both the Administrative Services and Stop Loss Agreements:

NOW, THEREFORE, in consideration of the mutual covenants and provisions contained herein and other good and valuable consideration, the parties agree as follows:

I. The Effective Dates of the Administrative Services and Stop Loss Agreements are hereby amended to extend the term from January 1, 2015 through December 31, 2015.

II. Section VIII. ("Duties of the Employer") of the Administrative Services Agreement is amended to include the following Subsection W. ("HDHP and HSA") and Subsection X. ("HSA Integration"):

W. **HDHP and HSA.** For Participants enrolling in a plan which may be paired with a health savings account (HSA), the City will: (a) make the establishment of HSAs completely voluntary; (b) not limit the ability of HSA eligible individuals to move their funds to another HSA beyond restrictions imposed by the Internal Revenue Code; (c) not impose conditions on the utilization of HSA funds beyond those permitted in the Internal Revenue Code; (d) not make or influence the investment decisions with respect to funds contributed to HSAs; (e) not represent that the HSAs are a welfare benefit plan established or maintained by the City; and (f) not receive compensation in connection with an HSA. BCBSAZ is not responsible for any HSA which may be established by a Participant or with determining whether a Participant is eligible to establish an HSA.

X. **HSA Integration.** When a Participant wishes to have the high deductible plan integrated with the HSA offered by BCBSAZ's contracted HSA administrator, the City shall obtain from each such adult Participant an authorization pursuant to the HIPAA Privacy Rule which authorizes BCBSAZ and its contracted vendors to provide to BCBSAZ's contracted HSA Administrator the Participant's protected health information to facilitate integration of the HSA and the HDHP. The City agrees to retain the HIPAA authorizations for the period of time required by HIPAA and provide copies to BCBSAZ upon request. The City will provide BCBSAZ with a list of all Enrollees who enroll in the HSA/HDHP that clearly identifies which of these enrollees has provided the City with the HIPAA authorization.

III. Exhibit C-1 of the Administrative Services Agreement is hereby amended by removing the existing Exhibit C-1 in its entirety, and replacing Exhibit C of the Stop Loss Agreement and Exhibit C-1 of the Administrative Services Agreement with the attached Exhibit C-1, entitled "Administrative Service Agreement Amendment (ASA Amendment) Effective Date: 01/01/2015 – 12/31/2015."

IV. The Administrative Services Agreement is hereby amended by removing Exhibit G of the Administrative Services Agreement in its entirety and

replacing it with the Exhibit G attached hereto and incorporated herein by this reference.

V. Exhibit H of the Administrative Services Agreement is hereby amended by removing the existing Blue Medical Option (this Blue Medical Option includes only benefits administered by BCBSAZ) and Red Medical Option (referred to collectively as the "Benefit Plan Booklets) in their entirety and replacing them with the attached PPO Red Medical Option, HAS White Medical Option and PPO Blue Medical Option (this Blue Medical Option includes only benefits administered by BCBSAZ), also referred to collectively as the "2015 Benefit Plan Booklets". The parties acknowledge that the new Exhibit H 2015 Benefit Plan Booklets are in draft form but may be changed after the execution but before the Effective Date of this amendment. If so, the new 2015 Benefit Plan Booklets will be, upon the acknowledgement of both parties' legal counsel that the changes are insubstantial, and are accepted as substitutes in the amended Administrative Services Agreement.

VI. Except for the provisions amended by items I through V. above, the Administrative Services Agreement as amended by the *Calendar Years 2012, 2013 and 2014 Amendments to the Memorandum of Agreement Between the City of Chandler and Blue Cross Blue Shield of Arizona, Inc.*, shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have caused this *Calendar Year 2015 Amendment* to be duly executed.

CITY OF CHANDLER,
an Arizona municipal corporation

By: _____
Mayor
DATE: _____

APPROVED AS TO FORM:

_____
City Attorney CH

ATTEST:

_____
City Clerk

BLUE CROSS BLUE SHIELD OF ARIZONA, INC.

By: _____
Title: Vice President
DATE: 8/20/14

APPROVED AS TO FORM
BCBSAZ Legal Division
By _____
Date 8/20/14
Attorney

EXHIBIT C-1

Administrative Service Agreement Amendment (ASA Amendment)

BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

Effective Date:	1/1/2015-12/31/2015	Date:	8/6/2014
Group / Bid ID:	28399	Bid/Renewal:	Renewal
Legal Name of Group:	City of Chandler	Days Notice:	210
Name of Group Health Plan:	City of Chandler Group Health Plan	SRE:	Ken Muth
Funding:	12/24 Incurred ASC, Medical and Pharmacy	Underwriter:	Anita Ortiz
Broker Paid:	LMI Benefits; Louis Montoya	UW Code:	LO
Commission:	0.0%	Pooling / Specific Stop Loss:	$300,000
Commission (% of Billed Rate):	0.0%	Aggregate Stop Loss:	110%
Total Enrollment:	1,530		

SOLD Plan(s) Benefit Outline

	Deductible	Coinsurance	OOP Max	OV	Spec	UC	ER	RX
Red Medical Option								
IN:	$250/$500	90%	$2,250/$4,500	$25	$40	$50	$100	$10/$20/$40, 2x MOD
OON:	$500/$1,000	70%	$4,500/$9,000					
Blue Medical Option								
IN:	$500/$1,000	85%	$2,500/$5,000	@ded & coins	@ded & coins	@ded & coins	$100	$10/$20/$40, 2x MOD
OON:	$1,500/$3,000	60%	$6,000/$12,000					
White Medical Option								
IN:	$1,500/$3,000	90%	$2,500/$5,000	@ded & coins	@ded & coins	@ded & coins	@ded & coins	$10/$20/$40, 2x MOD
OON:	$4,500/$9,000	70%	$7,500/$15,000					

SOLD Rates

Red Medical Option	Enrollment	Admin	SSL	ASL	Commissions	Other	Total Fixed Costs	ICAP	Expected Liability	Maximum Liability
Employee	340	$40.16	$17.71	$2.54	$0.00	$0.00	$60.41	$711.89	$707.58	$772.30
Employee + Spouse	222	$40.16	$29.57	$4.39	$0.00	$0.00	$74.12	$1,227.71	$1,190.22	$1,301.83
Employee + Child(ren)	203	$40.16	$26.20	$3.86	$0.00	$0.00	$70.23	$1,081.45	$1,053.36	$1,151.67
Employee + Family	573	$40.16	$43.03	$6.42	$0.00	$0.00	$89.60	$1,797.91	$1,724.07	$1,887.52
Total	1,338									

HCR Suite: N = Non-Grandfathered

Blue Medical Option	Enrollment	Admin	SSL	ASL	Commissions	Other	Total Fixed Costs	ICAP	Expected Liability	Maximum Liability
Employee	87	$40.16	$17.71	$2.48	$0.00	$0.00	$60.35	$693.83	$691.10	$754.18
Employee + Spouse	34	$40.16	$29.57	$4.28	$0.00	$0.00	$74.01	$1,196.58	$1,161.81	$1,270.59
Employee + Child(ren)	24	$40.16	$26.20	$3.76	$0.00	$0.00	$70.12	$1,054.01	$1,028.32	$1,124.14
Employee + Family	47	$40.16	$43.03	$6.26	$0.00	$0.00	$89.45	$1,752.31	$1,682.46	$1,841.76
Total	192									

HCR Suite: N = Non-Grandfathered

White Medical Option	Enrollment	Admin	SSL	ASL	Commissions	Other	Total Fixed Costs	ICAP	Expected Liability	Maximum Liability
Employee	0	$40.16	$17.71	$2.24	$0.00	$0.00	$60.11	$543.13	$553.86	$603.24
Employee + Spouse	0	$40.16	$29.57	$3.86	$0.00	$0.00	$73.59	$936.68	$925.12	$1,010.27
Employee + Child(ren)	0	$40.16	$26.20	$3.39	$0.00	$0.00	$69.76	$825.08	$819.83	$894.84
Employee + Family	0	$40.16	$43.03	$5.65	$0.00	$0.00	$88.84	$1,371.71	$1,335.85	$1,460.55
Total	0									

HCR Suite: N = Non-Grandfathered

Sold HealthEquity Account Pricing PEPM (not included above)

	Plan	Billed by BCBSAZ	Billed by HealthEquity	Total
Health Savings Account	White Medical Option	$2.70	$0.00	$2.70

Annual Set Up Fee (based on number HRA and FSA accounts and billed by HealthEquity)	<500 Accounts	500 - 2,999 Accounts	3,000+ Accounts
	$250	$500	$1,500

Groups selecting HealthEquity administration (including integration) services for HSA, HRA and/or FSA products hereby direct BCBSAZ to collect the HealthEquity administration fees reflected in the Administrative Service Agreement Amendment (ASA Amendment) and forward those fees to HealthEquity, along with the required personal health information. BCBSAZ is collecting the HealthEquity administrat a courtesy and is not responsible for any reconciliation, recoupment or adjustments to payments received and forwarded to HealthEquity on behalf of Employer. If Employer and HealthEquity negotiate alternative fees, Employer shall notify BCBSAZ.

Employer agrees to pay charges for HealthEquity administration services. For HSAs and HRAs, those charges apply to all employees enrolled in a health plan the group has paired with a Health Equity account. For FSAs, those charges apply to any employees for whom an FSA selection has been sent to BCBSAZ by the employer.

Proposed administration assumes BCBSAZ will retain Rx Rebates. In exchange for retaining Rx Rebates, BCBSAZ has adjusted the Admin PEPM by the Rx Rebate Credit. Rx Rebate Credit (PEPM) = -$11.40.

Premium tax is included in the specific and aggregate charges.

Minimum Monthly Attachment Level:	$1,775,729 based on 100% enrolled	Deposit Required:	No
Is Mayo Provider included in network?	No	Allotment $s Sold:	Yes
Rate Guarantee Sold:	Yes	$80,000 funds available Please refer to Assumption Page	
-Rate Guarantee Period:	2015 - Administration Fee		
-Rate Guarantee Details:	See Assumption Page	Performance Guarantees:	Yes
HealthEquity Integration:	Yes		

All information from the exhibit Assumptions #IASC-28399-2015, Performance Guarantees (Exhibit 1), 100+ Employer Application (Exhibit G) and Disclosure of "Eligible Indirect Compensation" (Exhibit 2) are incorporated herein by reference. Employer acknowledges electronic receipt of the Uniform Summaries of Benefits and Coverage (SBCs) for plans selected and the SBCs are incorporated herein by reference. As of the effective date on page 1, this amends and is made part of Employer's Administrative Services Agreement (ASA) with BCBSAZ. All provisions in the ASA not modified by this Amendment remain in full force and effect.

BCBSAZ reserves the right to adjust these premium rates retroactive to the first day of any billing month in which enrollment varies by no more than +25% / -15% percent from the current enrollment as of April 2014.

The health reform law provides for a transitional reinsurance program beginning in 2014. Self-insured plans are required to contribute to the reinsurance program.

The ACA prohibits waiting periods in excess of 90 days. By signing below you represent that you do not impose a waiting period which is longer than 90 days and that you have made all necessary changes to bring all waiting periods for your plan into compliance with the ACA requirements. You agree to promptly advise BCBSAZ of any change which may impact the accuracy of this representation. You agree to provide BCBSAZ with timely and accurate information regarding enrollee effective dates and shall ensure such effective dates comply with applicable laws.

This Rate Acceptance Form must be signed and returned prior to BCBSAZ issuing ID Cards. The Agreement will terminate if this Amendment is not signed and returned prior to the end of your current term. If any information on this Form is inaccurate, please provide the correct information on this Form.

James A. Brutto

BCBS Representative — Date: 8/6/2014

Group Representative — Date

Title

* BCBSAZ may adjust rates if the following requirements are not met:
  Where the employer contributes 100% of the employee cost, BCBSAZ requires 100% participation.
  Where the employer does not contribute 100%, BCBSAZ requires 70% of all eligible employees to participate.
  BCBSAZ requires a minimum of 50% of all full-time eligible employees in the group to be enrolled in the employer's group plan.
  Employer must contribute a minimum of 50% of the employee's health premium.
  Payroll deduction for employee contribution is required.

* Rates assume Blue Cross Blue Shield of Arizona is the sole medical and rx carrier.

* Rates assume Blue Cross Blue Shield of Arizona is the specific and aggregate stoploss carrier.

* BCBSAZ agrees to an administrative rate guarantee for 1/1/2014 thru 12/31/2015. This guarantee is based on Gross administration rate. BCBSAZ reserves the right to change the rate guarantee due to legislative changes. Rate changes will only be made at renewal time.

	PEPM
1/1/2014 - 12/31/2014 Gross Administration Rate	$ 52.60
1/1/2015 - 12/31/2015 Gross Administration Rate	$ 55.84

Guarantee is contingent upon BCBSAZ being selected as the sole stop loss carrier (Specific and Aggregate) for policy periods 1/2014 - 12/2014 and 1/2015 - 12/2015.

* BlueCard fees are included in the Attachment Point rate and are charged on the monthly invoice as a claim expense.

* BCBSAZ reserves the right to decline to provide coverage for residents of any state other than Arizona, if in BCBSAZ's sole opinion, such coverage would be inconsistent with state or federal law.

* The group will be billed each month prospectively for the Fixed Expenses.

* For HMO plans and for some outpatient behavioral health services for PPO plans, BCBSAZ contracts with a behavioral services administrator (BSA). The BSA makes medical necessity determinations based on its own medical necessity criteria. Services through the BSA are only available in Arizona. BCBSAZ pays a capitated amount per member per month to the BSA which generally differs from the capitated fee BCBSAZ charges Employer. The capitated fee BCBSAZ charges the employer is subject to change by BCBSAZ upon 60 days prior written notice. For HMO inpatient claims, a specified amount per member per month is placed into an inpatient risk fund from which inpatient claims are paid by BCBSAZ for services that have been approved by the BSA. The behavioral health provider is responsible for 100% of any excess claims payment over the amount funded and is entitled to 100% of the excess if the amount funded exceeds claims paid. The capitated fee(s) applicable to Employer is/are:
  Red Medical Option $1.99 PMPM
  Blue Medical Option $1.99 PMPM

* Costs for covered services provided by a chiropractor to PPO, EPO and indemnity members, including an allowance for BCBSAZ to maintain this arrangement, will be paid by the Employer to BCBSAZ on a per member per month (PMPM) basis. The PMPM rate each Employer pays BCBSAZ will differ from the capitated fee BCBSAZ negotiated with the chiropractic administrator. BCBSAZ negotiated the fee that BCBSAZ pays the chiropractic administrator on the basis of BCBSAZ's entire book of business, without regard to any individual Plan. The PMPM rate BCBSAZ charges the employer is subject to change by BCBSAZ upon 60 days prior written notice.
  The PMPM rate(s) for chiropractic services applicable to this Employer is/are:
  1. Red Medical Option $2.93 PMPM
  2. Blue Medical Option $2.93 PMPM
  3. White Medical Option $2.93 PMPM

  The PMPM capitated fee(s) BCBSAZ pays the chiropractic provider is/are:
  1. Red Medical Option $2.62 PMPM
  2. Blue Medical Option $2.62 PMPM
  3. White Medical Option $2.62 PMPM

* BCBSAZ and BCBSAZ's contracted pharmacy benefit manager enter into contracts with pharmaceutical manufacturers to receive rebate payments based on factors such as preferred drug list placement and the volume and/or market share of pharmaceutical products used by Participants in this Plan, participants in other group plans, and BCBSAZ subscribers ("rebate contracts"). BCBSAZ enters into rebate contracts on its own behalf, for its entire book of insured and administered business, and not on behalf of any specific individual or group benefit plan. BCBSAZ reserves the right to negotiate, enter into and terminate existing or future rebate contracts with pharmaceutical manufacturers at any time, and in its sole and absolute discretion.

  At Employer's request, the parties have agreed that BCBSAZ will provide Employer with an administrative fee credit, in the amount specified below, in lieu of BCBSAZ remitting, to Employer, any rebates attributable to drug utilization by Employer's participants. If BCBSAZ receives any rebates attributable to pharmaceutical products covered under the terms and conditions of this Agreement, and used by Participants of Employer's Plan, BCBSAZ shall retain any such rebates in exchange for the administrative credit BCBSAZ has extended to Employer. BCBSAZ shall not remit any rebate payments to Employer.

  Based on the amount of Rx rebates BCBSAZ received for its large group block of business for Calendar Year 2012, BCBSAZ calculates that the Rx rebates amount to approximately $5.88 Per Employee Per Month (PEPM) for Calendar Year 2012. Based on this group's contract period, claims experience and/or demographics, the group's administrative fees reflect a credit for Rx rebates as reflected in the ASA/Rate Acceptance Form. The parties agree to accept this credited amount regardless of the actual amount of rebates that BCBSAZ may receive for Participants' Rx utilization.

  The actual Rx PEPM rebate amount for your group, for Subtotal 4 Qtr 2012 – 3 Qtr 2013, was $11.21 PEPM.

* BCBSAZ and BCBSAZ's contracted pharmacy benefit manager enter into contracts with pharmaceutical manufacturers to receive rebate payments based on factors such as preferred drug list placement and the volume and/or market share of pharmaceutical products used by Participants in this Plan, participants in other group plans, and BCBSAZ subscribers ("rebate contracts"). BCBSAZ enters into rebate contracts on its own behalf, for its entire book of insured and administered business, and not on behalf of any specific individual or group benefit plan. BCBSAZ reserves the right to negotiate, enter into and terminate existing or future rebate contracts with pharmaceutical manufacturers at any time, and in its sole and absolute discretion.

  If BCBSAZ receives any rebates attributable to pharmaceutical products covered under the terms and conditions of this Agreement, and used by Participants of Employer's Plan, BCBSAZ shall remit any such rebates to Employer on an annual basis. BCBSAZ does not represent or warrant that Employer will receive any rebates.

  Employer acknowledges and agrees that the rebates received by BCBSAZ and remitted to Employer may result in Employer's overall cost of a particular drug falling below the amount Participants pay for such drug. Employer shall notify Participants in the Plan that Employer's cost for a drug may fall below the amount a Participant pays for the drug. Employer shall additionally notify Participants that other discounts offered to the general public by a pharmacy, including, but not limited to discounts for customers over age 55, may cause the drug cost that others pay, to fall below the amount that a Participant would pay for such drug pursuant to the terms and conditions of the Participant's coverage under this Agreement.

* BCBSAZ will create the Uniform Summaries of Coverage (SBC) for coverage provided by BCBSAZ. BCBSAZ will not create SBCs for any coverage the Group provides through a third-party or for health reimbursement arrangements, flexible spending accounts or health savings accounts provided by the Group. Unless directed by the Group, BCBSAZ will provide SBCs to Subscribers, as required by PPACA, except that the Group is solely responsible for delivering SBCs in accordance with PPACA: (i) to Subscribers during open enrollment; (ii) to newly eligible individuals; and (iii) to special enrollees.

* Pharmacy Network discounts are negotiated between BCBSAZ and our pharmacy benefit manager (PBM) over BCBSAZ's entire book of business and not on behalf of any group customer. You have been given the choice between the following PBM pricing models and have selected the Traditional model effective 1/1/2015.

  Pass Through PBM pricing model: allows you to pay the same discounted prices for prescription drugs that the PBM actually pays the pharmacies. Prices for the same drug may differ at different pharmacies. The Pass Through PBM pricing model passes on to you 100% of the specific pharmacies' network discount. However, it does not allow the PBM to lower the prices for expensive drugs by applying savings realized elsewhere.

  Traditional PBM pricing model: allows you to pay fixed discounted prices for prescription drugs regardless of the amount the PBM actually pays the pharmacies. This pricing model gives the PBM the flexibility to lower prices for more expensive drugs with savings realized elsewhere, but may not always result in the lowest price for every drug. The prices that the PBM actually pays the pharmacies for drugs may be higher or lower than the fixed price provided to you.

  Any projected savings discussed with you that may result from choosing one pricing model over the other are only estimates. Your actual savings may vary from these estimates.

* Beginning in 2015 the Affordable Care Act provides that certain large employers will be subject to a penalty if they fail to offer full-time employees and certain dependents health coverage which satisfies both a 60% minimum value standard and an affordability requirement and a full-time employee obtains a subsidy on the health insurance marketplace. Groups subject to these requirements and seeking to avoid a penalty are responsible for the ultimate determination of whether the minimum value and affordability requirements are satisfied.

  Using the minimum value calculator made available by HHS and the IRS, BCBSAZ estimates that the minimum value of the Red Medical Plan, Blue Medical Plan and White Medical Plan meet the minimum value standard. It is important that you independently review and confirm these results as they may be impacted by information not available to us (for example, benefits not provided by BCBSAZ, non-standard benefits not suited for the calculator and certain HSA contributions or HRA funds). BCBSAZ has included its conclusion(s) about minimum value in the plan(s) SBC(s) that BCBSAZ provides to Group. Any changes that Group makes to that conclusion based on Group's independent analysis will also affect the minimum value statement(s) in the SBC.

* BCBSAZ will provide funds to support the total requested allotment amounts under a self funding arrangement.

1/1/2015-12/31/2015	$ 80,000

  To monitor these allotments an available funds worksheet with be maintained by BCBSAZ.

  A . Requests for funds must be in writing.

  B . BCBSAZ will pay City approved vendors directly.

  C . Any unused funds will be carried over to the following policy period.

* Please reference the attached Performance Guarantees. Guarantees are effective for the 1/1/15-12/31/15 Policy Period.

EXHIBIT 1

PERFORMANCE GUARANTEE

THE PERFORMANCE GUARANTEE WHICH IS IMMEDIATELY FOLLOWING THIS PAGE AND TITLED ATTACHMENT B SHALL BE INCORPORATED AS EXHIBIT 1 INTO THIS CONTRACT.

The stated Performance Guarantee standards will be suspended for any time period in which the Employer fails to pay any fees and/or premiums timely.

ATTACHMENT B
PERFORMANCE GUARANTEES

Please fill in your proposed penalty amount to each of the following performance guarantees. Performance guarantees should total an equivalent of a minimum aggregate total of $100,000 per year. Should you not be able to commit to any of the following, please identify each exception in the Deviation section of your proposal response, referencing the comment by letter and proposing an alternative commitment with your penalty amount? Please note performance guarantees are to be in place not only during the initial term of the contract, but for each subsequent renewal term(s).

	Description of Service Performance Standards	Required Performance Guarantee	Describe the Method of Reporting Performance to the CITY	List the Frequency for which you will Report Status on each Measurement	Annual Dollar Value of Administrative Fees at Risk Paid to the CITY
			Customer/ Member Service		
1	Abandonment Rate - Telephone	3% or less Proposed: 5% or less	Measured non-group specific This penalty applies if BCBSAZ fails to perform in accordance with this standard two (2) consecutive quarters.	Quarterly	$3,000
2	Average Speed to Answer - Telephone	30 seconds or less Proposed: 45 seconds or less	Measured non-group specific This penalty applies if BCBSAZ fails to perform in accordance with this standard two (2) consecutive quarters.	Quarterly	$3,000
3	First Call Resolution - Telephone	90% or higher Not proposed	See Note 1 at the end of the table.		
4	Busy Signal Rate - Telephone	5% or less	Measured non-group specific	Quarterly	$3,000
5	Inquiry Responsiveness - Telephone	90% or more Not proposed	See Note 1 at the end of the table.		
6	Written Appeals "Level 1"	As set by Arizona Department of Insurance	97% of Level 1 appeals for the City will be decided within 30 days of receipt Measured group specific	Annually	$3,000
7	Written Appeals "Level 2"	As set by Arizona Department of Insurance	97% of Level 2 appeals for the City will be decided within 60 days of receipt Measured group specific	Annually	$3,000
8	Written Appeals "Level 3"	As set by Arizona Department of Insurance	97% of Level 3 appeals for the City will be referred to external review within 5 business days Measured group specific	Annually	$3,000
9	Customer/Member overall satisfaction - the satisfaction level conveyed by CITY members.	95% or greater in year one; 98% or greater in subsequent years Proposed: 90% or	Data based on survey with a 4-point scale.	Annually	$3,000

	Description of Service Performance Standards	Required Performance Guarantee	Describe the Method of Reporting Performance to the CITY	List the Frequency for which you will Report Status on each Measurement	Annual Dollar Value of Administrative Fees at Risk Paid to the CITY
		greater satisfied on a 4-point scale in year one and subsequent years			
			Implementation		
10	Eligibility Load - (dependent upon receiving a test file 45 business days prior to the start date.	Participant eligibility will be loaded 30 business days prior to the start date	Measured group specific 834 HIPAA/ 834 Flat File: BCBSAZ requires 60 business days to set up notice of electronic file format. Set up time frames for other formats will be determined during implementation planning.	N/A	$4,000
11	Initial and annual ID Cards	90% or more of ID cards distributed within 8 business days of the effective date.	Measured group specific 99% of ID Cards issued within 10 business days after receipt of finalized benefits and account structure, authorized signature documents and complete and accurate information in a format agreed upon between the City and BCBSAZ.	N/A	$4,000
12	Group Structure and Benefit Plan Design	The initial group structure and benefit plan design will be entered into the system 60 business days prior to the implementation date. This guarantee is dependent on receiving final sign-off from the City on the benefit plan design and summary documents 75 business days prior to the start date.	Measured group specific	N/A	$4,000
13	Turnaround Time on Resolution of Implementation Issues	Contractor guarantees a turnaround time of 5 business days for resolution of implementation issues. .	Measured group specific	N/A	$4,000
14	Client's Overall Satisfaction With Implementation Process	All deadlines are met, cards are distributed to the correct addresses on time, communication materials are created and distributed as indicated and agreed to, the benefit is set up to adjudicate claims according to the documentation	Measured group specific We will work with the City to develop a mutually agreed upon implementation plan.	N/A	$4,000

	Description of Service Performance Standards	Required Performance Guarantee	Describe the Method of Reporting Performance to the CITY	List the Frequency for which you will Report Status on each Measurement	Annual Dollar Value of Administrative Fees at Risk Paid to the CITY
		provided to and agreed upon by the City.			
15	Distribution of Plan Descriptive Material	All materials delivered to 98% (or more) of plan participants by the effective date.	Measured group specific	N/A	$4,000
16	Processing of Enrollment	98% (or more) of enrollments processed by the effective date.	Measured group specific	N/A	$4,000
17	Percent of ID cards distributed within 10 business days of receipt of eligibility data for initial enrollment and open enrollment periods.	99% within 10 business days	Measured group specific 99% of ID Cards issued within 10 business days after receipt of finalized benefits and account structure, authorized signature documents and complete and accurate information in a format agreed upon between the City and BCBSAZ.	N/A	$4,000
			Client Services and Account Management		
18	For bi-weekly changes, percent of ID cards distributed within 5 business days of receipt of eligibility data or request for replacement card.	99% within 5 business days	Measured group specific	Quarterly	$4,000
19	Monthly Eligibility Reconciliation	60 business days or less	Measured group specific	Quarterly	$4,000
20	Claim Refunds or un-cashed checks	30 business days or less Not proposed			
21	Internal Audit of claims	Annual self-audits to determine claim processing turnaround time; financial accuracy of claims; and claims processing accuracy.	Measured non-group specific	Quarterly	$4,000
22	Claims Processing Turnaround Time: Processing of a claim will be completed when it has been approved for payment, denied or pended with a request for further information.	90% of all fully documented claims received will be completely processed within 10 business days after they are received.	Measured non-group specific This penalty applies if BCBSAZ fails to perform in accordance with this standard two (2) consecutive quarters.	Quarterly	$4,000
23	Claim Financial Accuracy (dollar value)	99% of claims dollars submitted for payment will be accurately processed and paid.	Measured non-group specific This penalty applies if BCBSAZ fails to perform in accordance with this standard two (2) consecutive quarters.	Quarterly	$4,000

	Description of Service Performance Standards	Required Performance Guarantee	Describe the Method of Reporting Performance to the CITY	List the Frequency for which you will Report Status on each Measurement	Annual Dollar Value of Administrative Fees at Risk Paid to the CITY
24	Claim Overpayment: The Contractor will reimburse the City for any overpayment error in excess of $50 or 5%, whichever is more	less than $50 or 5%	Measured group specific for self-funded proposal and reimbursed if BCBSAZ is successful in collecting the money from the provider or subscriber	Quarterly	$4,000
25	Claims Processing Accuracy: Accurate processing includes payment amount; communication to claimant or provider; data entry errors affecting current or future benefit determinations and management reports.	97% of all claims will be processed accurately.	Measured non-group specific This penalty applies if BCBSAZ fails to perform in accordance with this standard two (2) consecutive quarters.	Quarterly	$4,000
26	Medicare Primary Claims Financial Accuracy	98% of all claim dollars submitted for payment will be accurate. Not proposed			
27	Respond to all inquiries from CMS within the required time frame including Medicare Refamation claims	95% or more Not proposed			
28	All Hospital Claims over $70,000 will be Audited as agreed to by the City and the Contractor.	95%	Measured non-group specific	Quarterly	$3,000
29	Will negotiate payment fee with out-of-network providers.	95% of out-of-network claims Not proposed	BCBSAZ will negotiate payment with non-network providers when appropriate (services not available in the network). This is accomplished using Letters of Agreement (LOA); however, we do not initiate LOAs for all non-network claims. BCBSAZ is not always able to successfully negotiate with all non-network providers for all LOA requests that we receive.		
30	Reach out to members for case management participation for all catastrophic Dx as agreed to by the City and the Contractor.	100% Proposed: Identified case management participants having total medical claims (includes pharmacy if BCBSAZ administers the pharmacy benefit) paid equal to or greater than $75,000 will receive an outreach call attempt	Measured group specific The guarantee is contingent upon the City providing 95% of correct phone numbers for the outreach activity. Within 90 days of group enrollment/renewal, BCBSAZ will run an inquiry against the enrollment data looking for valid phone numbers across the entire City enrollment. Valid	Annually	$3,000

	Description of Service Performance Standards	Required Performance Guarantee	Describe the Method of Reporting Performance to the CITY	List the Frequency for which you will Report Status on each Measurement	Annual Dollar Value of Administrative Fees at Risk Paid to the CITY
		within 90 days prior to or after the claim report identification. The $75,000 is calculated based on rolling 12 month claim utilization.	phone number is defined as a reasonable nine digit number and would not include number sequences such as 123456789, all same number, etc.		
31	Disease Management screening and reach-out to member.	90% within 30 business days Not proposed			
			Reports		
32	Data File Exchanges and Reconciliation Reports on a monthly basis.	95%	Measured group specific	Monthly	$3,000
33	Delivery of Management Reports: a) Monthly b) Quarterly c) Semi-annual d) Annual	Number of business days following the close of the period that management reports are due: a) 20 days or less b) 45 days or less c) 60 days or less d) 60 days or less	Measured group specific	Quarterly	$3,000
34	Status report/meeting	Within 45 business days (unless postponed by City)	Measured group specific	Periodic account management meetings with the City	$3,000
			Compliance		
35	HIPAA & HITECH Compliance Standards	100% Not proposed	We have standards and monitoring in place to comply with government rules and regulations.		
36	Reporting of potential fraud issue with prescription drug fills to the City	Within 5 business days of identification Proposed: Within 7 business days of identification	Measured group specific	Quarterly	$3,000
			Prescription Drugs		
37	Audit of RX claims performed annually for accuracy of payment	98%	Measured non-group specific	Annually	$3,000
38	Response to Specialty Drug Fill	Within 1 business day of notification Proposed: 90% of pharmacist-approved "clean" Prescription Drug prescriptions will have a call made to Subscriber to schedule delivery within 2 business	Measured non-group specific	Quarterly	$3,000

	Description of Service Performance Standards	Required Performance Guarantee	Describe the Method of Reporting Performance to the CITY	List the Frequency for which you will Report Status on each Measurement	Annual Dollar Value of Administrative Fees at Risk Paid to the CITY
		days.			

Note: BCBSAZ will determine the sample size of audited claims.

BCBSAZ will evaluate performance 90 days after the end of the 4th quarter of the performance period. Any penalties due to the group will be applied to the next renewal year. BCBSAZ will not be required to pay a penalty for Performance Guarantees if the group has not paid all premiums by the date due.

Claims processing penalties are not applicable on claims incurred outside of Arizona.

Note 1: BCBSAZ is currently participating in a pilot program with the Blue Cross Blue Shield Association to measure First Call Resolution (FCR) based on the customer's perception as to whether the call was resolved on first contact. We believe obtaining the customer's perception is necessary to achieve the desired customer experience. We are finding that customer survey results are lower than if we measured results internally. We may have answered the questions and completed the inquiry, however the customer still may not believe it has been resolved, if it was not resolved to their satisfaction. For example, they may disagree with a benefit, the information may be complete and correct, however the customer may be dissatisfied with the benefit, and the survey results may indicate this call was not resolved.

The survey sampling includes members that have contacted BCBSAZ within 2-3 days of the member's inquiry. Members may belong to individual policies, small group policies or large group policies. It is not group specific. It includes members calling to enrollment or claims customer service.

EXHIBIT G

EMPLOYER APPLICATION

THE EMPLOYER APPLICATION WHICH IS EXHIBIT G ARE THE PAGES IMMEDIATELY FOLLOWING THIS PAGE

EMPLOYER APPLICATION

An Independent Licensee of the Blue Cross and Blue Shield Association

REQUESTED EFFECTIVE DATE (MM/DD/YYYY): 1/1/2015

GROUP # 28399

☐ NEW

☑ CHANGE TO EXISTING GROUP (PLEASE FULLY COMPLETE ALL SECTIONS OF THIS APPLICATION EVEN IF SPECIFIC PROVISIONS REMAIN UNCHANGED.)

SECTIONS OF FORM TO BE CHANGED: ☑ I ☐ II ☐ III

SECTION I – EMPLOYER GROUP INFORMATION

LEGAL COMPANY NAME: City of Chandler	LEGAL ENTITY: ☐ CORP ☐ LLC ☑ MUNICIPALITY ☐ NON PROFIT ☐ PARTNERSHIP ☐ POLITICAL SUBDIVISION ☐ TRUSTS ☐ UNIONS
DBA: City of Chandler, Arizona	
GROUP HEALTH PLAN NAME (IF DIFFERENT THAN LEGAL COMPANY NAME): City of Chandler	

ARIZONA LOCATION STREET ADDRESS: 175 S. Arizona Avenue	CITY: Chandler AZ	ZIP CODE PLUS FOUR: 85225
BILLING ADDRESS ☐ SAME AS STREET ADDRESS: Mail Stop 703, P. O. Box 4008	CITY, STATE: Chandler, AZ	ZIP CODE PLUS FOUR: 85244

COUNTY: Maricopa	FEDERAL TAX ID NUMBER: 86-6000236	ARIZONA STATE TAX ID NUMBER: 07004582	PLAN YEAR ANNIVERSARY MONTH: January

HEADQUARTERS STATE (LEGAL ENTITY): Arizona	INCORPORATED STATE: Arizona	TYPE OF BUSINESS: Municipality

GROUP EXECUTIVE: Debra Stapleton		TITLE: Director of Human Resources
E-MAIL: debra.stapleton@chandleraz.gov	PHONE NUMBER: 480-782-2351	FAX: 480-782-2366
CHIEF FINANCIAL OFFICER: Dawn Lang		TITLE: Management Services Director
E-MAIL: dawn.lang@chandleraz.gov	PHONE NUMBER: 480-782-2255	FAX:
CHIEF EXECUTIVE OFFICER: Richard Dlugas		TITLE: City Manager
E-MAIL: richard.dlugas@chandleraz.gov	PHONE NUMBER: 480-782-2211	FAX: 480-782-2209
GROUP BENEFIT ADMINISTRATOR ☐ BILLING CONTACT: Rae Lynn Nielsen		TITLE: Benefits & Labor Relations Administrator
E-MAIL: raelynn.nielsen@chandleraz.gov	PHONE NUMBER: 480-782-2353	FAX:
OTHER CONTACT PERSON ☐ BILLING CONTACT ATTACHED SHEET FOR ADDITIONAL CONTACTS: Carol Osterhaus		TITLE: Benefits Analyst
E-MAIL: carol.osterhaus@chandleraz.gov	PHONE NUMBER: 480-782-2371	FAX: 480-782-2368

SECTION II – ADDITIONAL INFORMATION

1) DOMESTIC PARTNERS TO BE COVERED? ☐ YES ☑ NO

2) EMPLOYEE TERMINATION DATE ☑ END OF BILLING MONTH ☐ DATE OF LOSS OF ELIGIBILITY

3) NEW GROUP ENROLLMENT REGULATIONS

EMPLOYER'S ENROLLMENT WAITING PERIODS WILL BE WAIVED AT THE NEW GROUP'S INITIAL ENROLLMENT ☑ YES ☐ NO

4) RETIREE COVERAGE: DOES NOT APPLY TO GROUPS CONSIDERED SMALL FOR PURPOSES OF THE AFFORDABLE CARE ACT OR APPLICABLE STATE LAW (ACCOUNTABLE HEALTH PLAN).

RETIREMENT ELIGIBILITY	RETIREES TO BE COVERED?	☑ YES ☐ NO	IF YES: ☑ UNDER 65 ☑ 65 AND OLDER	RETIREES DEPENDENTS TO BE COVERED?	☑ YES ☐ NO	OTHER THAN NEWBORNS, ETC. FOR WHICH COVERAGE MAY BE MANDATED UNDER APPLICABLE ARIZONA LAW

5) RETIREMENT PARTICIPATION REQUIREMENTS

A) RETIREE MUST COMPLETE 5 YEARS OF SERVICE PRIOR TO RETIREMENT

B) RETIREE IS ELIGIBLE FOR COVERAGE ONLY THROUGH END OF BILLING PERIOD IN WHICH RETIREE REACHES AGE _____

C) OTHER: SEE ATTACHED

SECTION III – BROKER/CONSULTANT ☑ BROKER ☐ CONSULTANT		
LAST NAME Montoya	FIRST NAME Louie	MI
AGENCY NAME LMI Benefits Consulting Group		SUITE NO.
STREET ADDRESS 20439 N. 87th Dr.	CITY, STATE Peoria, AZ	ZIP CODE PLUS FOUR 85382
PHONE NUMBER 623-810-7246	FAX NUMBER 623-979-7929	
E-MAIL lmontoya@lmibenefits.com	BCBSAZ BROKER NUMBER	

SECTION IV – IMPORTANT - READ CAREFULLY

As the authorized representative of Company, I certify that the Company is the sole employer of the employees to be enrolled under this proposed contract for health insurance or services to administer the group health plan identified on this application. I also certify that the information provided on this Employer Application and all other applicable documents submitted in connection with this Application, is complete and accurate. I agree that Company shall promptly notify Blue Cross Blue Shield of Arizona (BCBSAZ) of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of dependents, and the termination date of any enrolled employee or dependent.

I understand and agree that BCBSAZ may, in its sole discretion, verify information with or through outside sources, including third party investigative firms, as BCBSAZ deems necessary or appropriate for finalizing its decision on this Application. I agree that if the information contained in this Application or other supporting documentation is incomplete, inaccurate, materially misleading, false, or fraudulent, that BCBSAZ has the right to (a) retroactively adjust the Company's rates and/or administrative fees if such information would have affected the rate/fee calculation; and (b) invalidate, or withdraw any rate/fee proposal, or terminate coverage for any group to the extent permitted by law. I understand and agree that this Application is not accepted until approved by BCBSAZ and that BCBSAZ's acceptance shall be based on information supplied by the Group, the requested benefits, and any other information obtained from outside sources. BCBSAZ's acceptance shall be evidenced by the execution of this Application by an authorized representative of BCBSAZ, at which time this Application shall become binding upon BCBSAZ and the group. Upon acceptance, this Application shall be attached to and shall become a part of the Group Master Contract or Administrative Services Agreement With/Without Stoploss (the "Contract"), as applicable. To the extent permitted by applicable law, BCBSAZ may terminate the Contract in accordance with the Contract terms, including the Group's failure to meet certain obligations under the Contract such as failure to pay premium/fees or comply with coverage requirements.

The Group agrees that it is solely responsible for: (i) determining employee and dependent eligibility for coverage and coverage effective and terminations dates (including application of required open and special enrollment periods), (ii) complying with applicable laws in establishing eligibility and coverage effective and termination dates, and (iii) providing BCBSAZ with timely and accurate eligibility and coverage effective and termination date information. Additionally, Company represents and warrants that it does not impose a waiting period which exceeds 90 days. Company will promptly advise BCBSAZ of any change in this representation. Company understands and agrees that federal law requires Company to provide dependent coverage for children under age 26, and prohibits Company from imposing pre-existing condition waiting periods.

By including my e-mail address on the reverse side, I authorize BCBSAZ to send me information via e-mail. I also understand I may change my e-mail address or rescind this permission at any time by contacting BCBSAZ through azblue.com.

COMPANY AUTHORIZED OFFICER / OWNER / PARTNER		
SIGNATURE X Debra Stapleton	PRINT NAME Debra Stapleton	
TITLE Human Resources Director		DATE 7/9/2014
STREET ADDRESS 175 S. Arizona Avenue	CITY, STATE Chandler Az	ZIP CODE PLUS FOUR 85225
BCBSAZ AUTHORIZED SIGNATURE X	PRINT NAME Michael Tilton	
TITLE Vice President, Sales		DATE 07/10/2014

Addendum to Employer Application
City of Chandler, #28399
Effective January 1, 2015

Billing Contact

Stacey Finkelstein, Employee Services & HRMS Supervisor
Office: 480-782-2356, Fax: 480-782-2366
stacey.finkelstein@chandleraz.gov
P. O. Box 4008, Mail Stop 703
Chandler, Arizona 85244

Other Contacts

Ruby Womack-Chappell, Human Resources Assistant
Office: 480-782-2346, Fax: 480-782-2345
ruby.womack-chapell@chandleraz.gov

Chris Jarosik, Human Resources Management Assistant
Office: 480-782-2356, Fax: 480-782-2366
christine.jarosik@chandleraz.gov

Julia House, Human Resources Assistant
Office: 480-782-2358, Fax: 480-782-2366
julia.house@chandleraz.gov

Denisse Ruiz, Human Resources Assistant
Office: 480-782-2355
denisse.ruiz@chandleraz.gov

See Resolution 4529, attached.

Chandler • Arizona
Where Values Make The Difference

Chandler
All-America City
2010

MEMORANDUM

DATE: JULY 18, 2011

TO: MAYOR AND CITY COUNCIL

THROUGH: RICH DLUGAS, CITY MANAGER
DEBRA STAPLETON, HUMAN RESOURCES DIRECTOR

FROM: VALERIE F. HERNANDEZ, BENEFIT PROGRAMS SUPERVISOR

SUBJECT: ADOPTION OF RESOLUTION NO. 4529 AUTHORIZING CITY STAFF TO PROVIDE SUVIVOR HEALTH CARE BENEFITS

RECOMMENDATION: Staff recommends that City Council pass and adopt Resolution No. 4529 authorizing City staff to provide survivor health care benefits.

BACKGROUND/DISCUSSION: The City Council has previously taken action to allow spouse and eligible children of public safety employees who are killed in the line of duty to retain their health care benefits through the City at the beneficiaries' full cost.

City Council has expressed interest in allowing a spouse and eligible children of any City employee who is killed in the course and scope of their employment to retain their group medical, dental, vision benefits at the regular employee's cost for the specific benefits elected.

PROPOSED MOTION: Move to pass and adopt Resolution No. 4529 authorizing City staff to provide survivor health care benefits.

RESOLUTION NO. 4529

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF CHANDLER AUTHORIZING MODIFICATION OF THE CITY'S SURVIVOR BENEFITS AND HEALTH CARE BENEFITS TO EXTEND ELIGIBILITY FOR GROUP HEALTH INSURANCE COVERAGE TO THE SPOUSE AND ELIGIBLE CHILDREN OF ANY EMPLOYEE KILLED IN THE LINE OF DUTY OR IN THE COURSE AND SCOPE OF CITY EMPLOYMENT

WHEREAS, the City has historically allowed the spouse and eligible children of public safety employees who are killed in the line of duty to retain their group medical, dental, and vision insurance coverage through the City, with the beneficiaries bearing the full premium cost;

WHEREAS, under A.R.S. § 38-1103, as recently amended, the City is required to pay the full medical insurance premiums for the spouse and any eligible children of a law enforcement officer killed in the line of duty for the first 12 months after the officer's death;

WHEREAS, the City Council wishes to extend, as a survivor benefit, the opportunity to retain group medical, dental, and vision insurance coverage through the City, at the regular employee cost for such coverage, to the spouse and eligible children of any employee of the City who is killed in the line of duty or in the course and scope of City employment beginning with benefit year 2012;

NOW, THEREFORE, BE IT RESOLVED by the City Council of the City of Chandler, Arizona, as follows:

1. The City shall make the necessary modifications to the group medical, dental, and vision insurance programs for City employees to extend, as a survivor benefit, eligibility for coverage to the spouse and eligible children of any employee killed in the line of duty or in the course and scope of their City employment.

2. Except as required under A.R.S. § 38-1103, the medical, dental, and vision insurance coverage shall be made available to the surviving spouse and children at the cost that would normally be paid by the employee for the level of coverage elected.

3. Eligibility for participation in the City's group health insurance programs shall terminate upon the surviving spouse's remarriage or attainment of the age of Medicare eligibility or the surviving eligible children's attainment of age 26.

4. This change shall become effective at the beginning of Benefit Year 2012, and shall be included, with necessary Personnel Rule amendments, if any, at the time the benefits package for Benefit Year 2012 is presented to the City Council for approval.

PASSED AND ADOPTED by the City Council of the City of Chandler, Arizona, this ____ day of July, 2011.

ATTEST:

CITY CLERK

MAYOR

CERTIFICATION

I HEREBY CERTIFY that the above and foregoing Resolution No. 4529 was duly passed and adopted by the City Council of the City of Chandler, Arizona, at a regular meeting held on the ____ day of July ___, 2011, and that a quorum was present thereat.

CITY CLERK

APPROVED AS TO FORM:

CITY ATTORNEY

EXHIBIT 2

For informational Purposes Only - NO Action Required

Re: 2014 Form 5500 Schedule C Service Provider Information – Disclosure of "Eligible Indirect Compensation" -

Dear Sir or Madam:

Blue Cross Blue Shield of Arizona ("BCBSAZ") is required to provide Employers with information regarding certain indirect compensation ("Eligible Indirect Compensation" or "EIC") paid by BCBSAZ to other Service Providers during 2014.

Under your contract with BCBSAZ, one of the benefits your employees and their dependents ("Participants") receive is access to healthcare services outside the geographic area BCBSAZ serves under a program known as BlueCard. Typically in that situation, Participants obtain care from healthcare providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (the "Host Blue"). Within that arrangement, BCBSAZ is referred to as the "Home Blue." The BlueCard Program is established and operated pursuant to policies established and enforced by the Blue Cross and Blue Shield Association.

A plan sponsor's reporting requirements for a self-funded plan on Schedule C are significantly streamlined for EIC about which a service provider has shared certain information. As such, below is a list of EIC that has been and/or is likely to be received in connection with the BlueCard Program. Note that the fees and compensation subject to disclosure under the Department of Labor rules include amounts that are not necessarily passed on to your ERISA Plan or your Participants. The financial terms of the BlueCard Program passed on to your ERISA plan, and additional details about the BlueCard Program, are described in your Agreement with BCBSAZ.

The following is a list of EIC:

1. **BlueCard Access Fees:** Access Fees are usually charged on a per-claim basis and are charged as a percentage of the savings that a Host Blue passes along to the Home Blue by virtue of its relationships with healthcare providers. These fees are paid by the Home Blue to the Host Blue and are charged for making the Host Blue's provider network available to the Home Blue's members. The BlueCard Access Fees charged directly to your ERISA Plan in connection with your Participants for 2013 are described herein.

   If your ERISA Plan's BlueCard arrangement with BCBSAZ is based on a per contract per month fee, the BlueCard Access Fees BCBSAZ pays to Host Plans may be a negotiated per contract per month fee or will be one or more of the following arrangements, depending on the size and distribution of your ERISA Plan's enrollment:

   Access Fees for 2014:

   Standard BlueCard Arrangement
   5.05% of savings (max = $2,000 per claim)

   Reduced BlueCard PPL Arrangement
   2.81% of savings (max = $2,000 per claim)

   The Access Fee max of $2,000 must be applied to the related submissions in the aggregate for interim bills rather than to each individual submission.

   Note: To be considered for reduced BlueCard PPO fees, the claim must be an account whose total BlueCard PPO enrollment exceeds 1,000 contracts.

For informational Purposes Only - NO Action Required

2. **Administrative Expense Allowances ("AEA"):** The AEA is usually a flat per-claim fee paid by the Home Blue to the Host Blue. It is paid for administrative services the Host Blue provides in processing the claim for benefits for a member of the Home Blue. The AEA fees charged directly to Employer's ERISA Plan in connection with your Participants' claims are specified in this disclosure. If Employer's ERISA Plan's BlueCard arrangement with BCBSAZ is based on a per contract per month fee, the BlueCard Access Fees BCBSAZ pays to Host Plans may be a negotiated per contract per month fee or will be one or more of the following arrangements, depending on the size and distribution of your ERISA Plan's enrollment:

Employer's ERISA Plan's enrollment:

AEA Fees for 2014:

Standard BlueCard Arrangement
- Institutional $11.00 per claim
- Professional $5.00 per claim
- Non-Participating Provider $3.00 per claim
- Medicare related claims $1.00 per claim

Reduced BlueCard PPO Arrangement
- Institutional $9.75 per claim
- Professional $4.00 per claim
- Non-Participating Provider $3.00 per claim
- Medicare related claims $1.00 per claim

Note: To be considered for reduced BlueCard PPO fees, the claim must be for an account whose total Blue PPO enrollment exceeds 1,000 contracts

Non-Standard negotiated AEA fees for 2013 and 2014:

Non-standard negotiated fees can range from either $5.48 to $14.72 per claim, or $9.13 to $24.53 per contract per month depending on the negotiated arrangement and/or the health plan product

3. **Use of Estimated or Average Pricing by Host Blues.** Some Host Blues use estimated or average prices to determine the negotiated price that is made available to BCBSAZ when Plan Participants access the Host Blue's participating provider network. This may result in a difference (positive or negative) between the price you pay on a specific claim and the actual amount paid to the provider by the Host Blue.

The following describes the formulas used for determining an estimated or average price:

Estimated: A percentage is used to modify the claim price for covered services. This percentage (either positive or negative) allows Host Blues to incorporate adjustments and actuarial projections prospectively into the final price. The percentage is determined by calculating the aggregate cost to the Host Blue over a look-back period less any initial payments made to providers divided by the total payments initially made to providers. The aggregate cost in the numerator includes all provider retrospective settlements, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, performance-related bonuses or incentives, interest, other non-claim transactions and any positive or negative balance in the variance account. The percentage is then actuarially adjusted for anticipated changes in claims expenses for the prospective period. The modifying percentages applied to claims from those Host Blues that will be used for estimated pricing have not been calculated as of the date of this letter.

Average: An average price is determined for a defined category of provider *(e.g.,*

institutional, professional, etc.) of a Host Blue in a given geographic area. The average is determined as follows:

Total amount paid to such providers over a look-back period, including initial payments as well as applicable claim and non-claim related transactions, which may include but are not limited to provider retrospective settlements, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, performance-related bonuses or incentives, interest, etc., and any positive or negative balance in the variance account

divided by

Total amount of such providers' corresponding charges for covered services over the same look-back period (claims for non-covered services are not included in the calculation)

This result is an average price that is applied to each claim for the defined category of provider of the Host Blue in the geographic area and presented as the negotiated price.

Although use of these pricing methods may result in a difference (positive or negative) between the price Employer pays and the amount actually paid to the provider, the price used to determine Employer's payment is a final price. Any positive or negative differences are accounted for in a variance account held by the Host Blue. Host Blues may prospectively increase or reduce estimated or average prices to correct for over-or underestimation of past prices *(i.e.,* prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from Employer's ERISA Plan. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices.

4. Fee for Recovery of Overpayments: In some cases, a Host Blue will undertake recovery efforts from its participating providers on behalf of Home Blues. These recoveries from a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse investigations, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In addition, the Host Blue may engage a third party vendor to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery and could be up to 35% of the recovered amount or could be assessed at up to 28% of total claims dollars to be audited. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Program Policies, which generally require correction on a claim-by-claim or prospective basis.

5. BlueCard Worldwide Program. The BlueCard Worldwide Program provides Participants with access to an international network of inpatient, outpatient and professional providers. Per claim fees associated with this BlueCard Program are as follows:

Institutional Claim	$17.00 per claim
Professional Claim	$4.75 per claim
Member responsibility	$3.75 per claim

Medical assistance and claims support services are also provided under the BlueCard Program by Mondial Assistance. The fees that the Host Blue pays to Mondial are as follows:

Medical Assistance	Fee (in dollars)
General Inbound Calls (questions related to the BlueCard Worldwide Program and related processes; requests for provider information for non-medical situations, etc.)	$8.04 / Call
Provider Inquiry/Referral (non-medical situation)	$10.07 / Call
Cashless access	$19.21 / Call
Phone Translation	$28.00 / Call
Fulfillment	$7.28 / Mailing
Provider Referral/visitation (medical situation)	$31.82 / Referral
Misrouted Calls	$3.21 / Call

Medical Monitoring	Fee (in dollars)
Medical Monitoring < 3 Days	$195.12 / Case
Medical Monitoring 3 – 10 Days	$353.97 / Case
Medical Monitoring > 10 days	$545.31 / Case

Claims Support Services	Fee (in dollars)
Claim Preparation – (Image claim, route claim, verify eligibility, conduct provider follow-ups)	$3.70 / Bill
Claim Preparation and Currency Conversation	$3.70 / Bill
Claim Preparation and Translation	$4.08 / Bill
Claim Preparation, Translation and Currency Conversion	$4.08 / Bill
Claim coding (code claim to ICD standards)	$4.20 / Bill
Misrouted claim (for example, domestic)	$1.50 / Claim
Claim Status inquiry	4.15 / Claim
Void Check Request	$1.13 / Payment
Other Document Translation (for example, medical records)	$28.00 / Page
Outside Translation Costs	At Cost

Claims Payment	
Payment Issuance (receive funds, match to file, purchase currency)	$2.22 / Payment
Currency Conversion gains/losses	At Cost

Additional Services	Fee (in dollars)
Medical Evacuation coordination	$739.47 / Case
Medical Repatriation coordination	$657.97 / Case
Repatriation of Remains coordination	$446.91 / Case
Medical Travel - case	$602.17 / Case
Medical Travel – Travel assistance	$47.40 / Case

For informational Purposes Only - NO Action Required

The following Service Providers received EIC from BCBSAZ during 2014:

Name of Service Provider Receiving EIC from BCBSAZ: SourceHOV LLC.
Address: 369 Inverness Parkway, Suite 300, Englewood, CO 80112
Service Provided: Claims Processing (Certain Specialty Type Claims) and Claims Edit Resolution
Basis of Compensation: $0.41 to $0.90 per Institutional Claim Processed (UB04); $0.28 to $0.55 per Professional Claim Processed (CMS1500); $0.31 to $0.32 per Dental Claim Processed; $1.019 - $2.038 per claim edit resolution

Name of Service Provider Receiving EIC from BCBSAZ: Sutherland Global Services, Inc.
Address: 2 Brighton Rd., Suite 300 Clifton, NJ 07012
Service Provided: Data entry for provider data, assistance with credentialing
Basis of Compensation: $22.80 per provider record completed and $22.76 per credentialing unit completed

Name of Service Provider Receiving EIC from BCBSAZ: Openspan
Address: 11175 Cicero Drive, Suite 200, Alpharetta, Georgia 30022
Service Provided: Automated resolution of claims edits
Basis of Compensation: $1 per claim finalized and $.60 per claim partially automated

Name of Service Provider Receiving EIC from BCBSAZ: Emdeon Inc.
Address: P.O. Box 572490, Murray Utah 84157-2490
Service Provided: Fee for the Recovery of Overpayments
Basis of Compensation: 21.5% of the Recovered Amount

Name of Service Provider Receiving EIC from BCBSAZ: Catamaran Health Solutions, Inc.[1]
Address: 1600 McConnor Parkway, Schaumberg, IL 60173-6801 (headquarters)
Service Provided: Pharmacy Claims Processing and select PBM services
Basis of Compensation: for electronic claims only
Traditional Pricing Model = $0.50 per net paid claim dispensed by Walgreens Mail Service
Pass-Thru Pricing Model = $1.00 per net paid claim

[1] *BCBSAZ paid compensation to Catamaran Health Solutions Inc. only for groups who used BCBSAZ to manage their pharmacy benefits.*

Pharmacy Rebates – BCBSAZ receives rebates from certain Pharmaceutical Manufacturers for certain drugs. Subject to the terms of your BCBSAZ Administrative Services Agreement your Group may be eligible for a Pharmacy Rebate. The current Rebate estimate for 100–plus member Groups is $5.69 per employee per month. BCBSAZ may earn interest income on Pharmacy Rebates during the period after the Rebate is paid to BCBSAZ and prior to payment to your Group.

Name of Service Provider Receiving EIC from BCBSAZ: KJB Health Care
Address: 5935 E. Kings Avenue, Scottsdale, AZ 85254
Service Provided: Clinical review of medication prior authorization and non-formulary requests
Basis of Compensation: Hourly, $100/hr

Name of Service Provider Receiving EIC from BCBSAZ: Inpharmative
Address: 8717 W. 110th St., Overland Park, KS 66210
Service Provided: Pharmacy Rebate Processing
Basis of Compensation: $0.04 per Claim Processed

BCBSAZ's list of affiliated Service Providers receiving EIC will be updated as necessary.

For informational Purposes Only - NO Action Required

If you have any questions, please contact your BCBSAZ Account Manager.

Sincerely,

Shawn A. Fried
Supervisor, Large Group Underwriting

cc:
Report File

City of Chandler
PPO Red Medical Option Benefit Plan

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") to provide its employees with health care coverage. The Plan is established by your employer and is maintained pursuant to a written document called a Plan Document.

Your employer has contracted with Blue Cross Blue Shield of Arizona ("BCBSAZ") to provide certain administrative claims processing and utilization management services for this PPO benefit plan. Benefits under the Plan are paid from the general assets of the Plan Sponsor*.

BCBSAZ, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BCBSAZ may also have a contract with your employer to provide stop-loss insurance to the Plan. The stop-loss insurance may be "aggregate" stop-loss, which reimburses the Plan whenever claims on all employees exceed a specified level in a Plan year, "specific" stop-loss, which reimburses the Plan whenever claims on any covered person exceeds a specified level; or a combination of both.

BCBSAZ is an independent contractor and shall not for any purpose be deemed an agent of your employer or the employer's Plan Administrator*, nor shall BCBSAZ and your employer be deemed partners, joint venturers or governed by any legal relationship other than that of independent contractor. In this book, BCBSAZ refers to the administrative services agreement and/or stop loss insurance agreement with your employer as a group master contract.

This benefit book describes the benefits for employees and their dependents that are eligible for and have elected coverage, under the PPO benefit plan. BCBSAZ may distribute a similar benefit book for insured employer groups and self-funded employer groups. This book by itself is not your employer's Summary Plan Description or a Plan Document. Your employer is responsible for providing those documents to you.

This PPO benefit plan gives you access to a network of providers that have agreed to negotiated discounts with BCBSAZ or a local Blue Cross and/or Blue Shield plan if covered services are rendered outside of Arizona.

Please note: Not all services are covered. As this is a self-funded employer health care plan, benefits provided in this PPO plan may not include all benefits required for those health care plans which are not self-funded. Read this benefit book carefully to understand the benefits and limitations of the PPO benefit plan.

*Plan Sponsor and Plan Administrator are terms defined under the Employee Retirement Income Security Act (ERISA). These parties are often your employer, but may be another entity, e.g., a trust or association sponsoring your Plan. Your Plan Document or Summary Plan Description names these parties for you.

BCBSAZ CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact BCBSAZ at one of the departments listed below or call the direct phone number on the back of your ID card.

BCBSAZ also makes information available at www.azblue.com and you may wish to look there before calling. BlueNet is the member area on www.azblue.com that allows you to manage your health insurance plan from anywhere you have Internet access. Go to www.azblue.com/member for more information and to register for a BlueNet account. Once you are registered for BlueNet, you have access to the following*:

Claims and benefits information
Track deductible, if applicable to your plan
Update account information
Verify enrollment status
Order ID cards

Search for providers
Compare hospitals
Research prescription benefits
HealthyBlue® - tools for a healthier life
Review Medical Coverage Guidelines

*Depending on your plan, access to links on BlueNet may vary.

BCBSAZ Customer Service
(benefit questions or claim information)

BCBSAZ customer service hours are Monday through Friday, 8:00 a.m. to 4:30 p.m. MST (except holidays).

Dedicated City of Chandler Customer Service (866) 595-5993

Send all correspondence to this address unless otherwise indicated below:

Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, Arizona 85002-3466

Claims

Mail new claims to:

Blue Cross Blue Shield of Arizona
P.O. Box 2924
Phoenix, Arizona 85062-2924

Claims for transplant travel and lodging:

Attn: Transplant Travel Claim Processor
Mail Stop: A116
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, Arizona 85002-3466

Claims for chiropractic services:

Claims Administration
American Specialty Health Networks, Inc.
P.O. Box 509001
San Diego, CA 92150-9001

Customer Walk-In Office Locations

Phoenix (main office)	2444 W. Las Palmaritas Drive, 85021-4883 (2 blocks north of Northern Avenue between the Black Canyon Freeway (I-17) and 23rd Avenue)
Tucson	5285 E. Williams Circle, Suite 1000, 85711- 7411 (East on Broadway Road, right on S. Williams Circle, left on E. Williams Circle)

Flagstaff	1500 E. Cedar Avenue, Suite 56, 86004 -1643 (Intersection of Cedar Avenue and West Street)
Chandler	2121 W. Chandler Blvd., Suite 115, 85224 (East of the 101 Freeway; West of Dobson Road)

Provider Network Status

Check the online provider directory at www.azblue.com or call BCBSAZ customer service at the numbers listed above.

BCBSAZ Other Information

Behavioral Services Administrator (BSA) (800) 224-2125

BlueCard® Program

Blue Cross Blue Shield (BCBS) Association (800) 810-2583
Web site: www.bcbs.com

Cancer Clinical Trials (for information on services directly associated with a cancer clinical trial or to obtain a copy of Arizona law requirements for cancer clinical trials)

Maricopa County	(602) 864-5841
Statewide	(800) 232-2345, ext. 5841

Care Management and Disease Management Support Line

Information on care management services, how to contact a care manager or how to make a referral and information on health management programs that support members with complex, catastrophic and/or chronic conditions.	(877) My-HBlue or (877) 694-2583

Chiropractic Benefits Administrator (800) 678-9133

Continuity of Care Requests (877) My-HBlue or (877) 694-2583

Hearing Impaired (TDD) (Claim information)

Maricopa County	(602) 864-4823
Statewide	(800) 232-2345, ext. 4823

Medical Appeals and Grievances

Attn: Medical Appeals and Grievances Mail Stop A116 BCBSAZ P.O. Box 13466 Phoenix, AZ 85002-3466	Maricopa County: (602) 544-4938 Statewide: (866) 595-5998 Fax: (602) 544-5601

Medical Coverage Guidelines (request a copy of the Medical Coverage Guidelines)

Maricopa County	(602) 864-4614
Statewide	(800) 232-2345, ext. 4614

BlueNet members' area of www.azblue.com under Claims & Benefits/Health Benefits/Medical Coverage Guidelines

Membership Services (change mail address, add or remove dependents, termination of coverage)

Maricopa County	(602) 864-4115
Statewide	(800) 232-2345, ext. 4115
Fax	(602) 864-4041

Attn: Membership Services
Mail Stop: A102
Blue Cross Blue Shield of Arizona
PO Box 13466
Phoenix, AZ 85002-3466

Precertification (your doctor must contact BCBSAZ)

Maricopa County	(602) 864-4320
Statewide	(800) 232-2345, ext. 4320

Precertification Denial Appeals

Maricopa County	(602) 544-4938
Statewide	(866) 595-5998
Fax	(602) 544-5601

Attn: Appeals
Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ 85002-3466

Prescription Benefit Unit

Maricopa County	(602) 864-4273
Statewide	(800) 232-2345, ext. 4273

Requests for Transplant Travel and Lodging Claim Forms

Maricopa County	(602) 864-4051
Statewide	(800) 232-2345, ext. 4051

Spanish-Language Telephone Service (en Español – preguntas sobre su solicitud, beneficios, reclamos, o pagos)

Maricopa County	(602) 864-4884
Statewide	(800) 232-2345, ext. 4884

Supply Line (provider directories, claim forms, health coverage appeal information packet, ID cards, Rx mail order packet)

Maricopa County	(602) 995-6960
Statewide	(800) 232-2345 ext. 6960

Social Media

Like us on Facebook: www.facebook.com/bcbsaz
Follow us on Twitter: www.twitter.com/bcbsaz
Email complaints and concerns to socialcares@azblue.com
iPhone and Android phone users can download our mobile application via Google Play or App Store

DEFINITIONS

"Allowed amount" means the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost-share payment.

BCBSAZ calculates deductible and coinsurance based on the allowed amount, less any access fees or precertification charges. BCBSAZ uses the allowed amount to accumulate toward any out-of-pocket maximum that applies to the member's benefit plan. The allowed amount does not include any balance bills from noncontracted providers. The allowed amount is neither tied to, nor necessarily reflective of, the amounts providers in any given area usually charge for their services.

If the allowed amount is calculated based upon a fee schedule, a change to the fee schedule may result in higher member cost-share.

The allowed amount is calculated as follows:

Type of Provider	Type of Claim	Basis for Allowed Amount	Payee for Reimbursement
Providers contracted with BCBSAZ	Emergency and non-emergency	Lesser of the provider's billed charges* or the applicable BCBSAZ fee schedule, with adjustments for any negotiated contractual arrangements and certain claim editing procedures	BCBSAZ reimburses the **provider** the allowed amount, less any member cost share
Providers contracted with the BSA	Emergency and non-emergency	The BSA fee schedule	The BSA reimburses the **provider** the allowed amount, less any member cost share
Providers contracted with the CBA	Emergency and non-emergency	The lesser of the provider's billed charges or the CBA fee schedule, with adjustments for any negotiated contractual arrangements	The CBA reimburses the **provider** the allowed amount, less any member cost share
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue")	Emergency and non-emergency	Lesser of the provider's billed charges* or the price the Host Blue plan has negotiated with the provider	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost share
Noncontracted providers (in Arizona and out-of-state)	Non-emergency	Lesser of the provider's billed charges* or the applicable BCBSAZ fee schedule, with adjustments for certain claim editing procedures	BCBSAZ reimburses the **member** the allowed amount, less any member cost share
Noncontracted providers (in Arizona and out-of-state)	Emergency	Billed charges*	BCBSAZ reimburses the **member** the allowed amount, less any member cost share

*A provider's billed charges are defined as the lowest price the provider is willing to accept as payment in full for a covered service when the provider has no contract with BCBSAZ, a Host Blue, or the BlueCard Worldwide program that governs the amount of reimbursement.

"BCBSAZ" or "We" means Blue Cross Blue Shield of Arizona when acting as the issuer of insurance coverage or as the administrator of a group benefit plan. Within this benefit book, "BCBSAZ" or "We" may also include the BSA or the CBA, when the BSA or CBA is performing functions delegated to it by BCBSAZ.

Blue Cross® Blue Shield® of Arizona is an independent licensee of the Blue Cross and Blue Shield Association.

BCBSAZ is a non-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 health care services organization as a line of business.

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

"Behavioral Services Administrator (BSA)" means the independent company that contracts with BCBSAZ to administer and deliver some of the behavioral and mental health benefits, along with certain other education and training benefits, available through some plans.

"Benefit book" means this document, which may also be referred to as benefit book or benefit plan book.

"Benefit plan" or "plan" means the document describing the benefits and terms of coverage that the sponsor of a group health plan provides to its group members and their dependents.

Your BCBSAZ plan includes this book and SBC, your application for coverage, your ID card, any plan that is issued to replace this plan and any rider, amendment or modification to this plan, including but not limited to, any changes in deductible, coinsurance or copay amounts. **Changing deductible options within a product does not constitute a new plan.**

Many group health insurance plans (other than government plans, church plans, and certain other types of plans) must comply with the federal Employee Retirement Income Security Act of 1974 (ERISA). If your group health insurance plan is subject to ERISA, your plan sponsor must maintain a summary plan description and provide the summary plan description to you upon written request. While your plan sponsor may include this benefit book as part of its summary plan description, this benefit book is not a summary plan description.

"Chiropractic Benefits Administrator (CBA)" means the independent company that administers chiropractic benefits for BCBSAZ. The CBA develops and manages the BCBSAZ network of chiropractic providers, processes chiropractic claims, determines medical necessity and handles utilization management, grievances and appeals related to chiropractic services.

"Contract holder" means the person to whom the benefit plan is issued. Any other person approved for coverage with the contract holder under this plan is a dependent. Under group coverage, the contract holder is the member who is eligible for coverage because of his or her affiliation with a group.

"Cosmetic" means surgery, procedures or treatment and other services performed primarily to enhance or improve appearance, including but not limited to, 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.

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

1. Are for comfort or convenience;
2. Do not seek to cure;
3. Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition (except as stated in "Home Infusion/Medication Administration Therapy") or other self care; **or**
4. Are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as an L.P.N., R.N. or licensed therapist.

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

"Emergency" means an illness or condition which requires relief of severe pain or if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize life, health or the ability to completely recover, resulting in serious impairment or permanent disability.

"Fee Schedules" mean proprietary schedules of provider fees compiled by BCBSAZ or BCBSAZ's contracted vendors. BCBSAZ or BCBSAZ's contracted vendors develop proprietary schedules of fees based on annual reviews of information from numerous sources, including, but not limited to: Medicare fee schedules from the Centers for Medicare and Medicaid Services (CMS), BCBSAZ's or the contracted vendor's historical claims experience, pricing information that may be available to BCBSAZ or the vendor, information and comments from providers and negotiated contractual arrangements with providers. **BCBSAZ and/or BCBSAZ's contracted vendors may change their fee schedules at any time without prior notice to members. If the allowed amount is calculated based upon a fee schedule, a change to the fee schedule may result in higher member cost-share.**

"Group" means the employer, trust or other entity that sponsors the group benefit plan on behalf of its employees or participants.

"Group Master Contract" (sometimes referred to as "Agreement") means the legal agreement between the group and BCBSAZ.

"Inpatient residential care" means medical or mental-behavioral care provided in a 24-hour facility licensed by the state in which it is located, and not licensed as a hospital, that offers integrated therapeutic services, educational services and activities of daily living. These services are part of a well-defined, individually tailored, medical or mental-behavioral treatment plan that is clinically appropriate based upon the individual's medical or mental-behavioral needs and is performed in a clinically appropriate facility.

"Medical Coverage Guidelines" means BCBSAZ medical, pharmaceutical, dental and administrative criteria that are developed from review of published, peer-reviewed medical, pharmaceutical and dental literature and other relevant information and used to help BCBSAZ determine whether a service, procedure, medical device or drug is eligible for benefits under a member's benefit plan. The Medical Coverage Guidelines also include prescription medication limitations. BCBSAZ periodically reviews and amends the Medical Coverage Guidelines in response to changes and advancements in medical knowledge and scientific study. Benefit determinations are based on the Medical Coverage Guidelines in effect at the time of service. You or your provider can review a specific guideline by going to the "Claims & Benefits" section on www.azblue.com and choosing "Health Benefits and Medical Coverage Guidelines." Specific Guidelines are also available by calling the number for requesting Medical Coverage Guidelines listed in the front of this book.

The CBA establishes medical coverage guidelines for chiropractic services. To obtain a copy of the guidelines applicable to chiropractic services, contact the CBA at the number listed in the front of this book or go to www.ashcompanies.com. Also, if the BSA provides or administers benefits under your plan, the BSA may establish medical coverage guidelines for services covered through the benefits it administers. Contact the BSA at the number listed at the front of this book for a copy of coverage guidelines maintained by the BSA.

"Member" or "You" means an individual, employee, participant or dependent covered under a benefit plan.

"Per diem" means a method of reimbursement based on a negotiated rate per day for payment of covered services provided to a patient in a facility.

"Pharmacy Coverage Guidelines" means BCBSAZ 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 BCBSAZ determine whether a medication or other products such as medical devices or supplies are eligible for benefits under a member's retail or mail order benefit. Pharmacy Coverage Guidelines are available by going to www.azblue.com under Prescription Medications and then Pharmacy Coverage Guidelines. Guidelines are also available by calling the number listed for the Prescription Benefit Unit listed in the front of this book.

"Physician," for purposes of classifying benefits and member cost-shares in this benefit plan, means a properly licensed M.D., D.O., D.P.M., or D.C.

"Primary Care Provider (PCP)" means a health care professional who is contracted with BCBSAZ as a PCP and generally specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, pediatrics or any other classification of provider approved as a PCP by BCBSAZ. Your benefit plan does not require you to have a PCP or to have a PCP authorize specialist referrals.

"Provider" means any properly licensed, certified or registered person or facility furnishing medical care to you, such as a doctor, hospital, laboratory or other health professional.

"Service" means a generic term referencing some type of health care treatment, test, procedure, supply, medication, technology, device or equipment.

"Specialist" means either a physician or other health care professional who practices in a specific area other than those practiced by primary care providers, or a properly licensed, certified or registered individual health care provider whose practice is limited to rendering mental health services. This definition of "specialist" does not apply to dentists. BCBSAZ does not require you to obtain an authorization or referral to see a specialist.

UNDERSTANDING THE BASICS

Your Responsibilities

Read your benefit materials. Before you receive any services you need to understand what is covered and excluded under your benefit plan, your cost-sharing obligations and the steps you can take to minimize your out-of-pocket costs. You need to carefully review this book, your SBC and other materials that BCBSAZ has provided to you.

Review your explanation of benefits (EOB) forms, other claim-related information and available claims history. Notify BCBSAZ of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

Tell us about changes. We need current information to correctly process your claims, update you on changes to your benefits and explain how we are administering your benefit plan. Check the BCBSAZ customer service section at the front of this book for information on contacting Membership Services. Tell us right away about any changes in the following:

- Individuals being added to the benefit plan: Spouse, newborns, adopted children, children placed for adoption, stepchildren
- Eligibility of you or your dependents for Medicare during the term of this contract
- Your mailing address or phone number
- Other medical coverage that you or your dependents add or lose, including any changes in benefits
- Eligibility of you or your dependents for Arizona Health Care Cost Containment System (AHCCCS) coverage during the term of this contract
- Individuals removed from the benefit plan due to divorce or death
- A disabled dependent age 26 or older who is no longer disabled

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

BCBSAZ ID Card

Your ID card has basic eligibility and cost-sharing information: Contract holder and dependent names, group number, ID number, card issue date and certain cost-sharing amounts.

- Bring your ID card with you each time you seek health care services.
- Have your ID card available for reference when you contact BCBSAZ for information.

Benefit Maximums

Some benefits may have a specific benefit maximum or limit based on dollar amount, number of days or visits, type, timeframe (calendar year or benefit plan), age, gender or other factors. If you reach a benefit maximum, any further services are not covered under that benefit and you may have to pay the provider's billed charges for those services. However, if you reach the benefit maximum on a particular line of a claim, you will be responsible for paying only up to the allowed amount for the remaining charges on that line of the claim.

All benefit maximums are included in the applicable benefit description.

Coverage Changes

Your benefits and coverage can change while this benefit plan is in effect. You will be notified of any changes as required by law.

Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available.

Covered Services

To be covered a service must be all of the following:

- A benefit of this plan;
- Medically necessary as determined by BCBSAZ;
- Not excluded;
- Not experimental or investigational as determined by BCBSAZ;
- Precertified where precertification is required;
- Provided while this benefit plan is in effect and while the person claiming benefits is eligible for benefits; **and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ.

Experimental or Investigational Services

BCBSAZ, in its sole and absolute discretion, decides whether a service is experimental or investigational. A service is considered experimental or investigational unless it meets all of the following criteria:

- The service must have final approval from the appropriate governmental regulatory bodies if applicable;
- The scientific evidence must permit conclusions concerning the effect of the service on health outcomes;
- The service must improve the net health outcome;
- The service must be as beneficial as any established alternative; **and**
- The improvement resulting from the service must be attainable outside the investigational setting.

In addition to classifying a service as experimental or investigational using the above criteria, BCBSAZ may also classify the service as experimental or investigational if any one or more of the following apply:

- The service 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 is submitted for precertification or rendered;
- The provider rendering the service documents that the service is experimental or investigational; **or**
- Published reports and articles in authoritative (peer-reviewed) medical and scientific literature show that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, appropriate selection, efficacy or efficacy as compared with the standard treatment for the diagnosis.

Medically Necessary

BCBSAZ, in its sole and absolute discretion, decides whether a service is medically necessary based on the following definition:

A medically necessary service is a service that meets all of the following requirements:

- Is consistent with the diagnosis or treatment of a symptom, illness, disease or injury;
- Is not primarily for the convenience of a member or a provider;
- Is the most appropriate site, supply or service level that can safely be provided; **and**
- Meets BCBSAZ's medical necessity guidelines and criteria in effect when the service is precertified or rendered. If no such guidelines or criteria are available, BCBSAZ will base its decision on the judgment and expertise of a BCBSAZ medical professional or medical consultant retained by BCBSAZ.

Medical Necessity Guidelines and Criteria

Listed below are some sources and criteria that BCBSAZ uses to make medical necessity decisions. BCBSAZ does not rely on each of these sources for every decision. Information on how to obtain a copy of the Medical Coverage Guidelines is in the BCBSAZ customer service section at the front of this book.

- Medical Coverage Guidelines (local medical policy)
- InterQual ® Clinical Decision Support Criteria
- Medical Policy Reference Manual (MPRM) of the Blue Cross Blue Shield Association
- Medicare Guidelines
- Pharmacy Coverage Guidelines
- Technology Evaluation Center (TEC) of the Blue Cross Blue Shield Association

BCBSAZ contracts with a behavioral services administrator (BSA) and a chiropractic benefits administrator (CBA) to administer some or all of these types of benefits for some plans. The BSA and CBA also make medical necessity determinations based on their own medical necessity criteria, which are also available to you on request.

BCBSAZ's decision about medical necessity may differ from your provider's opinion. A provider may prescribe, order, recommend or approve a service that BCBSAZ decides is not medically necessary and therefore is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered.

In addition, not all medically necessary services will be covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A service may be medically necessary and still excluded from coverage.

Provider Eligibility and Network Status

Check your provider's eligibility and network status before you receive services. Not all medical professionals are eligible providers, and not all eligible providers are contracted with BCBSAZ. If you don't know your provider's status with BCBSAZ, check our online provider directory at www.azblue.com or call BCBSAZ customer service.

Summary of Benefits and Coverage (SBC)

BCBSAZ gives you an SBC that shows applicable copays, access fees, coinsurance percentages, deductible amounts, other cost-sharing amounts; and other important information. Please keep your current SBC with your benefit book.

MEMBER COST-SHARING

Members pay part of the costs for benefits received under this plan. Depending on your particular benefit plan, the service you receive and the provider you choose, you may have an access fee, balance bill, coinsurance, copay, deductible or some combination of these payments. Each cost-share type is explained below. This section, the benefit descriptions in this book and your SBC will explain which cost-share types apply to each benefit.

If the allowed amount is calculated based upon a fee schedule, a change to the fee schedule may result in higher member cost-share.

BCBSAZ uses your claims to track whether you have met some cost-share obligations. We apply claims based on the order in which we process the claims and not based on date of service.

Access Fee

An access fee is a fixed fee you pay to a provider for certain covered services, usually at the time of service. If an access fee applies to a particular service, you must pay the access fee in addition to any other applicable cost-share for the service. Access fees do not count toward meeting your calendar-year deductible.

Balance Bill

The balance bill refers to the amount you may be charged for the difference between a noncontracted provider's billed charges and the allowed amount.

In-network providers will accept the allowed amount for covered services. They will not charge you for the difference between their billed charges and the allowed amount.

Noncontracted providers have no obligation to accept the allowed amount. You are responsible to pay a noncontracted provider's billed charges, even though BCBSAZ will reimburse your claims based on the allowed amount. Depending on what billing arrangements you make with a noncontracted provider, the provider may charge you for full billed charges at the time of service or seek to balance bill you for the difference between billed charges and the amount that BCBSAZ reimburses you on a claim.

Any amounts paid for balance bills do not count toward deductible, coinsurance or the out-of-pocket maximum.

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for covered services each calendar year (January through December) before the benefit plan begins to pay for covered services. The deductible applies to every covered service unless the specific benefit section says it does not apply.

Each individual member has a calendar-year deductible. If you have family coverage, there is also a calendar-year deductible for the family. Amounts counting toward an individual's calendar-year deductible will also count toward any family deductible. When the family satisfies its calendar-year deductible, it also satisfies the deductible for all the individual members.

Your benefit plan has two different deductibles, a deductible that applies to services received from in-network providers and a separate deductible that applies to services received from out-of-network providers. Amounts applied to the in-network deductible will also apply to meet the out-of-network deductible. However, the amounts applied to the out-of-network deductible **do not** apply to meet the in-network deductible. Deductible amounts are shown on your SBC.

The family deductible must be met on a family policy before the Plan will pay for covered services for any individuals covered through that policy.

The deductible is calculated based on the allowed amount.

Amounts you pay for copays and access fees do not count toward the deductible.

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for covered services after meeting any applicable deductible. BCBSAZ subtracts any applicable access fees or precertification charges from the allowed amount before calculating coinsurance. Coinsurance applies to every covered service unless the specific benefit section says it does not apply. In most cases, your coinsurance percentage is higher when you use an out-of-network provider.

BCBSAZ normally calculates coinsurance based on the allowed amount. **There is one exception.** If a hospital provider's billed charges are less than the hospital's DRG reimbursement, BCBSAZ will calculate your coinsurance based on the lesser billed charge.

Copay

A copay is a specific dollar amount you must pay to the provider for some covered services. If a copay applies to a covered service you must pay it when you receive services. You may have different copays for various covered services. See your SBC for specific amounts. If a copay does not apply to a service, you pay the applicable deductible and coinsurance, unless otherwise specified within the benefit provision.

Out-of-Pocket Maximum (Individual & Family)

An out-of-pocket maximum is the amount each member must pay each year before the Plan begins paying 100 percent of the allowed amount on covered services, for the remainder of the calendar year. The payments listed below do not count toward the out-of-pocket maximum. You must keep paying them even after you reach your out-of-pocket maximum:

- Amounts above a benefit maximum
- Any amounts for balance billing
- Any amounts for noncovered services
- Any charges for lack of precertification

If you have family coverage, there is an out-of-pocket maximum 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.

Precertification Charges

If your out-of-network provider does not obtain precertification from BCBSAZ for a service that requires it, you are subject to a precertification charge or complete loss of benefit. Applicable precertification charges are shown on your SBC.

Amounts applied as precertification charges do not count toward the calendar-year deductible or out-of-pocket maximum.

The SBC sent with your member ID card shows the actual cost-share amounts for your plan (for example copay amounts, coinsurance percentage, deductible). Some of these amounts are also shown on your ID card.

PROVIDERS

Eligible Providers

Eligible providers include the properly licensed, certified or registered providers listed below, when acting within the scope of their practice. Benefits may also be available from other health care professionals whose services are mandated by Arizona state law or federal law or who are accepted as eligible by BCBSAZ. The fact that a service is rendered by an eligible provider does not mean that the service will be covered. Eligible providers are not necessarily contracted with BCBSAZ. For information on a provider's status as an eligible or network provider, check our online provider directory at www.azblue.com, or call BCBSAZ customer service, before you receive services.

Eligible providers include the following:

Professional	Facility Ancillary
• Board Certified Applied Behavioral Analyst (BCABA) • Certified Nurse First Assist (CRNFA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Doctor of chiropractic (D.C.) • Doctor of dental surgery (D.D.S.) • Doctor of medical dentistry (D.M.D.) • Doctor of medicine (M.D.) • Doctor of optometry (O.D.) • Doctor of osteopathy (D.O.) • Doctor of podiatry (D.P.M.) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner • Licensed professional counselor • Physician Assistant (PA) • Psychologist (Ph.D., Ed.D. and Psy.D.) • Perfusionist • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational or physical therapist • Surgical Assist (SA) • Surgical Technician (ST)	• Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long Term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Rehabilitation Treatment Centers (substance abuse centers) • Retail, mail order and specialty pharmacies • Skilled Nursing Facility • Specialty Laboratory • Sleep Lab • Urgent Care

Choosing a Provider

Please call BCBSAZ customer service before you receive services if you have any questions about a provider's eligibility or network participation with BCBSAZ.

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

In-Network Providers (Contracted)

In-network providers are the following: (1) health care providers who have a contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ members); and (2) out-of-state providers licensed in the United States who have a PPO contract with a Host Blue plan. In-network providers will file your claims with BCBSAZ or the Host Blue plan with which they are contracted. The provider's contract generally prohibits the provider from charging more than the allowed amount for covered services. However, when there is another source of payment, such as liability insurance, all providers may be entitled to collect their balance bill from the other source, or from proceeds received from the other source. The provider's contract does allow the provider to charge you up to the provider's billed charges for non-covered services. We recommend that you discuss costs with the provider before you obtain non-covered services.

BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan directly reimburse in-network providers for your benefit plan's portion of the allowed amount for covered services. **You are responsible to pay your member cost-share directly to the provider.**

In-network providers must be licensed in the United States. Except for emergencies, in-network providers must render covered services in the United States in order for covered services to be considered in-network and subject to in-network member cost-share. If an in-network provider renders covered services outside the United States, the covered services will be considered out-of-network and subject to out-of-network member cost-share, including balance bills (except for emergencies).

Out-of-Network Providers (Contracted and Noncontracted)

Out-of-network providers are: (1) Providers who are contracted with a Host Blue plan as "Participating" only providers; (2) Eligible providers who have no contract with BCBSAZ or a Host Blue plan (Noncontracted providers); and (3) Providers who are contracted with the BlueCard Worldwide program.

- **Participating-Only Providers**

  Participating-only providers are contracted with a Host Blue plan as "Participating" and are not contracted as PPO or Preferred providers. Participating-only providers are out-of-network providers. Participating-only providers will submit your claims to the Host Blue plan with which they are contracted. If you receive covered services from a Participating-only provider, you will pay out-of-network deductible and coinsurance and access fees. However, you will not have to pay the balance bill because the provider is contracted.

- **Noncontracted Providers**

  Eligible providers who have no provider participation agreement with BCBSAZ or any Host Blue plan are noncontracted providers. Noncontracted providers are out-of-network providers.

  If you receive covered services from an eligible noncontracted provider, you will pay out-of-network deductible and coinsurance, access fees and the balance bill. Noncontracted providers may bill you up to their full billed charges. The difference between the noncontracted provider's billed charges and payment under this benefit plan may be substantial. Please check with the noncontracted provider regarding the amount of your financial responsibility before you receive services.

  BCBSAZ does not send claim payments to noncontracted providers. BCBSAZ will send payment to you for whatever benefits are covered under your benefit plan. You are responsible for paying the noncontracted provider. A noncontracted provider will not receive a copy of your explanation of benefits (EOB) and will not know the amount this benefit plan paid you for the claim.

- **Providers Contracted with the BlueCard Worldwide Program**

  Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. For covered services from these providers, you will pay out-of-network deductible and coinsurance and access fees (except for emergency services), plus the balance bill.

Provider Status and Payment – Summary Table

Provider contract status	Network status and applicable cost share	Provider required to file claim on member's behalf	Accept BCBSAZ Allowed Amount[1] and do not Balance Bill	Payee for Reimbursement
Providers contracted with BCBSAZ	In-network[2]	Yes	Yes	BCBSAZ reimburses the **provider** the allowed amount, less any member cost-share
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue") as PPO providers	In-network[2]	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share

Providers contracted with Host Blue as Participating only providers	Out-of-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share
Providers contracted with Blue Card World Wide Program	Out-of-network	Yes	No	Blue Card Worldwide reimburses the **provider** the allowed amount less any member cost share
Noncontracted providers (in Arizona and out-of-state) (must be eligible providers)	Out-of-network	No (provider may elect to do so as courtesy to member)	No. May charge up to full billed charges. Difference between billed charges and BCBSAZ member reimbursement may be substantial[3]	BCBSAZ reimburses the **member** the allowed amount, less any member cost-share. Provider does not get copy of member's EOB or know reimbursement amount.

[1]See "Definitions" section for basis of allowed amount computation.

[2]In-network providers must be licensed in the United States. Except for emergencies, in-network providers must render covered services in the United States in order for covered services to be considered in-network and subject to in-network member cost-share. If an in-network provider renders covered services outside the United States, the covered services will be considered out-of-network and subject to out-of-network member cost-share, plus balance bills.

[3]**Please check with the noncontracted provider regarding the amount of your financial responsibility before you receive services.**

All providers may charge you up to full billed charges for non-covered services. We recommend that you discuss costs with the provider before you obtain non-covered services.

Differences in Financial Responsibility

The following **example** shows how out-of-pocket expenses can differ depending on the provider you choose. This example is provided for demonstration purposes only. Your savings may vary depending on your benefit plan and your chosen provider.

In this example, the member has already satisfied the calendar-year deductible and has a 20 percent coinsurance for an in-network provider and 40 percent coinsurance for an out-of-network provider.

Billed Charges	Allowed Amount	Financial Responsibility	In-Network Providers 20% coinsurance	Out-of-Network (noncontracted) Providers 40% coinsurance
$1,000	$400	BCBSAZ pays:	$320	$240
		You pay:	$ 80 coinsurance amount	$160 coinsurance +600 balance bill $760

Locating an In-Network Provider

Check the BCBSAZ provider directory to locate an in-network provider who offers the services you are seeking and contact the provider for an appointment.

If you cannot get an appointment with the in-network provider, you may either call BCBSAZ or ask an in-network provider with whom you have an existing treatment relationship for help in getting an appointment or locating another provider.

Precertifications for Out-of-Network Providers

BCBSAZ does not guarantee that every specialist or facility will be in our network. Not all providers will contract with health insurance plans. If you believe or have been told there is no in-network provider available to render covered services that you need, you may ask your treating provider to request precertification of in-network cost-share for services from an out-of-network provider. BCBSAZ will not issue this precertification if we find that an in-network provider is available to treat you. The section on precertification explains how to make this request.

Continuing Physician Care from an Out-of-Network Physician (M.D., D.O.)

You may be able to receive benefits at the in-network level for services from an out-of-network Arizona physician, under the circumstances described below. Continuity of care benefits are subject to all other applicable provisions of your benefit plan.

Continuity of care only applies to otherwise covered services rendered by doctors of medicine and osteopathy who are located in Arizona. Continuity of care is not available for facility services. If the hospital or other facility at which your physician practices is not an in-network facility, the out-of-network provisions of coverage will apply to covered facility services.

New Members	**Current Members**
A new member may continue an active course of treatment with an out-of-network Arizona physician 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 thirty (30) days from the effective date of coverage; **or** 2. Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; **and**	A current member may continue an active course of treatment with an out-of-network Arizona physician if BCBSAZ terminates the physician from the network for reasons other than medical incompetence or unprofessional conduct if: The member has: 1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of the physician's termination; **or** 2. Entered the third trimester of pregnancy on the effective date of the physician's termination, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; **and**
The member's physician agrees in writing to do all of the following: 1. Accept the BCBSAZ allowed amount applicable to covered services as if provided by an in-network physician, subject to the deductible, coinsurance and copay requirements of this benefit plan; 2. Provide BCBSAZ with any necessary medical information related to your care; **and** 3. Comply with BCBSAZ's policies and procedures, as applicable, including precertification, network referral, claims processing, quality assurance and utilization review.	

Information on requesting continuity of care is listed in the BCBSAZ customer service section at the front of this book.

Out-of-Area Services

BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Plans referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Arizona, but inside the United States (not BlueCard Worldwide), the claims for those services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between BCBSAZ and other Blue Cross and/or Blue Shield Plans. National Account arrangements are contractual agreements between BCBSAZ and other Blue Cross and/or Blue Shield Plans regarding reimbursement for covered services provided to members of certain self-funded group health plans by providers contracted with the other Blue Cross and/or Blue Shield Plans.

Typically, when accessing care outside Arizona but inside the United States (not BlueCard Worldwide), you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Plan in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-contracted healthcare providers. BCBSAZ's payment practices in both instances are described in this benefit plan book.

BlueCard Program

Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for fulfilling BCBSAZ's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Arizona but inside the United States (not BlueCard Worldwide) and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed charges for your covered services; **or**
- The negotiated price that the Host Blue makes available to BCBSAZ.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSAZ uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Precertification requirements and other benefit plan limitations apply to services received outside Arizona. You must make sure the provider obtains any required precertification. Otherwise, BCBSAZ may deny your benefits or require you to pay a precertification charge.

For assistance in locating a local BCBS network provider in another state, call (800) 810-BLUE (2583) or check the "BlueCard Doctor & Hospital Finder" online at www.bcbs.com.

See the "Provider" section and the definition of "Allowed Amount" in this benefit book for information regarding payment for services provided by non-contracted providers outside Arizona.

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue. The amount you pay for covered healthcare services under a National Account arrangement will be calculated based on either: (1) the negotiated price made available to BCBSAZ by the Host Blue; or (2) the lesser of the provider's billed charges or the negotiated price made available to BCBSAZ by the Host Blue.

BlueCard Outside the United States (BlueCard Worldwide)

Always go directly to the nearest hospital in the event of an emergency. Emergency services are covered outside the United States. In-network member cost-sharing will apply to covered Emergency Services. See the Emergency Services section of this benefit book.

The BlueCard Worldwide program helps Blue Cross and/or Blue Shield members arrange medical services when they are outside the United States. BlueCard Worldwide works differently than BlueCard inside the United States.

If you need to locate a doctor or hospital or need medical assistance services outside the United States, call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Except for emergencies, you cannot obtain services at the in-network cost-share from providers located outside the United States. Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. If you receive covered services from a provider who is contracted with the BlueCard Worldwide program, you will pay out-of-network deductible and coinsurance and BCBSAZ access fees, plus the balance bill (except for emergency services).

- **Inpatient Services**

  In most cases, hospitals contracted with the BlueCard Worldwide program will not require you to pay for covered inpatient hospital services, except for your member cost-share (out-of-network deductible and coinsurance and BCBSAZ access fees). In such cases, the BlueCard Worldwide hospital will submit your claim for processing. **You must still contact BCBSAZ to obtain precertification for non-emergent inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the United States are generally not contracted with the BlueCard Worldwide program and will require you to pay for services in full at the time of service. Complete a BlueCard Worldwide claim form and send the claim form with the provider's bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claim processing. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide.

Services Received on Cruise Ships

If you receive health care services while on a cruise ship, you will pay in-network cost-share, and the allowed amount will be based on billed charges. A cruise ship claim is not considered an out-of-country claim. Claims should be submitted and processed through BCBSAZ, not through the BlueCard Worldwide program. Please call the BCBSAZ Customer Service department at the phone number listed in the front of this book for more information, or mail copies of your receipts to the BCBSAZ general correspondence address listed at the front of this book.

PRECERTIFICATION

Precertification

Precertification is the process BCBSAZ uses to determine eligibility for benefits.

When Is Precertification Required and What Happens If You Don't Obtain It

Not all services require precertification. Each benefit description in this booklet tells you whether precertification is required for that benefit. If it is required, your provider must obtain it on your behalf before rendering services.

Notwithstanding any other language in this benefit book, BCBSAZ may change the services that require precertification at any time. If the benefit description does not indicate that precertification is required, and you or your provider are unsure, go to www.azblue.com for a listing of medications and services that require precertification or call the Customer Service number listed in the front of this book.

If precertification is required, but not obtained, the consequences vary by benefit. The benefit description section in this book tells you which consequences will apply to specific benefits including:

- Your benefits may be denied
- You may have to pay a precertification charge
- Your cost-sharing payments may be substantially higher

How to Obtain Precertification

Ask your provider to contact BCBSAZ for precertification before you receive services. Your provider must contact BCBSAZ because he or she has the information and medical records we need to make a benefit determination. BCBSAZ will rely on information supplied by your provider. If that information is inaccurate or incomplete, it may affect the decision on your claim. You are responsible for checking with your provider to make sure that the provider has obtained any required precertification.

Factors BCBSAZ Considers in Evaluating a Precertification Request for Services or Medications

- Applicability of other benefit plan provisions (limitations, exclusions and benefit maximums);
- If the treating provider or location of service is in-network;
- Whether the service is medically necessary or investigational; **and**
- Whether your coverage is active.

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

Prescription Medication Exception

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

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

If there is no in-network provider available to deliver covered services, your treating provider may contact BCBSAZ and ask BCBSAZ to precertify the in-network cost-share for services from an out-of-network provider. BCBSAZ will evaluate whether there is an in-network alternative. If BCBSAZ determines that an in-network provider is available to treat you, BCBSAZ will not precertify in-network cost-share for services from your out-of-network provider of choice.

Precertification of in-network cost-share for services from an out-of-network provider is a process separate from precertification of services. If you want an out-of-network provider to render services that require precertification, and you also want to be eligible for the in-network cost-share, you must ensure that your

provider makes two separate precertification requests: one for the service itself and one for use of the out-of-network provider. The benefit descriptions in this book refer only to your obligation to obtain precertification for the service. If BCBSAZ precertifies you for the in-network cost-share, your services will be subject to the in-network cost-share. You will still be responsible for any balance bill, plus your in-network cost-share.

If BCBSAZ Precertifies Your Service

- Precertification is not a pre-approval or a guarantee of payment. Precertification made in error by BCBSAZ is not a waiver of BCBSAZ's right to deny payment for noncovered services.
- You and your provider will receive a letter explaining the scope of the precertification.

If BCBSAZ Denies Your Precertification Request

Denial of precertification is an adverse benefit determination. As explained in the section on Claims, BCBSAZ will send you a notice explaining the reason for the denial, and your right to appeal the BCBSAZ decision. Information on where to file an appeal is in the BCBSAZ Customer Service section at the front of this book.

If your request for precertification of a service is denied because BCBSAZ decides that the service is not medically necessary, remember that BCBSAZ's interpretation of medical necessity is a benefits determination made in accordance with the provisions of this plan. Your provider may recommend services or treatment not covered under this plan. You and your provider should decide whether to proceed with the service or procedure if BCBSAZ denies precertification.

DESCRIPTION OF BENEFITS

Please review this section for an explanation of covered services and benefit-specific limitations and exclusions. Also be sure to review "What is Not Covered" for general exclusions and limitations that apply to all benefits.

To be covered and eligible for benefits, a service must be:

- A benefit of this plan;
- Medically necessary as determined by BCBSAZ;
- Not excluded;
- Not experimental or investigational as determined by BCBSAZ;
- Precertified if precertification is required;
- Provided while this benefit plan is in effect and while the person claiming benefits is an eligible member; **and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ.

BCBSAZ does not determine whether a service is covered under this benefit plan until after services are provided and BCBSAZ receives a complete claim describing the services actually rendered.

Most diagnosis, management and treatment of behavioral health conditions that are eligible for benefits, including medication management, are covered under your behavioral and mental health benefit. Depending on how your provider submits a claim and the scope of services provided, certain services involving both behavioral health and medical diagnoses may be covered under the behavioral and mental health benefit, and cost-shares for behavioral and mental health services will apply.

Benefits are listed in alphabetical order:

A. AMBULANCE SERVICES

Precertification: Not required.

Your Cost-Share: The Plan pays 100 percent of the allowed amount.

Benefit Description: Ground ambulance transportation from the site of an emergency, accident or acute illness to the nearest facility capable of providing appropriate treatment; **or**

Interfacility ground or air ambulance transfer for admission to an acute care facility, extended active rehabilitation facility or skilled nursing facility when the transferring facility is unable to provide the level of service required; **or**

Air ambulance transportation to the nearest facility capable of providing appropriate treatment when the emergency, accident or acute illness occurs in an area inaccessible by ground vehicles or transport by ground ambulance would be harmful to the member's medical condition.

Benefit-Specific Exclusion: All other expenses for travel and transportation are not covered, except for the limited travel benefits described in "Transplant Travel and Lodging."

B. BEHAVIORAL AND MENTAL HEALTH SERVICES (including chemical dependency or substance abuse treatment)

B.1.1 Inpatient Hospital

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share:

In-Network Facility and Professional Services: You pay in-network deductible and coinsurance.

Out-of-Network Facility and Professional Services: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for:

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

B.1.2 Inpatient Subacute Hospitalization - Behavioral Health Facility Services

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share:

In-Network Facility and Professional Services: You pay in-network deductible and coinsurance.

Out-of-Network Facility and Professional Services: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description:

Benefits are available for:

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

Benefits are available for inpatient behavioral and mental health services that meet all the following criteria:

- The facility is licensed to provide behavioral health services to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time.
- The facility's designated medical director is a physician or registered nurse practitioner and provides direction for physical health services provided at the facility;
- A physician or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- The facility's designated clinical director is a behavioral health professional and provides direction for the behavioral health services provided at the facility;
- The facility has 24/7 onsite registered nursing coverage; **and**
- The facility has sufficient behavioral or mental health professional staff to provide appropriate treatment.

Changing Types of Inpatient Care (applicable to B.1.1 and B.1.2 above): Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient subacute and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit-Specific Exclusions (applicable to B.1.1 and B.1.2 above):

- Custodial Care
- Medications dispensed at the time of discharge from a hospital

- Private Duty Nursing
- Respite Care

B.2 Behavioral and Mental Health Services (Outpatient Facility and Professional Services)

Precertification: Required for partial hospitalization. Not required for other outpatient services. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share:

BSA: Your cost-share is waived.

Non-BSA (in-network): You pay one copay per member, per provider, per day for services provided during an office or home visit. The amount of your copay will vary depending on the type of provider you see during the visit. See your SBC for the applicable copay. You pay in-network deductible and coinsurance for outpatient services delivered in locations other than the provider's office or the member's home.

Non-BSA (out-of-network): You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Non-emergency outpatient behavioral and mental health services are available either through BSA providers or from non-BSA providers. Those services include psychotherapy, outpatient therapy for chemical dependency or substance abuse, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, intensive outpatient services, counseling for personal and family problems, electroconvulsive therapy (ECT) and partial hospitalization.

B.3 Behavioral Therapy Services For The Treatment Of Autism Spectrum Disorder

Precertification: Not required.

Your Cost-Share:

BSA: Your cost-share is waived.

Non-BSA (in-network): You pay one copay per member, per provider, per day for services provided during an office or home visit. The amount of your copay will vary depending on the type of provider you see during the visit. See your SBC for the applicable copay. You pay in-network deductible and coinsurance for outpatient services delivered in locations other than the provider's office or the member's home.

Non-BSA (out-of-network): You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definitions:

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

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

Benefit Description: Behavioral therapy services for the treatment of Autism Spectrum Disorder are available for members who have been diagnosed with Autism Spectrum Disorder. Services are available either through the BSA or from non-BSA providers. Covered behavioral therapy services must be delivered by a provider who is licensed or certified as required by law.

Benefit-Specific Exclusions (applicable to all Behavioral and Mental Health Services):

- Activity therapy, milieu therapy and any care primarily intended to assist an individual in the activities of daily living
- Biofeedback and hypnotherapy
- Development of a learning plan and treatment and education for learning disabilities (such as reading and arithmetic disorders)
- Inpatient and outpatient facility charges for services provided by the following facilities: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes.
- IQ testing
- Lifestyle education and management services
- Neurofeedback
- Neuropsychological and cognitive testing
- Sensory integration, LOVAAS therapy and music therapy
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

C. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

Precertification: Not required.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for outpatient Phase I and II cardiac rehabilitation programs and pulmonary rehabilitation services.

D. CATARACT SURGERY

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible, coinsurance and copays for the cataract surgery and any associated services. The cost-share amount will depend on the provider's network status and the place you receive services. In addition, you pay any amounts above the $250 maximum per member, per six (6) month period, for eyeglasses. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: There is a maximum benefit of $250 per member, per six (6) month period for eyeglasses following cataract surgery.

Benefit Description: Benefits are available for the removal of cataracts, including placement of a single intraocular lens at the time of the cataract removal. Benefits are also available for the first pair of eyeglasses post-cataract surgery or external contact lenses for treatment of keratoconus. The eyeglasses or external contact lenses must be prescribed and purchased within six (6) months of the surgery.

Benefit-Specific Exclusion: Procedures associated with cataract surgery that are not included in the benefit description, including replacement, piggyback or secondary intraocular lenses and any other treatments or devices for refractive correction.

E. CHIROPRACTIC SERVICES

Precertification: Not required.

Your Cost-Share:

In-Network: You pay one copay, per member, per provider, per day for office, home, or walk-in clinic visits, and physical and occupational therapy provided by the chiropractor.

Out-of-Network: You pay out-of-network deductible and coinsurance for services rendered by an out-of-network provider. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: There is a chiropractic visit limit of twenty (20) visits per member, per calendar year. In- and out-of-network visits count toward the twenty (20) visit limit. Physical therapy and occupational therapy services provided and billed by a chiropractor will apply towards the twenty (20) visit limit.

Benefit Description: Benefits are available for chiropractic services.

Benefit-Specific Exclusions:

- Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Spinal decompression or vertebral axial decompression therapy

F. CLINICAL TRIALS FOR TREATMENT OF CANCER AND OTHER LIFE-THREATENING DISEASES

Precertification: Required for services directly associated with a clinical trial for treatment of cancer or other life-threatening diseases or conditions. Precertification will be issued in accordance with the requirements of applicable law, regardless of whether the clinical trial would otherwise be considered investigational. See specific benefit provisions for precertification charges.

Precertification of covered services directly associated with an eligible clinical trial is not a guarantee of coverage, assurance that the clinical trial satisfies the requirements of applicable law or evidence of any determination that the service provided through the clinical trial is safe, effective or appropriate for any member.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: A "life-threatening disease or condition" is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefit Description: Benefits are available for covered services directly associated with a member's participation in a clinical trial meeting all requirements specified by applicable Arizona and/or federal law. Benefits are limited to those services eligible for coverage under this plan that would be required if you received standard, non-investigational treatment. If you have any questions about whether a particular service will be covered, please contact BCBSAZ customer service. You or your provider must inform BCBSAZ that you are enrolled in a clinical trial, that the trial meets the requirements of applicable law, and that the services to be rendered are directly associated with the trial. Otherwise, BCBSAZ will administer your benefits according to the other terms of your benefit plan, which may result in a denial of benefits.

Benefit-Specific Exclusions:

- Investigational medications (except as stated in *"Prescription Medications for the Treatment of Cancer")* and devices
- Any item, device or service that is the subject of the clinical study, or which is provided solely to meet the need for data collection and analysis
- Costs and services customarily paid for by government, biotechnical, pharmaceutical and medical device industry sources
- Costs to manage the clinical trial research
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses

- Services not otherwise covered under this plan

G. DENTAL SERVICES BENEFIT

Not all dentists who are contracted with BCBSAZ are contracted to provide medical-related dental services. Call BCBSAZ customer service with questions.

1. Dental Accident Services

Precertification: Not required.

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

Benefit-Specific Definitions:

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

A "sound tooth" is a tooth that is:

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

Benefit Description: Benefits are only available for the following services to repair or replace sound teeth damaged or lost by an accidental dental injury:

Covered Services:

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

Benefit-Specific Exclusions:

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

2. Dental Services Required for Medical Procedures

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

Benefit Description: Benefits are available for dental services which are required in order to perform the medical services listed in this benefit. These dental services may either be part of the medical procedure or may be performed in conjunction with and made medically necessary solely because of the medical procedure.

Benefits are available for the following:

- Diagnostic services prior to planned organ or stem cell transplantation 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

Benefit-Specific Exclusions:

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

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

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

- Children 5 years or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office
- Malignant hypertension
- Mental retardation
- Senility or dementia
- Unstable cardiovascular condition
- Uncontrolled seizure disorder

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

Precertification: Not required.

Your Cost-Share: The Plan pays 100 percent of the allowed amount for services received from in-network providers. You pay out-of-network deductible and coinsurance for services received from out-of-network providers. In addition, your cost-share is waived for one FDA-approved manual or electric breast pump and breast pump supplies per female member, per calendar year when received from in-network providers. If you receive services from a noncontracted provider, you also pay the balance bill.

1. Durable Medical Equipment (DME)

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

- Be designed for repeated medical use in the home setting;

- Be specifically designed to improve or support the function of a body part;
- Cannot be primarily useful to a person in the absence of an illness or injury; **and**
- Intended to prevent further deterioration of the medical condition for which the equipment has been prescribed.

Benefits are available for DME rental up to the purchase price of the item, as determined by BCBSAZ, and for DME repair or replacement due to normal wear and tear caused by use of the item in accordance with the manufacturer's instructions or due to growth of a child.

Benefits are limited to the allowed amount for the DME item base model. BCBSAZ will determine what is covered as the base model. Deluxe or upgraded DME items may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusions: The following services or charges are not covered:

- Charges for continued rental of a DME item after the purchase price is reached
- Repair costs that exceed the replacement cost of the DME item
- Repair or replacement of DME items lost or damaged due to neglect or use that is not in accordance with the manufacturer's instructions or specifications

2. Medical Supplies

Benefit Description: Benefits are available for the following medical supplies:

- Any device or supply required by applicable law or as otherwise permitted under the Medical Coverage Guidelines
- Blood glucose monitors
- Blood glucose monitors for the legally blind and visually impaired
- Diabetic injection aids and drawing-up devices
- Diabetic syringes and lancets
- Ostomy and urinary catheter supplies
- Peak flow meters
- Supplies associated with oxygen or respiratory equipment
- Test strips for glucose monitors and urine test strips
- Volume nebulizers

Benefits are limited to the allowed amount for the medical supply base model. BCBSAZ will determine what is covered as the base model. Deluxe or upgraded medical supplies may be eligible for coverage based upon BCBSAZ medical necessity criteria.

3. Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- Prosthetic appliances to replace all or part of the function of an inoperative or malfunctioning body organ or to replace an eye or limb lost as a result of trauma or disease
- Orthotics (such as foot orthotics, collars, braces, molds) to protect, restore or improve impaired bodily function
- Wig(s) for individuals diagnosed with alopecia (absence of hair) resulting from illness or injury (up to a maximum benefit of $300 per member, per calendar year)
- Orthopedic shoes that are:
    - attached to a brace;
    - therapeutic shoes (depth inlay or custom-molded) along with inserts, for individuals with diabetes; or
    - covered in accordance with BCBSAZ medical necessity criteria.

Benefits are limited to the allowed amount for the prosthetic appliance or orthotic base model. BCBSAZ will determine what is covered as the base model. Deluxe or upgraded prosthetic appliances or orthotics may be eligible for coverage based upon BCBSAZ medical necessity criteria.

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

- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, corsets, cushions, dentures, diatherapy machines, disposable hygienic items, dressing aids and devices, elastic/support/compression stockings except TED hose, elevators, exercise equipment, foot stools, garter belts, grab bars, health spas, hearing aid batteries, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, mineral baths, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas and vehicle or home modifications.
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for help in daily living, socialization, personal comfort, convenience or other nonmedical reasons
- Manual and electric breast pumps and supplies for male members
- Replacement of external prosthetic devices due to loss or theft
- Strollers of any kind
- Supplies used by a provider during office treatments
- Tilt or inversion tables or suspension devices
- Wig(s), when hair loss results from male or female-pattern baldness or natural or premature aging

I. EDUCATION AND TRAINING

Precertification: Not required.

Your Cost-Share: See descriptions under subheadings.

1. Diabetes and Asthma Education and Training

Your Cost-Share: Waived.

Benefit Description: Benefits are available for diabetes and asthma education and training that meet the following criteria:

- An in-network provider delivers the education and training;
- Education and training are provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Training is conducted in person; **and**
- Your health care provider prescribes the training as part of a comprehensive plan of care related to your condition to enhance therapy compliance and improve self-management skills and knowledge.

Benefit-Specific Exclusion: Diabetes and asthma education and training provided by an out-of-network provider.

2. Nutritional Counseling and Training

Your Cost-Share: Cost-share is waived for services from in-network providers. You pay out-of-network deductible and coinsurance for services from an out-of-network provider. If you receive services from a noncontracted provider, you pay the balance bill.

Benefit Description: Nutritional counseling and training is available only for members diagnosed with the following conditions:

- Coronary Artery Disease
- Heart Failure
- High Cholesterol
- Hypertension
- Obesity
- Pre-Diabetes

- Renal Failure/Renal Disease

3. **Lifestyle Education and Management Services, Biofeedback and Hypnotherapy**

Your Cost-Share: Your cost-share is waived for services provided through the BSA. If you are referred to a BCBSAZ or community resource, you may be responsible for additional fees. Check with the provider regarding fees before obtaining services.

Benefit Description:

- Lifestyle education and management services, which are designed to provide members with information, skills and social support to maximize health
- Biofeedback
- Hypnotherapy

Lifestyle education and management services, biofeedback and hypnotherapy services are available only through the BSA. **BSA services are available only in Arizona.**

J. EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)

Precertification: Not required.

Your Cost-Share: For emergency services, you will pay your in-network cost share, even for services from out-of-network providers.

Emergency Room: You pay one access fee per member, per facility, per day plus in-network deductible and coinsurance. Covered ancillary services provided on the same day as the emergency room visit are paid at 100 percent of the allowed amount.

Admission to the Hospital from the Emergency Room: The emergency room access fee is waived if you are admitted to the hospital. Following admission, you pay in-network deductible and coinsurance for all other hospital and professional services related to the emergency.

If you receive emergency services from a noncontracted facility or professional provider, BCBSAZ will base the allowed amount used to calculate your cost-share on billed charges.

For all non-emergency services following the emergency treatment and stabilization, you pay applicable deductible, coinsurance, copays and access fees. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which may be substantial.

Benefit Description: Benefits are available for services needed to treat an emergency.

Teletrauma Services:

If a member is receiving covered emergency services, benefits may be available for teletrauma consultations between providers at the facility where the member is being treated and providers at certain Level 1 trauma centers. In order for teletrauma services to be covered, the member must be receiving emergency treatment in a facility that is not equipped to handle that member's medical condition and the treating providers must need the consultation to appropriately treat or stabilize the member. A teletrauma consultation may include telephonic or electronic communications between providers and video presentation of the member's condition. Both facilities must have certain equipment to facilitate the teletrauma communications.

For purposes of this benefit, "trauma" is defined as a physical wound or injury that results from a sudden accident or violent cause and which, if not immediately treated, is likely to result in death, permanent disability or severe pain.

K. EOSINOPHILIC GASTROINTESTINAL DISORDER

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and 25 percent of the Cost of amino-acid based formula ('Formula").

Benefit-Specific Definitions: "Cost" is defined as either billed charges, if the Formula is purchased from an out-of-network provider, or the allowed amount, if purchased from an in-network provider.

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

- At risk of mental or physical impairment if deprived of the Formula;
- Diagnosed with eosinophilic gastrointestinal disorder; **and**
- Under the continuous supervision of a physician or a registered nurse practitioner.

L. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share:

Implanted Devices: Your cost-share is waived for professional charges for implantation and/or removal of FDA-approved implanted contraceptive devices for female members when the purpose of the procedure is contraception, as documented by your provider on the claim, and the device is inserted and/or removed in an in-network physician office. You pay applicable deductible, coinsurance and copays when the location of service is outside an in-network physician office. If you receive services from a noncontracted provider, you also pay the balance bill.

Sterilization Procedures: Your cost-share is waived for professional and facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim. You pay out-of-network deductible and coinsurance for professional and facility charges from out-of-network providers for FDA-approved sterilization procedures provided to female members. You pay applicable deductible, coinsurance and copays for professional and facility charges from in- and out-of-network providers for FDA-approved sterilization procedures provided to male members. If you receive services from a noncontracted provider, you also pay the balance bill.

Hormonal Contraceptive Methods: (includes oral contraceptives, patches, rings and contraceptive injections). See the *"Physician Services"* section and the *"Prescription Medications Obtained From a Retail or Mail Order Pharmacy"* section for benefits and cost-share.

Emergency Contraception: FDA-approved over-the-counter emergency contraception is covered when prescribed by a physician or other provider. See the *"Prescription Medications Obtained From a Retail or Mail Order Pharmacy"* section for benefits and cost-share.

Barrier Contraceptive Methods: (includes diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides). See the *"Physician Services"* section and the *"Prescription Medications Obtained From a Retail or Mail Order Pharmacy"* section for benefits and cost-share.

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

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.

M. FERTILITY AND INFERTILITY SERVICES

Precertification: Not required.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available to diagnose infertility or to treat the underlying medical condition causing the infertility.

Benefit-Specific Exclusion: Services to improve or achieve fertility (ability to conceive) or to treat infertility (inability to conceive).

N. HOME HEALTH AND HOME INFUSION - MEDICATION ADMINISTRATION THERAPY

Precertification: Required for certain medications covered under this benefit. Go to www.azblue.com for a listing of medications that require precertification or call the Customer Service number listed in the front of this book. If you fail to obtain precertification for these medications, they will not be covered.

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

Benefit Description: Benefits are available for the following services:

- Home infusion medication administration therapy, including:
  - Blood and blood components
  - Hydration therapy
  - Intravenous catheter care
  - Intravenous, intramuscular or subcutaneous administration of medication
  - Specialty injectable medications, as defined by BCBSAZ
  - Total parenteral nutrition
- Enteral nutrition (tube feeding) when it is the sole source of nutrition. Sole source of nutrition is defined as the inability to orally receive more than 30 percent of daily caloric needs.
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition and other services that require skilled nursing care.

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

- A licensed home health agency must provide the services;
- A health care provider must order the services pursuant to a specific plan of home treatment;
- Services must be provided in the member's residence;
- The health care provider must regularly review the appropriateness of the services ("regularly" means at least every thirty (30) days or more frequently if appropriate under the treatment plan); and
- The services must be provided by a licensed practical nurse (L.P.N.) or a registered nurse (R.N.) or another eligible provider.

Benefit-Specific Exclusions:

- Continuous home health services or shift nursing, including 24 hour continuous nursing care
- Custodial care
- Respite care

O. HOSPICE SERVICES

Precertification: Not required for inpatient hospice admissions. Required for non-emergency inpatient admissions not related to hospice services. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

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

Benefit Description: When a member elects to use the hospice benefit, it is in lieu of other medical benefits available under this plan, except for care unrelated to the terminal illness or related complications.

The hospice agency determines the required level of care, which is subject to the medical necessity provision of the benefit plan. Once the member selects the hospice benefit, the hospice agency coordinates all of the member's health care needs related to the terminal illness.

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

Benefits are available for the following:

- ***Continuous Home Care:*** 24-hour skilled care provided by an RN or LPN during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- ***Inpatient Acute Care:*** Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- ***Respite Care:*** Admission of the member to an approved facility to provide rest to the member's family or primary caregiver
- ***Routine Care:*** Intermittent visits provided by a member of the hospice team

P. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

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

Q. INPATIENT HOSPITAL

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

For bariatric surgeries received from in- and out-of-network providers, you pay applicable deductible and 50 percent of the allowed amount. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share is waived for facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim.

Please note: You pay in-network cost-share for services received from in- and out-of-network anesthesiologists only when services are received in-network.

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

Benefit Description:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including radiology and laboratory services
- 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, except in conjunction with a noncovered transplant
- Room and board in a semi-private room, unless the hospital only has private rooms. If the hospital only has private rooms, only standard private rooms are covered (not deluxe).

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

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

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance. If you receive services at a noncontracted provider, you also pay the balance bill, in addition to applicable deductible and coinsurance.

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

Benefit Description: An intense therapy program provided in a facility licensed to provide extended active rehabilitation. This care is for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

S. LONG-TERM ACUTE CARE (INPATIENT)

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill, in addition to applicable deductible and coinsurance.

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

Benefit Description: Specialized acute, medically complex care for patients provided in a facility licensed to provide long-term acute care. This care is for patients who require hospitalization on an extended basis in a facility offering specialized treatment programs and aggressive clinical and therapeutic interventions.

Benefit-Specific Exclusions:

- Custodial Care
- Private Duty Nursing
- Respite Care

T. MATERNITY

Precertification: Not required

Your Cost-Share:

Inpatient Services: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Outpatient Services:

In-Network: You pay one physician visit copay, which covers all prenatal visits, the physician's Global Charge and other physician office and home visits submitted with a primary diagnosis of maternity. If the amount of your physician visit copay changes during the course of your pregnancy, you will also pay the difference between the two copay amounts in addition to the original copay amount (even though you already paid the original copay amount). If maternity is not the primary diagnosis on a claim submitted by your provider for a physician visit, you will pay an additional physician visit copay per member, per provider, per day. You pay in-network deductible, coinsurance, and copays for other covered maternity services from any other in-network providers.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided in the member's home must be rendered by an eligible provider. Your cost-share will vary depending on the type of provider and the provider's network status.

Applicable deductible, coinsurance and copays are waived for maternity services covered under the "*Preventive Services*" benefit and delivered by an in-network provider. If you receive these services from an out-of-network provider, the services will be covered through your maternity benefit and you will pay the out-of-network cost-share. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share obligations may be affected by the automatic addition of a newborn or adopted child, as described in the **Plan Administration** section of this book. If you have coverage only for yourself and no dependents, automatic addition of a child will result in a change from individual coverage to family coverage. If you currently have a per person deductible and out-of-pocket maximum, when a child is added to your plan, you will also be required to meet a family deductible and out-of-pocket maximum, and you may be required to pay additional premium.

Benefit-Specific Definition:

Global Charge: A fee charged by the delivering provider that may include certain prenatal, delivery and postnatal services.

Benefit Description:

Maternity benefits are available for covered services related to pregnancy. This includes certain screening tests such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases and others as determined by BCBSAZ. Certain tests, including some genetic screening, may not be covered. For a complete listing of covered prenatal screening, please call BCBSAZ customer service at the numbers listed in the front of this benefit book.

Maternity benefits are available for the expense incurred by a birth mother (who is not a member) for the birth of any child legally adopted by a member, if all of the following requirements are met:

- The member adopts the child within one year of birth;
- The member is legally obligated to pay the costs of birth; **and**
- The member has provided notice to BCBSAZ within sixty (60) days of the member's acceptability to adopt children.

This adopted child maternity benefit is secondary to any other coverage available to the birth mother. Contact Membership Services at the number listed in the front of this book to receive a BCBSAZ adoption packet.

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

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

U. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and 50 percent of the Cost of Medical Foods.

Benefit-Specific Definitions: "Cost" is defined as either billed charges, if the member buys the Medical Foods from an out-of-network provider or the allowed amount, if the member buys the Medical Foods from an in-network provider.

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

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

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

- Administered for the medical and nutritional management of a member who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation;
- Essential to the member's optimal growth, health and metabolic homeostasis;
- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an M.D. or D.O. physician or a registered nurse practitioner;
- Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs (metabolic formula only); **and**
- Processed or formulated to contain less than one gram of protein per unit of serving (modified low protein foods only).

Benefit Description: Benefits are available for Medical Foods to treat Inherited Metabolic Disorders.

Benefit-Specific Exclusions:

- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available for purchase without a prescription or order from an M.D. or D.O. physician or registered nurse practitioner
- Foods and formulas that do not require supervision by an M.D. or D.O. physician or a registered nurse practitioner
- Medical food benefits are not available for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
- Spices and flavorings

Claim submission for Medical Foods

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

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

Please contact BCBSAZ at the Supply Line number listed at the front of this book to request copies of the Medical Foods Claim Form. To obtain reimbursement for Medical Foods you purchased directly, please submit the Medical Foods Claim Form and the dated receipt to the address for claims submission at the front of this book.

Medical Foods also may be covered under the *"Home Health and Home Infusion—Medication Administration Therapy"* benefit. Medical Foods are not covered under *the "Prescription Medications Obtained from a Retail or Mail Order Pharmacy"* or the *"Specialty Self-Injectable Medications"* benefits.

V. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Precertification: Not required.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

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

W. OUTPATIENT SERVICES

Precertification: Not required.

Your Cost-Share: Outpatient services are often available in multiple settings, and generally result in separate charges for professional and facility services. Your cost-share will vary depending on the

type of outpatient service, the location of the service, and the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

For bariatric surgeries received from in- and out-of-network providers, you pay applicable deductible and 50 percent of the allowed amount. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share is waived for facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception as documented by your provider on the claim.

Please note: You pay in-network cost-share for services received from in- and out-of-network anesthesiologists only when services are received in-network.

Diagnostic Laboratory Services

- ***In-Network Physician's Office:*** You pay the physician visit copay (copay is waived if you receive only covered laboratory services during your visit).
- ***In-Network Clinical Laboratory and Hospital Outpatient Laboratory Department:*** Your cost-share is waived.
- ***In-Network Inpatient Laboratories:*** You pay applicable deductible and coinsurance.
- ***Out-of-Network Physician's Office, Clinical Laboratory or Hospital Outpatient Laboratory Department:*** You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Radiology Services: The Plan pays 100 percent of the allowed amount for ultrasounds and basic x-rays. You pay applicable deductible and coinsurance for any other in-network radiology service. You pay out-of-network deductible and coinsurance for services received from out-of-network providers. If you receive services from a noncontracted provider, you also pay the balance bill.

MRI, MRA, Nuclear Medicine, Radiation Therapy, PET and CT Scans: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided by a radiologist or pathologist, including a dermapathologist, are always subject to applicable deductible and coinsurance, even when the services are provided in a physician's office.

Benefit Description: Benefits are available for the following outpatient services:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including laboratory and radiology services
- Outpatient surgery, which is defined as operative procedures and other invasive procedures such as epidural injections for pain management and various scope procedures, such as arthroscopies and colonoscopies.
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant

X. PHARMACY BENEFIT

Precertification (Prior Authorization): Required for certain medications. Contact the Pharmacy Benefit Customer Service number listed in the front of this book for a list of medications that require precertification. If you do not obtain precertification for medications that require precertification, the medications will not be covered.

Information About This Benefit

Contact the Pharmacy Benefit Customer Service number listed in the front of this book to request any of the following:

- A list of covered medications that require precertification;
- A list of covered vaccines;

- An exception to BCBSAZ prescription medication limitations;
- Information on the assigned cost-share Level of a covered medication; or
- Other information about this Pharmacy Benefit.

Your Cost-Share:

In-Network:

Medications Obtained From Retail/Mail Order Pharmacies: You pay a Level 1, 2 or 3 prescription copay for most medications. You pay the greater of the Level 3 copay or 50 percent coinsurance for compounded medications.

Your cost-share is based on the Level to which BCBSAZ has assigned the medication at the time the prescription is filled. **No exceptions will be made regarding the assigned Level of a medication.** BCBSAZ may change the Level of a medication at any time without notice.

Your cost-share is waived for preventive medications and for covered vaccines. BCBSAZ will determine which medications are considered preventive and for which your cost-share is waived. BCBSAZ also determines which vaccines are covered and for which your cost-share is waived.

Your cost-share is waived for the following contraceptive methods when prescribed by your provider and obtained from an in-network pharmacy:

- FDA-approved diaphragms, cervical caps and cervical shields
- FDA-approved emergency contraception for female members of any age
- FDA-approved generic oral, patch, vaginal ring and injectable contraceptives
- FDA-approved brand oral, patch, vaginal ring and injectable contraceptives with no generic equivalent components
- Female condoms
- Sponges and spermicides for female members

Contraceptives must be prescribed for or include the purpose of contraception and not be prescribed solely for some other medical reason to be covered with no member cost-share.

Out-of-Network: You pay your in-network cost-share amount plus the balance bill.

Benefit-Specific Definitions:

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

"PBM" means the independent pharmacy benefit manager that contracts with BCBSAZ to administer the prescription medication benefits covered under this benefit plan.

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

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

You may obtain prescription medications covered under this benefit from retail pharmacies or the in-network mail order pharmacy. Compounded medications are eligible for coverage only when purchased through retail pharmacies.

Covered medications are subject to limitations, including but not limited to, quantity, age, gender, dosage, and frequency of refills. BCBSAZ and/or the PBM determines which medications are subject to limitations. **Medication limitations are subject to change at any time without prior notice.**

The following medical devices are covered under this benefit: diabetic test strips, lancets, diabetic syringes/needles for insulin and spacer devices for asthma medications. Certain vaccines are covered when obtained from in-network retail pharmacies and administered by a certified, licensed pharmacist.

Benefit-Specific Exclusions:

- Abortifascient medications
- Administration of a covered medication
- All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms
- Biologic serums
- Certain categories of injectable medications
- Compounded medications obtained from a mail order pharmacy
- Formula for Eosinophilic Gastrointestinal Disorder
- Medications, devices, equipment and supplies lawfully obtainable without a prescription, except as stated in this benefit plan
- Medical devices, except as stated in this benefit
- Medical Foods
- Medication delivery implants
- Medications designated as clinic packs
- Medications dispensed to a member who is an inpatient in any facility
- Medications for athletic performance
- Medications for lifestyle enhancement
- Medications labeled "Caution - Limited by Federal Law to Investigational Use" or words to that effect and any experimental medications as determined by BCBSAZ and/or the PBM, except as stated in this benefit plan
- Medications obtained from an out-of-network mail order pharmacy
- Medications packaged with one other or multiple other prescription products
- Medications packaged with over-the-counter medications, supplies, medical foods, vitamins or other excluded products
- Medications that exceed BCBSAZ and/or the PBM's limitations, including, but not limited to, quantity, age, gender and refill limits.
- Medications used for any cosmetic purpose, including but not limited to, Tretinoin for members age 26 and older
- Medications used to treat a condition not covered under this plan
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging or name
- Prescription medications dispensed in unit-dose packaging, unless that is the only form in which the medication is available
- Prescription refills for medications that are lost, stolen, spilled, spoiled or damaged
- Medications designed for weight gain or loss, including but not limited to, Xenical® and Meridia®, regardless of the condition for which it is prescribed
- Medications to improve or achieve fertility or treat infertility
- Specialty self-injectable medications
- Transsexual medications
- Any other preventive service required by federal or state law to be covered

X. PHYSICAL THERAPY (PT) - OCCUPATIONAL THERAPY (OT) - SPEECH THERAPY (ST)

Precertification: Not required.

Your Cost-Share: You pay one copay per member, per provider, per day for services received from in-network providers. You pay out-of-network deductible and coinsurance for services received from out-of-network providers. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Maximum: You have a combined in- and out-of-network maximum of sixty (60) PT, OT, and ST visits per member, per calendar year.

Benefit Description: Benefits are available for physical therapy, occupational therapy and speech therapy services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience, except for limited hospice benefits
- Cognitive therapy
- Computer speech training and therapy programs and devices
- Custodial Care
- Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines
- Physical or occupational therapeutic services performed in a group setting of 2 or more individuals
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Strength training, cardiovascular endurance training, fitness programs, strengthening programs and other services designed primarily to improve or increase strength

Y. PHYSICIAN SERVICES

Precertification: Not required.

Your Cost-Share:

In-Network: You pay one copay, per member, per provider, per day for office, home and walk-in clinic visits. If you receive preventive services during one of these visits, your copay may be waived, as described in the *"Preventive Services"* section of this benefit book.

Your copay will be waived if you receive only the following services and no other covered service during your visit:

- Covered immunizations
- Covered laboratory services

Allergy injections: The Plan pays 100 percent of the allowed amount for allergy injections received from in-network providers. You pay one copay, per member, per provider, per day if an office visit is billed. You pay in-network deductible and coinsurance if a serum is mixed.

Your cost-share will be waived for the following services, when the purpose of the procedure is contraception as documented by your provider on the claim:

- Professional physician services for FDA-approved sterilization procedures provided to female members, regardless of the location of service.
- Professional physician services for fitting, implantation and/or removal of FDA-approved contraceptive devices in female members provided during a physician office, home or walk-in clinic visit.
- FDA-approved implanted contraceptive devices in female members
- The following FDA-approved prescription hormonal and barrier contraceptive methods and devices for female members: patches, rings, contraceptive injections, diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides

If you receive preventive physician services from an in-network physician, your cost-share may be waived, as described in this benefit section and in the *"Preventive Services"* section of this benefit book. You pay in-network deductible and coinsurance for non-preventive physician services provided in locations other than an office, home or walk-in clinic, including but not limited to, inpatient and outpatient facilities. You pay applicable copays or in-network deductible and coinsurance for physician services for sterilization procedures provided to male members.

Out-of-Network: You pay out-of-network deductible and coinsurance for services rendered by an out-of-network physician. If you receive services from a noncontracted provider, you also pay the balance bill.

See the "Emergency" section for cost-share for emergency professional services.

Professional services provided by a radiologist or pathologist, including a dermapathologist, are always subject to applicable deductible and coinsurance, regardless of where the radiologist or pathologist performs the services.

Benefit Description: Benefits are available for the following:

- General surgical procedures (including assistance at surgery) provided outside a physician's office. Only certain surgical assistants are eligible providers. Call BCBSAZ customer service at the numbers listed in the front of this book to verify that the surgical assistant chosen by your physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your physician are in-network providers.
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics)
- Inpatient medical visits
- Second surgical opinions
- FDA-approved patches, rings and contraceptive injections for female members
- FDA-approved diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides for female members
- FDA-approved emergency contraception
- Professional physician services for FDA-approved sterilization procedures
- Professional physician services for fitting, implantation and/or removal of FDA-approved contraceptive devices in female members
- FDA-approved implanted contraceptive devices for female members
- Abortifacient medications, including oral medications as described in the BCBSAZ Medical Coverage Guidelines.

Multiple surgical procedures may be performed during a single operative session. In general, covered secondary procedures are reimbursed at reduced levels. Noncontracted providers may balance bill you for secondary, incidental or mutually exclusive procedures, in addition to the primary surgical procedure.

You may receive services in a physician's office that incorporate services or supplies from a provider other than your physician. If those services or supplies are rendered and billed by a provider other than your physician, you will pay the cost-share applicable to the billing provider, in addition to the cost-share for your office visit. Examples of services or supplies from another provider include durable medical equipment from a medical supply company, specialty injectable medications provided by a pharmacy, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.

Z. POST-MASTECTOMY SERVICES

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

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

Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage, as described above under "Benefit Description," will be provided in a manner determined in consultation between the attending physician

and the member being treated. These benefits are provided subject to the same deductibles and coinsurance generally applicable to other medical and surgical benefits provided under this plan, as described above in "Your Cost-Share" and in the SBC for this benefit plan. If you would like more information on WHCRA benefits, call BCBSAZ customer service at the number listed in the front of this benefit book.

AA. PREGNANCY, TERMINATION

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

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

The treating provider certifies in writing the abortion is medically necessary in order to save the life of the mother or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.

Benefits are also available for abortifacient medications, including some oral medications as described in the BCBSAZ Medical Coverage Guidelines.

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

BB. PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER

Precertification: May be required depending on the medication received. A list of medications that require precertification is available online at www.azblue.com or you or your provider may contact BCBSAZ at the numbers listed in the front of this book. This list is subject to change at any time without prior notice. If you fail to obtain precertification for medications that require precertification, the medications will not be covered.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

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

Benefit Description: Benefits are available, to the extent required by applicable state law, for off-label use of prescription medications and services directly associated with the administration of prescription medications for the treatment of cancer.

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

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

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

DD. PREVENTIVE SERVICES

Precertification: Not required.

Your Cost-Share:

All preventive services listed in this benefit section, except for mammography, foreign travel immunizations and certain services cross-referenced in other benefit sections, must be received from in-network providers or the services will not be covered. For services listed in this benefit section and cross-referenced in other benefit sections, see the cross-referenced benefit section to determine whether services from out-of-network providers are covered and, if applicable, cost-share for those services from out-of-network providers.

Your cost-share is waived, regardless of the location where services are provided, if:

- You receive services from an in-network provider;
- you receive one of the services listed in the Benefit Description subsection of this Preventive Services section; and
- the procedure code, the diagnosis code or the combination of procedure codes and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive.

Please note: You pay in-network cost-share for services received from in- or out-of-network anesthesiologists, when associated with a colonoscopy screening.

Out-of-Network Mammography Services: Deductible is waived. You pay out-of-network coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Out-of-Network Foreign Travel Immunizations: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

For more information on the foreign travel immunizations covered under this benefit, go to the Medical Coverage Guidelines available at www.azblue.com/member, or call BCBSAZ Customer Service at the number listed in the front of this book.

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

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

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

- Preventive physical examination, i.e. routine physical examination, including the following services when done for screening purposes only:
    - resting electrocardiogram (EKG)
    - lung function test (spirometry)
    - vision and hearing screening (this may include newborn audiological evaluation in the hospital)
    - fecal occult blood test
    - general health laboratory panel (bilirubin, calcium, carbon dioxide, chloride, creatinine, alkaline phosphatase, potassium, total protein, sodium, ALT, SGPT, AST, SGOT, BUN, TSH)
    - thyroid function testing (TSH)
    - complete blood count (CBC)
    - lipid panel (cholesterol panel and triglycerides)
    - fasting glucose (blood sugar)
    - urinalysis
    - blood lead

- sexually transmitted disease (STD) testing
- prostate specific antigen (PSA) testing
- TB testing

- Aspirin prescribed for prevention of cardiovascular disease for men ages 45 to 79 and women ages 55 to 79. See the "Pharmacy Benefit" section.
- Behavioral intervention to promote breast-feeding for women
- Bone density testing for osteoporosis
- Counseling and behavioral interventions to promote sustained weight loss for obese adults
- Counseling (annually) for HIV infection for all sexually active women
- Counseling (annually) on sexually transmitted infections for all sexually active women
- Counseling for female members who are at increased risk for breast cancer about medications to reduce the risk of breast cancer. For female members at increased risk of breast cancer and at low risk of adverse medication effects, coverage of risk-reducing medications, such as tamoxifen or raloxifene
- Counseling for members ages 10-24 regarding minimizing the risk of UV radiation exposure to reduce the risk of skin cancer
- Counseling for tobacco cessation and augmented pregnancy counseling for members who use tobacco
- Counseling on contraceptive methods for all women with reproductive capacity
- FDA-approved contraceptive methods for female members, as prescribed. See the "Family Planning", "Physician Services" and "Pharmacy Benefit" sections.
- FDA-approved sterilization procedures for female members, as prescribed. See the "Family Planning" and "Physician Services" benefit sections.
- Folic acid supplementation prescribed for females. See the "Pharmacy Benefit" section.
- Interventions, including counseling and education, to prevent initiation of tobacco use in school-aged children and adolescents
- Lactation support counseling during pregnancy and/or in the post-partum period
- Mammogram
- Oral fluoride supplementation prescribed for children ages 6 months through 5 years who live in areas where the water service is deficient in fluoride
- Physical therapy or exercise for members age 65 and older living in community dwellings to minimize falls
- Rental or purchase of manual or electric breast pumps and breast pump supplies when obtained from in-network durable medical equipment (DME) providers. See the "Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics" benefit section.
- Repeated antibody testing for unsensitized Rh(D)-negative pregnant women at 24-28 weeks gestation, unless the biological father is known to be Rh(D) negative
- Routine gynecologic exam including Pap test and other cervical cancer screening test
- Routine immunizations and immunizations for foreign travel, as determined by BCBSAZ
- Routine iron supplementation prescribed for asymptomatic children ages 6 months through 12 months who are at increased risk for iron deficiency anemia
- Screening and counseling (annually) for interpersonal and domestic violence
- Screening (annually) for lung cancer with low-dose computed tomography (LDCT) for members age 55-80 with a 30 year or more year history of smoking and who currently smoke or have quit smoking within the past 15 years. Screenings will be discontinued if the member (1) has not smoked for 15 years or more; (2) develops a health problem that limits life expectancy; or (3) is unwilling to have curative lung surgery.
- Screening, counseling and intervention for obesity
- Screening for abdominal aortic aneurysm for men ages 65 to 75 who have ever smoked
- Screening for alcohol misuse and behavioral counseling interventions for pregnant women
- Screening for asymptomatic bacteriuria for pregnant women at 12-16 weeks gestation or at first prenatal visit, if later
- Screening for depression for members age 18 and older
- Screening for gestational diabetes mellitus (GDM) at (1) the first prenatal visit (2) prior to 24 weeks of gestation based upon risk factors for type 2 diabetes, such as obesity, family history of type 2 diabetes or fetal macrosomia during a previous pregnancy; and (3) after 24 weeks of gestation.
- Screening for Hepatitis B virus infection for pregnant women at their first prenatal visit
- Screening for Hepatitis C virus infection for persons at high risk for infection
- Screening for Hepatitis C virus infection for adults born between 1945 and 1965 (one-time screening)
- Screening for iron deficiency anemia for asymptomatic pregnant women

- Screening for major depressive disorders for members ages 12 through 18
- Screenings for newborns as required by Arizona and federal law
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Screening sigmoidoscopy or colonoscopy
- Smoking cessation medications and devices, as prescribed
- Vision screenings for children under age 5
- Vitamin supplementation for members age 65 and older living in community dwellings to minimize falls

For information on the foreign travel immunizations covered under this benefit, go to the Medical Coverage Guidelines available at www.azblue.com/member, or call BCBSAZ Customer Service at the number listed in the front of this book.

Benefit-Specific Exclusions:

- Abortifascient medications
- All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.
- Any service or test not specifically listed in this benefit description or in another section of this benefit book, such as chest X-rays, will not be covered when performed for preventive or screening purposes
- Except as stated in this benefit book, preventive services provided by an out-of-network provider.

Services or tests listed under this benefit and provided to a member with a specific diagnosis, signs or symptoms of a condition or disease for which the test is being performed may be covered through another benefit section of this plan. Certain maternity services covered under this benefit are also available through the "Maternity" benefit.

EE. RECONSTRUCTIVE SURGERY AND SERVICES

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for reconstructive surgery, which is surgery performed to improve or restore the impaired function of a body part or organ resulting from one of the following:

- Congenital defects;
- Illness and disease;
- Injury and trauma;
- Surgery; **or**
- Therapeutic intervention

Benefit-Specific Exclusion: Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy in accordance with state and federal law.

FF. SKILLED NURSING FACILITY (SNF)

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance. If you receive SNF services at a noncontracted provider, you also pay the balance bill, in addition to applicable deductible and coinsurance.

Benefit-Specific Maximum: You have a combined in- and out-of-network maximum of 240 days per member, per calendar year.

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

Benefit Description: Benefits are available for inpatient skilled nursing facility services provided in a facility licensed to offer skilled nursing services and meeting BCBSAZ's definition of skilled nursing care. Skilled nursing services are provided by and under the supervision of qualified and licensed professionals, such as a licensed practical nurse (L.P.N.) or registered nurse (R.N.) and provided at a level of complexity and sophistication requiring assessment, observation, monitoring and/or teaching or training to achieve the medically desired outcome.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ]

GG. SPECIALTY SELF-INJECTABLE MEDICATIONS

Precertification: Required for all specialty self-injectable medications. If you fail to obtain precertification, these medications will not be covered.

Your Cost-Share: You pay a Level A, B, C or D copay. Copays do not apply to deductibles.

If a member obtains a specialty self-injectable medication from an eligible provider other than a pharmacy contracted with BCBSAZ for the specialty self-injectable medications benefit ("specialty pharmacy"), the medication is excluded from coverage under this benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

Additional Information About Medication Levels

Copays are based on the Level to which BCBSAZ has assigned the medication at the time the prescription is filled. BCBSAZ may change the Level of a medication at any time without notice. Go to www.azblue.com to view a list of contracted specialty pharmacies and the specialty self-injectable medication list. To confirm the status and Level of a particular specialty self-injectable medication, you may also call the BCBSAZ Prescription Benefits Unit at the number listed in the front of this book.

No exceptions will be made concerning the assigned Level of a medication or the copay that will apply, regardless of the medical reasons requiring use of the medication. This means if you are taking a Level B, C or D medication, you pay the applicable copay for that Level even if there is no equivalent medication on a lower Level or you are unable to take a medication on the lower Level for any reason.

The assignment of a medication to any particular Level is not a recommendation on the use of a medication.

Benefit Description: Benefits are available for specialty self- injectable medications obtained from a specialty pharmacy contracted with BCBSAZ. Go to www.azblue.com to view a list of contracted specialty pharmacies and the specialty self-injectable medication list. To confirm the status and level of a particular specialty self-injectable medication, you may also call the BCBSAZ Prescription Benefits Unit at the number listed in the front of this book. Coverage of specialty self-injectable medications is determined by the Medical Coverage Guidelines and Pharmacy Coverage Guidelines and subject to change without notice.

Specialty self-injectable medications are subject to limitations contained in the Medical Coverage Guidelines and Pharmacy Coverage Guidelines and may change at any time without prior notice.

Benefit-Specific Exclusions:

- All benefit-specific exclusions listed under "Prescription Medications Obtained from a Retail or Mail Order Pharmacy," except for the exclusion for specialty self-injectable medications
- Medications obtained from a pharmacy not specifically contracted with BCBSAZ as a specialty pharmacy

HH. TRANSPLANTS - ORGAN - TISSUE - BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES

Precertification: Required prior to any organ, tissue or bone marrow transplant or stem cell procedure. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

If both a donor and a transplant recipient are covered by a BCBSAZ plan or a plan administered by BCBSAZ, the transplant recipient pays the cost-share related to the transplant.

BCBSAZ is contracted with certain facilities to provide covered transplants to BCBSAZ members. Not all such facilities are contracted to provide services related to a covered transplant, such as pre-transplant testing, certain types of chemotherapy and radiation therapy and other services covered under this plan. If you receive pre-transplant testing or other services associated with the transplant from a facility that is not contracted with BCBSAZ or a Host Blue to provide those services, you will pay your out-of-network cost-share, plus the balance bill.

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

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

Benefit Description: The following transplants are eligible for coverage if they meet the Medical Coverage Guidelines:

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

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

- Inpatient and outpatient facility and professional services
- Air and ground transportation of a medical team to and from the site in the contiguous states of the United States to obtain tissue that is subsequently transplanted into a member
- Bone marrow search and procurement of a suitable bone marrow donor when a member is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
- Chemotherapy or radiation therapy associated with transplant procedures
- Harvest and reinfusion of stem cells or bone marrow

- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ. Covered donor expenses include complications and medically necessary follow-up care related to the donation for up to six (6) months post transplant, as long as the recipient's BCBSAZ coverage remains in effect.
- Pre-transplant testing and services

Benefit-Specific Exclusions:

- Expenses related to a noncovered transplant
- Expenses related to donation of an organ to a recipient who is not covered by BCBSAZ
- Transplants that do not meet the Medical Coverage Guidelines

II. TRANSPLANT TRAVEL AND LODGING

Precertification: Not required.

Your Cost-Share: Not applicable.

Benefit Maximum: Benefits are limited to $10,000 per member, per transplant. Covered expenses incurred by a donor, recipient or caregiver accumulate toward the member's $10,000 per transplant maximum.

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

Benefit Description: Coverage is available for reimbursement of travel and lodging expenses, as listed below, that are incurred by a member receiving a covered transplant, a donor donating for a covered transplant and a caregiver for the donor or recipient member. Total reimbursement will not exceed actual expenses, up to a maximum of $200 per day. The daily maximum is an aggregate amount, not a per person amount, for the member receiving a covered transplant, donor and caregiver.

To qualify for reimbursement, all the following criteria must be met:

- BCBSAZ has precertified the transplant procedure;
- The distance from the member's, donor's or caregiver's residence must be more than seventy-five (75) miles from the transplant facility;
- The member is receiving a covered solid organ, bone marrow or stem cell transplant;
- The member must receive the transplant from a provider contracted with BCBSAZ, a provider contracted with the local Blue Cross and/or Blue Shield plan where services are rendered or a Blue Distinction Centers for Transplants (BDCT) facility;
- The member or donor must be receiving medically necessary pre and post-operative treatments, including without limitation, treatment of complications related to the covered transplant or routine follow-up care for a covered transplant or a transplant that occurred while the member was covered by another insurance plan; **and**
- The expenses are for any of the following:
    - Meal expenses;
    - Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; bus; train or air fare; **and**
    - Room charges from hotels, motels and hostels or apartment rental.

Benefit-Specific Exclusions:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of $200 per day per covered member
- All travel and lodging expenses in excess of the $10,000 per member, per transplant maximum
- Ambulance transportation (ground or air)

- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with noncovered transplant services or any follow-up care, including treatment of complications
- Expenses for travel or lodging related to evaluation, consultation or medical testing to determine if a member is a candidate for transplantation
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Travel and lodging expenses for transplants other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service
- Travel and lodging expenses for members, donors or caregivers when the member, donor or caregiver does not travel more than seventy-five (75) miles for an authorized transplant or transplant related services, including follow-up care and treatment of complications
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement

To request reimbursement of eligible transplant travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to BCBSAZ. The address for claims submission and phone number for requesting claim forms are listed in the BCBSAZ customer service section at the front of this book.

JJ. URGENT CARE

Precertification: Not required.

Your Cost-Share: You pay one urgent care copay per member, per provider, per day for services from a provider who is contracted with BCBSAZ to render urgent care services. You pay applicable cost-share if you receive urgent care services from an in-network provider who is not specifically contracted for urgent care services. You pay out-of-network deductible and coinsurance if you receive services from an out-of-network urgent care provider. If you receive services from a noncontracted provider, you also pay the balance bill.

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

Benefit Description: BCBSAZ has contracted with certain free-standing urgent care providers to render these services to its members. These providers are listed in your provider directory and on the BCBSAZ Web site at www.azblue.com under "Urgent Care Centers."

Please be aware that the BCBSAZ network includes some providers, such as hospitals, that offer urgent care services, but are not specifically contracted with BCBSAZ as urgent care providers. No matter what the circumstances, if you obtain urgent care services at a hospital or a hospital's on-site urgent care department, you will be responsible for the applicable emergency room access fee, plus in-network deductible and coinsurance.

KK. VISION EXAMS (ROUTINE)

Precertification: Not required.

Your Cost-Share:

For Members Under Age 5: Applicable deductible, coinsurance and copays are waived for services from an in-network provider. For services from an out-of-network vision care provider, you pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

For Members Age 5 and Older: You pay a routine vision exam copay for an exam by an in-network vision care provider. If you receive the exam from an out-of-network vision care provider, you pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

If a medical condition is identified during your routine vision exam, you will be responsible for additional cost-sharing.

Benefit-Specific Definition: A "routine vision exam" is an exam generally performed to determine the need for corrective lenses.

Benefit Description: Benefits are available for routine vision exams. Routine vision exam services do not have to meet the medical necessity requirement.

Benefit-Specific Exclusions:

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

WHAT IS NOT COVERED

NOTWITHSTANDING ANY OTHER PROVISION IN THIS PLAN, NO BENEFITS WILL BE PAID FOR EXPENSES ASSOCIATED WITH THE FOLLOWING:

Abortions, except as stated in this plan

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

Acupuncture

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

Bariatric Surgeries excluded by the BCBSAZ Medical Coverage Guidelines

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

Biofeedback and hypnotherapy, except as may be available through the BSA

Blood Administration for the purpose of general improvement in physical condition

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

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

Care required by state or federal 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. Inpatient and outpatient facility charges for services provided by residential treatment facilities are not covered except for certain very limited situations based upon BCBSAZ medical necessity criteria. All other inpatient and outpatient services provided by residential treatment facilities are not covered.

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

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

Complications of Noncovered Services – Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under this plan.

Computer Speech Training, Therapy Programs and Devices

Consumable Medical Supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as stated in this plan

Cosmetic Services and any Related Complications – Surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy.

Cosmetics and health and beauty aids

Counseling – Counseling and behavioral modification services, except as stated in this plan

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

Custodial Care

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

Dietary and Nutritional Supplements – All dietary, caloric and nutritional supplements, such as specialized formulas for infants, children or adults or other special foods or diets, even if prescribed, except as stated in this plan

Expenses for services that exceed benefit limitations

Expenses incurred for or in connection with an injury or illness, arising out of, or in the course of, any employment for wage or profit

Experimental or Investigational Services

Fees - Associated with the collection or donation of blood or blood products

Fees – Fees other than for medically appropriate, in-person, direct member services, except as stated in this plan

Fees – Fees for concierge medicine services

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, except arch supports may be covered when medically necessary for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

Foot Care – Services for foot care, including trimming of nails or treatment of corns and calluses, except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

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

Genetic and Chromosomal Testing, Screening and Therapy – Genetic and chromosomal testing, screening and therapy for an individual who is asymptomatic, unaffected or not displaying signs or symptoms of a disorder for which the test, screening or therapy is performed

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

Growth Hormone – Growth hormone, except as specified in the Medical Coverage Guidelines. Growth hormone to treat Idiopathic Short Stature (ISS) is expressly excluded.

Hearing Services and Devices, except as stated in this plan

Inpatient or Outpatient Long Term Care

Lifestyle education and management services, except as stated in this plan

Lodging and Meals – Lodging and meals, except as stated in this plan

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

Manipulation of the Spine Under Anesthesia

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

Massage Therapy – Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines

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

Medications – Medications which are:

- Not FDA approved
- Not required by the FDA to be obtained with a prescription, except as stated in this plan
- Not used in accordance with the Medical Coverage Guidelines or Pharmacy Coverage Guidelines
- Used to treat a condition not covered by BCBSAZ
- Off-label, unlabeled and orphan medications, except as stated in this plan

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

Membership Costs or Fees associated with health clubs and weight loss programs.

Neurofeedback

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

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

Over-the-Counter Items – Medications, devices, equipment and supplies that are lawfully obtainable without a prescription, except as stated in this plan

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

Phase 3 Cardiac Rehabilitation

Private Duty Nursing

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

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

Respite Care, except as stated in this plan

Reversal of Sterilization

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

Sensory Integration, LOVAAS Therapy and Music Therapy

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

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 Weight Loss and Gain, except as stated in this plan

Services from a Family Member – Services delivered by an eligible provider who is a member of your immediate family or a member of a Dependent's immediate family. "Immediate family" members are: parents, siblings, children, stepparents, stepchildren, spouses, domestic partners, grandparents, grandchildren and any of the preceding individuals related to the member by marriage. When a provider is also the covered person, services rendered by that provider for himself or herself are also excluded from coverage

Services from Ineligible Providers

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

Services Paid for By Other Organizations – Services customarily paid for by an employer, such as worksite or ergonomic evaluations; the government; a school; biotechnical, pharmaceutical or medical device industry sources; or other individuals and organizations

Services Prior to Member's Coverage Effective Date

Services Provided After the Member's Coverage Termination Date, except as stated in this plan

Services Related to or Associated with Noncovered Services

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

Sexual Dysfunction – Services for sexual dysfunction, regardless of the cause

Smoking Cessation, except as stated in this plan

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, except as stated in this plan

Telemedicine Services, except as stated in this plan

Telephonic and Electronic Consultations – Telephonic and electronic consultations, except as stated in this plan

Therapy Services, except as stated in this plan

Therapy to Improve General Physical Condition including, but not limited to, inpatient and outpatient routine long term care

Training and Education – Training and education, except as stated in this plan

Transportation – Transport services and travel expenses, except as stated in this plan

Transsexual Treatment, Surgery, Medications and Related Services

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; vision examinations for fitting of eyeglasses and contact lenses, except as stated in this plan

Vitamins – All vitamins, minerals and trace elements that are lawfully obtainable without a prescription, except as stated in this plan

Workers' Compensation – Illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election

CLAIMS INFORMATION

Filing Claims

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

Time Limit for Claim Filing

A complete claim, as described below, must be filed within one year from the date of service. Any claim not filed within one year of the date of service may be denied.

Claim Forms

Claim forms are available from BCBSAZ. Go to the "Forms" section of the "Member" area of www.azblue.com or call the Supply Line telephone number listed at the front of this book.

Complete Claims

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

- Billed charges
- Date of service(s)
- Diagnosis code
- Group number
- Member ID number
- Member name
- Name of provider
- Patient name
- Patient's birth date
- Procedure code
- Provider ID number
- Signature of provider who rendered services

BCBSAZ may reject claims that are filed without complete information needed for processing. If BCBSAZ rejects a submitted claim due to lack of information, BCBSAZ will notify you or the provider who submitted the claim. Lack of complete information may also delay processing.

Medical Records and Other Information Needed to Process a Claim

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

Explanation of Benefits (EOB) Form

After your claim is processed, BCBSAZ will send you an EOB. The CBA or BSA will send you an EOB for any claim for chiropractic or behavioral health benefits, as applicable.

Your BCBSAZ EOBs also will be available through the member portal on www.azblue.com. An EOB shows services billed, whether the services are covered or not covered, the allowed amount and the application of cost-sharing amounts. BCBSAZ, the CBA or the BSA will also send your in-network provider the information that appears on your EOB. BCBSAZ and the CBA do not send EOBs to out-of-network providers. Out-of-network providers do not receive any written information on how much BCBSAZ or the CBA paid on a claim or the reasons for how the claim processed. Save the EOB for your personal records. BCBSAZ, the CBA or the BSA may charge a fee for duplication of claims records. Carefully review your EOB for any discrepancies or inconsistencies with the amounts your provider actually collects from you or bills to you.

Monthly Statement

Some EOBs may be consolidated and sent to you in the form of a monthly statement rather than single EOBs.

Concurrent Care Decisions

BCBSAZ may require that your provider submit a plan of care. Based on that plan, BCBSAZ may precertify a certain number of visits or services over a certain period of time. You may request precertification for additional periods of care as long as your request is made at least seventy-two (72) hours prior to the expiration of an existing plan of care. BCBSAZ will make a determination as soon as possible in accordance with medical exigencies, but no later than seventy-two (72) hours after receipt of the request. If that precertification is denied, you may appeal that denial in the same way you appeal any other coverage denial.

Notice of Determination

If your claim is filed properly and your claim is then denied in whole or in part, you will receive notice of an adverse benefit determination that will:

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

Pharmacy Prescriptions; Submission of Claims by Members

When you submit a prescription to either a retail or mail order pharmacy, the prescription is not considered to be a claim. If you have any concerns about fulfillment of the prescription, you must submit a claim to BCBSAZ for the prescription. Send BCBSAZ a claim in the following circumstances:

- The pharmacy tells you that you are not eligible for coverage
- Coverage for the prescription was denied in whole or in part
- You feel that you paid the wrong copay or other cost-sharing amount for the prescription
- You were required to pay other amounts you feel you are not required to pay
- Other dispute or discrepancy regarding your prescription medication coverage

If the pharmacy tells you that you are not eligible for coverage and you are unable to purchase a temporary supply of medication that is needed immediately, please contact BCBSAZ member services immediately by calling the number on the back of your identification card.

Time Period for Claim Decisions:

Post-Service Claims

Within thirty (30) days of receiving your claim for a service that was already rendered, BCBSAZ will send you an Explanation of Benefits (EOB) adjudicating the claim, or a notice that BCBSAZ has requested records needed to make a decision on your claim.

If BCBSAZ cannot make a decision on your claim within thirty (30) days, BCBSAZ may extend the initial processing time by fifteen (15) days by notifying you, within the initial 30-day period, of the need for an extension and the date by which a determination can be expected. If the extension is necessary to obtain additional information, the extension notice will describe the information needed. You or your provider will have at least forty-five (45) days to submit the information.

Pre-Service Claims

When you request coverage for a service that has not yet been rendered (precertification), BCBSAZ will make a precertification decision within a reasonable time period considering the medical circumstances, but not later than ten (10) business days from receipt of the precertification request.

If BCBSAZ requires more time to make a precertification decision, BCBSAZ may extend the time by an additional fifteen (15) days by notifying you, within the initial 10-day period of need for an extension and the date by which a determination can be expected. If the extension is necessary to obtain additional information, the extension notice will describe the information needed. You and your provider will have at least forty-five (45) days to submit the information.

Urgent Claims

Federal law defines an "urgent" medical situation as the following: (a) one in which application of the "non-urgent" time periods could seriously jeopardize the member's life, health or ability to regain maximum function or (b) one which, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

When you request coverage for an urgent care claim, a determination will be made as soon as possible in accordance with medical exigencies, but no later than twenty-four (24) hours after receipt of the request.

PLAN ADMINISTRATION

Coordination of Benefits

The Group Master Contract between the group and BCBSAZ contains a coordination of benefits provision that prevents duplication of payments. Under the provision, if you are eligible for benefits under any other group health insurance, the combined benefit payments from all coverages will not exceed 100 percent of the billed charges. In addition, BCBSAZ's payment will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If your other group health insurance does not include a coordination of benefits provision, that coverage pays first. If your other group health insurance provides for coordination of benefits, the following rules will be used to determine which coverage will pay first:

- If the person is an inpatient on the day this benefit plan becomes effective and benefits are payable under the person's prior health care coverage for the inpatient stay, the prior health care coverage pays first.
- If the person who received care is covered as an active employee under one benefit plan and as a dependent under another, the employee coverage pays first.
- If the person who receives care is covered as an active employee under one benefit plan and as an inactive employee under another, the coverage through active employment pays first.
- If the person who receives care is a dependent child, then the plan benefits of the parent whose birthday occurred earlier in a calendar year shall cover the child first.
- If both parents have the same birthday, the benefits of the plan that covered a parent longer shall cover a dependent child first.
- If one of the plans determines the order of benefits based upon the gender of a parent and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rule shall determine the order of benefits.
- If the dependent child's parents are legally separated or divorced, the following applies:
  - If a court decree specifies the parent who is financially responsible for the child's health care expenses, that parent's coverage pays first.
  - If there is no applicable court decree, the custodial parent's coverage pays first. If the custodial parent has remarried, the stepparent's coverage pays second. The non-custodial parent's coverage pays last.
  - If the parents have joint custody, the plan benefits of the parent whose birthday occurred earlier in a calendar year pays first.

When none of the above applies, the coverage you have had for the longest continuous period of time pays first (see *"Non-Duplication of Benefits"*).

BCBSAZ does not coordinate benefits for services covered by the retail and mail order pharmacy benefit. For this benefit, BCBSAZ will pay primary, without regard to the member's other coverage.

Non-Duplication of Benefits

If services are covered under this benefit plan and one or more other group benefit plans that are issued or administered by BCBSAZ, the rules described above in *"Coordination of Benefits"* will be used to determine which coverage pays first. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If services are covered under this benefit plan and one or more BCBSAZ individual contracts, benefits will be paid first under the individual contract. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed 100 percent of the amount BCBSAZ would have paid if you had no other coverage. BCBSAZ does not coordinate benefits with non-group coverage provided by an insurance plan other than BCBSAZ.

BCBSAZ does not coordinate benefits for services covered by the retail and mail order pharmacy benefit. For this benefit, BCBSAZ will pay primary, without regard to the member's other coverage.

Definitions Related to Eligibility and Administration

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

- **"Disabled Dependent Child"** is a child who has reached age 26 and who meets criteria for coverage under this plan described in "Eligibility Requirements," below.

- **"Employee/Retiree"** refers to the person eligible for this benefit plan because of his/her employment relationship or former employment relationship or affiliation to the group. An employee is also the contract holder under this plan.

- **"Group"** refers to the employer or other entity to which a Group Master Contract is issued and under which the contract holder and dependents become entitled to health coverage.

- **"Group Master Contract"** refers to the agreement between the group and BCBSAZ. The Group Master Contract controls the administration of the group coverage and is on file with the group. The coverage described in this book will terminate when the Group Master Contract terminates. The group is responsible to notify members if the group terminates the Group Master Contract or if the Group Master Contract is terminated for non-payment of premiums. BCBSAZ will notify members if the Group Master Contract is terminated for any other reason.

- **"Open Enrollment"** is an annual period during which the contract holder and dependents are eligible to enroll for coverage or change benefit plan options. The benefit plan administrator will notify the contract holder if the group has established such an open enrollment period. Contract holders and dependents can change benefit plans only during an open enrollment period, except as set forth in this benefit book.

Eligibility Requirements

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

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

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

  - Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;
  - Is continuously incapable of self-sustaining employment because of mental or physical disability on the date the dependent reaches age 26; **and**
  - Is dependent on the contract holder for maintenance and support, as determined by BCBSAZ criteria.

  Medical reports, acceptable to BCBSAZ, must substantiate the incapacity and must be submitted by the contract holder within thirty-one (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 review by BCBSAZ.

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

- **Retiree** – Please see your benefit plan administrator to determine eligibility requirements for a retiree and his/her eligible dependents.

Effective Date of Coverage

- **Contract Holder** – A contract holder's effective date of coverage will be either the date the contract holder becomes eligible to enroll or the first billing date after the contract holder becomes eligible to enroll as determined by the Group, as long as the contract holder completes the application process within thirty-one (31) days of becoming eligible. See your SBC for contract holder effective date.

- **Dependent** – Dependent coverage is available only if an eligible contract holder has enrolled for coverage. Eligible dependents will have the same effective date as the contract holder if they are included on the application at the time the contract holder first enrolls. If the contract holder and/or dependents do not enroll when first eligible, the contract holder and/or dependents may only apply for coverage at the group's annual open enrollment period, except as stated in *"Special Enrollment Provisions"* or if court-ordered. The effective date of coverage for an application made during an open enrollment period is the group's anniversary date following that open enrollment period.

- **Spouse** – The effective date for a new spouse will be the date of marriage, as long as the contract holder completes an application within thirty-one (31) days of that date; otherwise, the spouse may not enroll until the next open enrollment period, unless he or she qualifies under *"Special Enrollment Provisions."*

- **Newborn/Adopted Child/Child Placed for Adoption** – A child is eligible for coverage under this benefit plan following birth or adoption, so long as: (1) the parent or guardian covered under this benefit plan remains eligible for coverage; and (2) the parent or guardian covered under this benefit plan submits the appropriate enrollment documentation to the group to enroll the child for coverage within thirty-one (31) days following the date of birth, adoption or placement for adoption. No claims will be paid until the child is enrolled in this benefit plan and BCBSAZ receives notification from the group that indicates the child has been enrolled in this benefit plan. If the parent or guardian covered under this benefit plan does not enroll the child within thirty-one (31) days following the date of birth, adoption or placement for adoption, the parent or guardian covered under this benefit plan must wait until the next open enrollment period to enroll the child.

  Contact Membership Services at the number listed in the front of this benefit book to receive a BCBSAZ adoption packet.

- **Other Children** – The effective date for a dependent child who is not a newborn child, adopted child or a child placed for adoption (as described above) shall be the date the child becomes an eligible dependent, as long as the contract holder completes an application to add the child within thirty-one (31) days of that date. If an application is not completed within thirty-one (31) days, the child may not enroll until the next open enrollment period, unless the child qualifies under *"Special Enrollment Provisions."*

- **Retiree** – Please see your benefit plan administrator to determine effective dates of coverage for a retiree and his/her eligible dependents.

Loss of Eligibility

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

Some groups have up to thirty-one (31) days to notify BCBSAZ that a contract holder or dependent has become ineligible. Until BCBSAZ receives notice and processes the termination of eligibility, BCBSAZ may quote benefits, give precertification or pay claims that ultimately will be recouped from members or providers, if it is later determined the member was ineligible on the date services were received. Such benefit quotations or precertifications become null and void, regardless of whether the group has notified the contract holder that eligibility terminated.

Contract holder eligibility ends on the following days:

- The end of the month in which the contract holder was entitled to receive compensation from the group, regardless of the date such compensation is actually paid.

- The end of the month in which an approved leave of absence expires, if the contract holder fails to return to active employment.

- The date of death.

- The end of the month in which the Group and/or Contractholder fails to pay any amounts due and any grace period available under Arizona law is exhausted.

Dependent eligibility ends on the following days:

- For a dependent spouse and any children of that spouse who are not the birth or adopted children of the contract holder, the end of the month during which the divorce decree becomes final.
- The end of the month in which the child turns age 26, if the child is not a disabled dependent child.
- The end of the month in which the disability or dependency ceases for a disabled dependent child over age 26.
- The end of the month in which a child covered by a medical support order is no longer eligible under the court order or administrative order.
- The end of the month in which the contract holder's death occurs or as might otherwise be provided in the Group Master Contract.
- The surviving dependent spouse, and any eligible dependent children of any employee killed in the line of duty or in the course and scope of City Employment are covered until the end of the month in which the spouse remarries or attains Medicare eligibility; or to the end of the month in which the eligible dependent child turns age 26.

Retiree eligibility:

Please see your benefit plan administrator for information regarding loss of retiree's eligibility and termination dates of coverage and the dates for a retiree's dependents.

Date of Termination of Coverage

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

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

Contract holders' and/or dependents' coverage ends no later than the date the Group Master Contract terminates.

When a contract holder's coverage terminates, coverage for all dependents also terminates. Members may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Members may also be eligible for individual portability coverage or may apply to BCBSAZ for an individual conversion contract.

BCBSAZ will issue a certificate of creditable coverage upon receipt of notice of the contract holder's termination. Members may request a certificate of creditable coverage at anytime up to twenty-four (24) months after termination of coverage.

Special Enrollment Provisions

A special enrollment period is available for the following qualifying events, as applicable to the individual seeking coverage when such individual requests coverage under this benefit plan by completing an application within thirty-one (31) days of the loss of other coverage:

- A person loses minimum essential coverage, as that term is defined in applicable law
- A person gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption
- The death of the covered employee
- A person has coverage through his or her spouse and the spouse dies
- A person has coverage through his or her spouse and a divorce or legal separation occurs

- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of the covered employee's employment
- The divorce or legal separation of the covered employee from the covered employee's spouse
- The covered employee becomes entitled to Medicare
- A dependent child ceases to be a dependent child under the generally applicable requirement of the plan
- A proceeding in a case under title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time
- Exhaustion of a person's COBRA coverage;
- Termination of the employer's contribution toward coverage
- Termination of the covered employee's eligibility for coverage
- The covered employee's employer terminates coverage
- The covered employee is employed by an employer that offers multiple health benefit plans and the covered employee elects a different plan during open enrollment
- A person loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- A person received notice that he or she is eligible for a Medicaid or CHIP premium assistance subsidy
- A person exhausts a lifetime maximum on all benefits under the other policy or plan (qualifying event is denial of claim due to operation of a lifetime maximum;
- A person no longer lives, resides or works in the other plan's service area and no other benefit plan is available to that person
- Any other special enrollment rights available under applicable state or federal law

Leave of Absence

If a Contract holder takes a leave of absence, the group may continue coverage for the Contract holder and covered dependents for up to the length of the approved absence, subject to payment of applicable premiums.

BCBSAZ will also continue coverage for members during any leave of absence the group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 and any amendments or successor provisions. If the Contract holder returns to active employment by the end of the leave of absence period, coverage under this benefit plan will continue for the Contract holder and covered dependents, so long as the group maintains coverage with BCBSAZ. If not, the Contract holder will cease to be eligible and coverage for the Contract holder and dependent(s) will terminate as described in *"Termination of Coverage."*

Medical Support Orders

Coverage is available to a child of the contract holder in accordance with any court order or administrative order issued by a court of competent jurisdiction, that requires the contract holder to provide health benefits coverage for such child.

The order must clearly specify the name of the contract holder, the name and birth date of each child covered by the order and the time period to which the order applies.

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

Termination of Coverage

Benefits After Termination

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

Continuation of Coverage

Under federal law it is the group's responsibility, as plan administrator, to inform employees and dependents of the availability, terms and conditions of continuation of coverage available under COBRA.

COBRA requires most employers who have twenty or more employees and sponsor a group health plan to offer employees and their covered dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Continuation of coverage is available when an employee is absent from employment by reason of service in the uniformed services, as defined by applicable federal law. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Disability Extension of Benefits

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

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

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

If your group discontinues coverage, you are eligible for this extension of benefits whether covered as an active employee, the dependent of an active employee or a qualified COBRA beneficiary on the date the group discontinues coverage through BCBSAZ.

If you are eligible for an extension of benefits because of an individual termination as described above and you elect continuation coverage under COBRA, the extension of benefits shall run concurrently with your continuation coverage under COBRA, until the 12-month extension of benefits period is exhausted. Because these provisions run concurrently, please contact your employer before making any changes to or terminating your COBRA continuation coverage.

Individual Portability Coverage

You are eligible for certain individual coverage with no medical underwriting or pre-existing condition waiting periods if you meet **all** of the following criteria:

- You have eighteen (18) months of prior continuous creditable coverage; the most recent coverage must be with a group, government or church plan, **and**
- You are no longer eligible for a group plan, Medicare or Medicaid, **and**
- Coverage was not terminated for non-payment of premium or fraud, **and**
- You elected and exhausted COBRA continuation coverage (or other similar coverage) if this coverage was available to you, **and**
- You apply for individual portability coverage within sixty-three (63) days of the date your group (or COBRA) coverage ends.

Please contact BCBSAZ for information on individual portability coverage.

Transfer Coverage

Each Blue Cross and Blue Shield (BCBS) plan is required to offer a transfer policy to members of other BCBS plans who are under age 65.

If you cease to be a member under this benefit plan (for any reason other than the group changing insurance plans) and you move to an area served by another Blue Cross and/or Blue Shield plan, you may be eligible to enroll for transfer coverage with the BCBS plan serving your new address.

Transfer coverage available to you from the other BCBS plan may be very different from the coverage under this plan.

If you do not wish to enroll in the transfer coverage, you may be eligible for other policies issued by other BCBS plans.

Benefit-Specific Eligibility

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

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

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

GENERAL PROVISIONS

Appeal and Grievance Process

Members may participate in BCBSAZ's appeals and grievances processes, which are described in detail in the Health Coverage Appeal Information Packet, a separate document provided to you. You may ask BCBSAZ for another copy of the Health Coverage Appeal Information Packet at any time by submitting a request through www.azblue.com or by calling the BCBSAZ Supply Line telephone number listed in the front of this book.

You do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ. To appeal a denial of precertification for urgently needed services you have not yet received, please call the BCBSAZ Precertification Denial Appeals telephone number listed in the front of this book.

Billing Limitations and Exceptions

When there is another source of payment such as a liability insurer, in-network providers may be entitled to collect any difference between the allowed amount and the provider's billed charges from the other source or from proceeds received from the other source, pursuant to A.R.S. § 33-931.

A.R.S. § 33-931 may give providers medical lien rights independent of this benefit plan or any contract with BCBSAZ. BCBSAZ is not a party to any collection dispute that may arise under the provisions of A.R.S. § 33-931.

Blue Cross and Blue Shield Association

You hereby expressly acknowledge and agree to the following:

i. This benefit plan constitutes a contract between the group and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSAZ to use the Blue Cross and/or Blue Shield service marks in the State of Arizona;
ii. BCBSAZ is not contracting as the agent of the Association;
iii. In accepting the benefits of this plan, you are not relying on any representations by the Association or any other Blue Cross or Blue Shield plan, other than BCBSAZ; **and**
iv. You will not seek to hold the Association or any Blue Cross and Blue Shield plan other than BCBSAZ, accountable or liable for BCBSAZ's obligations herein.

Broker Commissions

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

Claim Editing Procedures

In order to process claims accurately, BCBSAZ uses a computer system to verify benefits, eligibility, claims accuracy and compliance with BCBSAZ coding guidelines and the Medical Coverage Guidelines. BCBSAZ uses claims coding and editing logic to process professional and outpatient facility claims for surgery, laboratory, radiology, maternity and dental services. This system logic is designed to identify the following: procedure unbundling (billing multiple procedure codes to represent a procedure that can be described with a more comprehensive code), separate billing for included (incidental) services, procedures not usually performed together (mutually exclusive) procedures, correct use of coding guidelines, member's age and sex edits. The system logic does not audit the diagnosis code to change or modify the intensity of service of office visit (evaluation and management) codes. BCBSAZ periodically updates its computer system claim edits.

Confidentiality and Release of Information

BCBSAZ takes confidentiality very seriously. We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with state and federal law. If you wish to authorize someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from www.azblue.com or call BCBSAZ customer service and request a hard copy of the CIRF form.

Court or Administrative Orders Concerning Dependent Children

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

Access to Information Concerning Dependent Children

BCBSAZ is not a party to domestic disputes. Parental disputes over dependent coverage and information must be resolved between the parents of the dependent child. Under Arizona law, both parents have equal rights of access to information about their children, unless there is a court order denying such access. Absent a copy of such order and subject to the confidentiality provisions described above, BCBSAZ provides equal parental access to information.

Discretionary Authority

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

Provider Treatment Decisions and Disclaimer of Liability

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

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

Lawsuits against BCBSAZ

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

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

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

Failure to comply with these provisions may result in dismissal of the lawsuit.
A member must complete all applicable levels of appeal before bringing a lawsuit other than a suit filed pursuant to the Health Care Insurer Liability Act. Failure to complete the mandatory levels of the appeal process may result in dismissal of the lawsuit for failure to exhaust BCBSAZ's administrative remedies.

By providing this notice BCBSAZ does not waive, but expressly reserves all applicable defenses available under Arizona and federal law.

Legal Action and Applicable Law

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

This benefit book and the contract between BCBSAZ and the sponsor of your group health plan were issued in Arizona to a group headquartered in Arizona. The only state law governing the benefit book and the contract is the law of the state of Arizona. This benefit plan may not provide all benefits required by other state laws.

Jurisdiction and Venue

Maricopa County, Arizona shall be the site of jurisdiction and venue for any legal action or other proceeding that arises out of or relates to the contract or this benefit plan.

Lawsuits by BCBSAZ

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

Non-Assignability of Benefits

The benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against BCBSAZ and imposes no duty or obligation on BCBSAZ. BCBSAZ will not honor any such purported sale, assignment, pledge, transfer or grant.

Medicaid Reimbursement

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

Member Notices and Communications

BCBSAZ sends notices and other communications to members by U.S. mail to the last address on file with BCBSAZ Membership Services. BCBSAZ may also elect to send some notices and communications electronically if the member has consented to electronic receipt. Notice is deemed complete when sent to the member's last address of record, as follows: (1) on delivery, if hand-delivered; (2) if mailed, on the earlier of the day actually received by the member or 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.

Payments Made in Error

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

Plan Amendment

There is no guarantee of continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted or changed upon notice to the group and/or contract holder or as required to comply with state or federal laws. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available. Please review and retain this book, any replacement books, SBCs, all riders and amendments and other communications concerning your coverage.

Retroactive Changes

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

Prescription Medication Rebates and Medication Level Assignments

BCBSAZ enters into contracts with pharmaceutical manufacturers to receive rebate payments based on the volume and/or market share of pharmaceutical products utilized by BCBSAZ subscribers. These rebate contracts are subject to renegotiation and/or termination from time to time at BCBSAZ's sole discretion. BCBSAZ's rebate contracts with pharmaceutical manufacturers generally work as follows: BCBSAZ submits data regarding utilization of specific medication(s) to the pharmaceutical manufacturer. The pharmaceutical manufacturer compares the data to the utilization level and/or market share required by the applicable rebate contract. If the utilization and/or market share meets the requirements of the rebate contract, the manufacturer issues a rebate payment to BCBSAZ after receipt of the data. As utilization and/or market share increases, the amount of the rebate payable to BCBSAZ may increase.

Rebates may be paid on medications that are covered under the pharmacy benefits of this benefit plan. The BCBSAZ Pharmacy and Therapeutics (P&T) Committee decides which medications to place on which levels of the tiered pharmacy benefit. The P&T Committee is comprised of pharmacists, BCBSAZ employees and other members as needed. The community physician members of the P&T Committee are not informed of potential rebate contracts or rebate payments when deciding which medications to place on certain levels. Certain BCBSAZ employees are aware of the potential rebate contracts or rebate payments. The P&T Committee decisions are not binding and can be overridden by BCBSAZ.

The rebates BCBSAZ receives are not reimbursable to you. Your employer receives either: (a) a credit against administrative costs/fees or (b) the prescription medication rebate dollar amount attributable to your employer group.

Rebates received by BCBSAZ may result in the overall cost of a particular medication falling below the amount you pay for such medication pursuant to the coverage described in this benefit plan. Other discount programs offered by a pharmacy may result in members of the public paying a lower cost for some medications than you pay under this benefit plan.

Provider Contractual Arrangements

The BCBSAZ allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors such as type and location of provider and other relevant information. For that reason, BCBSAZ network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate.

Release of Records

Subject to Arizona or federal law, the member agrees that BCBSAZ may obtain, from any provider, insurance company or third party, all records or information relating to the member's health, condition, treatment, prior health insurance claims or health benefit program.

Rescission of Coverage

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

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

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

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. In-network providers generally cannot charge you for providing BCBSAZ with health records needed to process claims, grievances or appeals. Noncontracted providers have no contractual obligation to provide records to BCBSAZ free of charge. If you receive services from a noncontracted provider who charges for record preparation, costs or copies, you will need to make arrangements with your provider to obtain any records required by BCBSAZ and pay any applicable fees.

Statement of ERISA Rights

(Does Not Apply to Government Plans, Church Plans or Other Non-ERISA Qualified Plans)

As a member of a group health insurance benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

For purposes of ERISA, your employer is the "Plan Administrator." BCBSAZ is not the Plan Administrator.

ERISA provides that all members shall be entitled to:

- **Receive information about your plan and benefits**

  Under ERISA, you are entitled to examine, without charge, at the Plan Administrator's office and other locations, such as worksites and union halls, all documents governing the Plan that are available from the Plan Administrator, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Upon written request to the Plan Administrator, you may obtain copies of the Plan documents, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may charge you for the copies.

- **Continue group health plan coverage**

  COBRA is the abbreviation for a federal law that regulates continuation of health care coverage for you, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Unless you have an agreement with your employer to pay your COBRA premiums, you or your dependents will be responsible for full payment of the premium to continue coverage under your group plan. Review your benefit book and talk to your benefits administrator about your COBRA continuation coverage rights.

- **Receive credit for pre-existing condition waiting periods**

  If you have creditable coverage from one health plan, you may receive credit toward meeting the pre-existing condition waiting period of another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ends. You must request such a certificate before losing coverage or within 24 months of losing your coverage.

  Without evidence of creditable coverage, you may be subject to a pre-existing condition waiting period of 11 months from your effective date (or 18 months, if you are a late enrollee in your group plan).

- **Prudent actions by plan fiduciaries**

  In addition to creating certain rights for group members, ERISA also imposes certain duties on the "plan fiduciaries," those responsible for administration of the health plan. The plan fiduciaries have a duty to operate the plan prudently and in the interest of you and other members.

- **Enforce your rights**

  No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

  If your claim for a benefit is denied in whole or in part, you have a right to know why it was denied, obtain copies of documents related to the decision (at no charge) and appeal any denial, all within the time periods required by ERISA.

  Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with your Questions**

  If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Third-Party Beneficiaries

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

Your Right to Information

You have the right to inspect and copy your information and records maintained by BCBSAZ, with some limited exceptions required by law. This right is described in the Notice of Privacy Practices provided to you at the time of enrollment and available by request from BCBSAZ. If you choose to review your medical records in person, BCBSAZ will require a reasonable amount of time to research and retrieve the records before scheduling a time with you to review the records.

Subrogation

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") that provides its employees and their dependents ("Participants") with health care coverage.

BCBSAZ performs claims administration for the Plan and now also provides subrogation recovery services for the Plan as described in this section.

Here is the way subrogation works. Sometimes you and/or your dependent ("you") require hospital and/or medical services due to an injury in an accident or due to a condition caused by another person's negligence. In such cases, the person causing the accident ("third party") is responsible for payment of your hospital and medical expenses. The Plan, who pays for your covered hospital and medical services, has the right to recover these payments from the third party or from you if you have recovered from the third party. When the Plan exercises its rights to be reimbursed, the process is known as subrogation, recovery and/or reimbursement ("subrogation").

During the subrogation process, BCBSAZ, on behalf of the Plan, will continue to pay your covered hospital and medical services on behalf of the Plan just as it always has. However, if a third party is legally obligated to pay for your expenses, the Plan will then exercise its rights to be reimbursed for 100 percent of what the Plan paid without any reduction for attorneys' fees and/or court costs and regardless of whether you were made whole. In addition, the Plan has first priority from any judgment, payment or settlement.

The Plan's rights apply to any settlement of a claim regardless of whether anyone has started litigation. Any right a Participant might have to be "made whole",(i.e., to be fully compensated for his/her injuries prior to any right the Plan has to recover its cost) is superseded by the Plan's subrogation rights. The Plan may subrogate against all money that you or anyone recovers regardless of the source of the money and regardless of where the money is located and/or regardless of how it is held. The Plan will also have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of recovery or settlement.

You must promptly execute and deliver any documents relating to settlement of claims, settlement negotiations or litigation when the Plan asks you to so the Plan can exercise its subrogation rights. Also, you or your legal representative must (1) promptly notify the Plan in writing of any settlement negotiations before you enter into any settlement agreement, (2) disclose to the Plan any amount recovered from any person or entity that may be liable and (3) not make any distributions of settlement or judgment proceeds without the Plan's prior written consent. No waiver, release of liability or other documents executed by you without such written notice to the Plan shall be binding upon the Plan.

City of Chandler
PPO Blue Medical Option Benefit Plan

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") to provide its employees with health care coverage. The Plan is established by your employer and is maintained pursuant to a written document called a Plan Document.

Your employer has contracted with Blue Cross Blue Shield of Arizona ("BCBSAZ") to provide certain administrative claims processing and utilization management services for this PPO benefit plan. Benefits under the Plan are paid from the general assets of the Plan Sponsor*.

BCBSAZ, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BCBSAZ may also have a contract with your employer to provide stop-loss insurance to the Plan. The stop-loss insurance may be "aggregate" stop-loss, which reimburses the Plan whenever claims on all employees exceed a specified level in a Plan year, "specific" stop-loss, which reimburses the Plan whenever claims on any covered person exceeds a specified level; or a combination of both.

BCBSAZ is an independent contractor and shall not for any purpose be deemed an agent of your employer or the employer's Plan Administrator*, nor shall BCBSAZ and your employer be deemed partners, joint venturers or governed by any legal relationship other than that of independent contractor. In this book, BCBSAZ refers to the administrative services agreement and/or stop loss insurance agreement with your employer as a group master contract.

This benefit book describes the benefits for employees and their dependents that are eligible for and have elected coverage, under the PPO benefit plan. BCBSAZ may distribute a similar benefit book for insured employer groups and self-funded employer groups. This book by itself is not your employer's Summary Plan Description or a Plan Document. Your employer is responsible for providing those documents to you.

This PPO benefit plan gives you access to a network of providers that have agreed to negotiated discounts with BCBSAZ or a local Blue Cross and/or Blue Shield plan if covered services are rendered outside of Arizona.

Please note: Not all services are covered. As this is a self-funded employer health care plan, benefits provided in this PPO plan may not include all benefits required for those health care plans which are not self-funded. Read this benefit book carefully to understand the benefits and limitations of the PPO benefit plan.

*Plan Sponsor and Plan Administrator are terms defined under the Employee Retirement Income Security Act (ERISA). These parties are often your employer, but may be another entity, e.g., a trust or association sponsoring your Plan. Your Plan Document or Summary Plan Description names these parties for you.

BCBSAZ CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact BCBSAZ at one of the departments listed below or call the direct phone number on the back of your ID card.

BCBSAZ also makes information available at www.azblue.com and you may wish to look there before calling. BlueNet is the member area on www.azblue.com that allows you to manage your health insurance plan from anywhere you have Internet access. Go to www.azblue.com/member for more information and to register for a BlueNet account. Once you are registered for BlueNet, you have access to the following*:

Claims and benefits information
Track deductible, if applicable to your plan
Update account information
Verify enrollment status
Order ID cards

Search for providers
Compare hospitals
Research prescription benefits
HealthyBlue® - tools for a healthier life
Review Medical Coverage Guidelines

*Depending on your plan, access to links on BlueNet may vary.

BCBSAZ Customer Service
(benefit questions or claim information)

BCBSAZ customer service hours are Monday through Friday, 8:00 a.m. to 4:30 p.m. MST (except holidays).

Dedicated City of Chandler Customer Service (866) 595-5993

Send all correspondence to this address unless otherwise indicated below:

Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, Arizona 85002-3466

Claims

Mail new claims to:

Blue Cross Blue Shield of Arizona
P.O. Box 2924
Phoenix, Arizona 85062-2924

Claims for transplant travel and lodging:

Attn: Transplant Travel Claim Processor
Mail Stop: A116
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, Arizona 85002-3466

Claims for chiropractic services:

Claims Administration
American Specialty Health Networks, Inc.
P.O. Box 509001
San Diego, CA 92150-9001

Customer Walk-In Office Locations

Phoenix (main office) 2444 W. Las Palmaritas Drive, 85021-4883
(2 blocks north of Northern Avenue between
the Black Canyon Freeway (I-17) and 23rd Avenue)

Tucson	5285 E. Williams Circle, Suite 1000, 85711- 7411 (East on Broadway Road, right on S. Williams Circle, left on E. Williams Circle)
Flagstaff	1500 E. Cedar Avenue, Suite 56, 86004 -1643 (Intersection of Cedar Avenue and West Street)
Chandler	2121 W. Chandler Blvd., Suite 115, 85224 (East of the 101 Freeway; West of Dobson Road)

Provider Network Status

Check the online provider directory at www.azblue.com or call BCBSAZ customer service at the numbers listed above.

BCBSAZ Other Information

Behavioral Services Administrator (BSA) (800) 224-2125

BlueCard® Program

Blue Cross Blue Shield (BCBS) Association (800) 810-2583
Web site: www.bcbs.com

Cancer Clinical Trials (for information on services directly associated with a cancer clinical trial or to obtain a copy of Arizona law requirements for cancer clinical trials)

Maricopa County	(602) 864-5841
Statewide	(800) 232-2345, ext. 5841

Care Management and Disease Management Support Line

Information on care management services, how to contact a care manager or how to make a referral and information on health management programs that support members with complex, catastrophic and/or chronic conditions. (877) My-HBlue or (877) 694-2583

Chiropractic Benefits Administrator (800) 678-9133

Continuity of Care Requests (877) My-HBlue or (877) 694-2583

Hearing Impaired (TDD) (Claim information)

Maricopa County	(602) 864-4823
Statewide	(800) 232-2345, ext. 4823

Medical Appeals and Grievances

Attn: Medical Appeals and Grievances
Mail Stop A116
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85002-3466

Maricopa County: (602) 544-4938
Statewide: (866) 595-5998
Fax: (602) 544-5601

Medical Coverage Guidelines (request a copy of the Medical Coverage Guidelines)

Maricopa County	(602) 864-4614
Statewide	(800) 232-2345, ext. 4614

BlueNet members' area of www.azblue.com under Claims & Benefits/Health Benefits/Medical Coverage Guidelines

Membership Services (change mail address, add or remove dependents, termination of coverage)

Maricopa County	(602) 864-4115
Statewide	(800) 232-2345, ext. 4115
Fax	(602) 864-4041

Attn: Membership Services
Mail Stop: A102
Blue Cross Blue Shield of Arizona
PO Box 13466
Phoenix, AZ 85002-3466

Precertification (your doctor must contact BCBSAZ)

Maricopa County	(602) 864-4320
Statewide	(800) 232-2345, ext. 4320

Precertification Denial Appeals

Maricopa County	(602) 544-4938
Statewide	(866) 595-5998
Fax	(602) 544-5601

Attn: Appeals
Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ 85002-3466

Prescription Benefit Unit

Maricopa County	(602) 864-4273
Statewide	(800) 232-2345, ext. 4273

Requests for Transplant Travel and Lodging Claim Forms

Maricopa County	(602) 864-4051
Statewide	(800) 232-2345, ext. 4051

Spanish-Language Telephone Service (en Español – preguntas sobre su solicitud, beneficios, reclamos, o pagos)

Maricopa County	(602) 864-4884
Statewide	(800) 232-2345, ext. 4884

Supply Line (provider directories, claim forms, health coverage appeal information packet, ID cards, Rx mail order packet)

Maricopa County	(602) 995-6960
Statewide	(800) 232-2345 ext. 6960

Social Media

Like us on Facebook: www.facebook.com/bcbsaz
Follow us on Twitter: www.twitter.com/bcbsaz
Email complaints and concerns to socialcares@azblue.com
iPhone and Android phone users can download our mobile application via Google Play or App Store

DEFINITIONS

"Allowed amount" means the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost-share payment.

BCBSAZ calculates deductible and coinsurance based on the allowed amount, less any access fees or precertification charges. BCBSAZ uses the allowed amount to accumulate toward any out-of-pocket maximum that applies to the member's benefit plan. The allowed amount does not include any balance bills from noncontracted providers. The allowed amount is neither tied to, nor necessarily reflective of, the amounts providers in any given area usually charge for their services.

If the allowed amount is calculated based upon a fee schedule, a change to the fee schedule may result in higher member cost-share.

The allowed amount is calculated as follows:

Type of Provider	Type of Claim	Basis for Allowed Amount	Payee for Reimbursement
Providers contracted with BCBSAZ	Emergency and non-emergency	Lesser of the provider's billed charges* or the applicable BCBSAZ fee schedule, with adjustments for any negotiated contractual arrangements and certain claim editing procedures	BCBSAZ reimburses the **provider** the allowed amount, less any member cost share
Providers contracted with the BSA	Emergency and non-emergency	The BSA fee schedule	The BSA reimburses the **provider** the allowed amount, less any member cost share
Providers contracted with the CBA	Emergency and non-emergency	The lesser of the provider's billed charges or the CBA fee schedule, with adjustments for any negotiated contractual arrangements	The CBA reimburses the **provider** the allowed amount, less any member cost share
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue")	Emergency and non-emergency	Lesser of the provider's billed charges* or the price the Host Blue plan has negotiated with the provider	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost share
Noncontracted providers (in Arizona and out-of-state)	Non-emergency	Lesser of the provider's billed charges* or the applicable BCBSAZ fee schedule, with adjustments for certain claim editing procedures	BCBSAZ reimburses the **member** the allowed amount, less any member cost share
Noncontracted providers (in Arizona and out-of-state)	Emergency	Billed charges*	BCBSAZ reimburses the **member** the allowed amount, less any member cost share

*A provider's billed charges are defined as the lowest price the provider is willing to accept as payment in full for a covered service when the provider has no contract with BCBSAZ, a Host Blue, or the BlueCard Worldwide program that governs the amount of reimbursement.

"BCBSAZ" or "We" means Blue Cross Blue Shield of Arizona when acting as the issuer of insurance coverage or as the administrator of a group benefit plan. Within this benefit book, "BCBSAZ" or "We" may also include the BSA or the CBA, when the BSA or CBA is performing functions delegated to it by BCBSAZ.

Blue Cross® Blue Shield® of Arizona is an independent licensee of the Blue Cross and Blue Shield Association.

BCBSAZ is a non-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 health care services organization as a line of business.

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

"Behavioral Services Administrator (BSA)" means the independent company that contracts with BCBSAZ to administer and deliver some of the behavioral and mental health benefits, along with certain other education and training benefits, available through some plans.

"Benefit book" means this document, which may also be referred to as benefit book or benefit plan book.

"Benefit plan" or "plan" means the document describing the benefits and terms of coverage that the sponsor of a group health plan provides to its group members and their dependents.

Your BCBSAZ plan includes this book and SBC, your application for coverage, your ID card, any plan that is issued to replace this plan and any rider, amendment or modification to this plan, including but not limited to, any changes in deductible, coinsurance or copay amounts. **Changing deductible options within a product does not constitute a new plan.**

Many group health insurance plans (other than government plans, church plans, and certain other types of plans) must comply with the federal Employee Retirement Income Security Act of 1974 (ERISA). If your group health insurance plan is subject to ERISA, your plan sponsor must maintain a summary plan description and provide the summary plan description to you upon written request. While your plan sponsor may include this benefit book as part of its summary plan description, this benefit book is not a summary plan description.

"Chiropractic Benefits Administrator (CBA)" means the independent company that administers chiropractic benefits for BCBSAZ. The CBA develops and manages the BCBSAZ network of chiropractic providers, processes chiropractic claims, determines medical necessity and handles utilization management, grievances and appeals related to chiropractic services.

"Contract holder" means the person to whom the benefit plan is issued. Any other person approved for coverage with the contract holder under this plan is a dependent. Under group coverage, the contract holder is the member who is eligible for coverage because of his or her affiliation with a group.

"Cosmetic" means surgery, procedures or treatment and other services performed primarily to enhance or improve appearance, including but not limited to, 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.

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

1. Are for comfort or convenience;
2. Do not seek to cure;
3. Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition (except as stated in *"Home Infusion/Medication Administration Therapy"*) or other self care; **or**
4. Are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as an L.P.N., R.N. or licensed therapist.

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

"Emergency" means an illness or condition which requires relief of severe pain or if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize life, health or the ability to completely recover, resulting in serious impairment or permanent disability.

"Fee Schedules" mean proprietary schedules of provider fees compiled by BCBSAZ or BCBSAZ's contracted vendors. BCBSAZ or BCBSAZ's contracted vendors develop proprietary schedules of fees based on annual reviews of information from numerous sources, including, but not limited to: Medicare fee schedules from the Centers for Medicare and Medicaid Services (CMS), BCBSAZ's or the contracted vendor's historical claims experience, pricing information that may be available to BCBSAZ or the vendor, information and comments from providers and negotiated contractual arrangements with providers. **BCBSAZ and/or BCBSAZ's contracted vendors may change their fee schedules at any time without prior notice to members. If the allowed amount is calculated based upon a fee schedule, a change to the fee schedule may result in higher member cost-share.**

"Group" means the employer, trust or other entity that sponsors the group benefit plan on behalf of its employees or participants.

"Group Master Contract" (sometimes referred to as "Agreement") means the legal agreement between the group and BCBSAZ.

"Inpatient residential care" means medical or mental-behavioral care provided in a 24-hour facility licensed by the state in which it is located, and not licensed as a hospital, that offers integrated therapeutic services, educational services and activities of daily living. These services are part of a well-defined, individually tailored, medical or mental-behavioral treatment plan that is clinically appropriate based upon the individual's medical or mental-behavioral needs and is performed in a clinically appropriate facility.

"Medical Coverage Guidelines" means BCBSAZ medical, pharmaceutical, dental and administrative criteria that are developed from review of published, peer-reviewed medical, pharmaceutical and dental literature and other relevant information and used to help BCBSAZ determine whether a service, procedure, medical device or drug is eligible for benefits under a member's benefit plan. The Medical Coverage Guidelines also include prescription medication limitations. BCBSAZ periodically reviews and amends the Medical Coverage Guidelines in response to changes and advancements in medical knowledge and scientific study. Benefit determinations are based on the Medical Coverage Guidelines in effect at the time of service. You or your provider can review a specific guideline by going to the "Claims & Benefits" section on www.azblue.com and choosing "Health Benefits and Medical Coverage Guidelines." Specific Guidelines are also available by calling the number for requesting Medical Coverage Guidelines listed in the front of this book.

The CBA establishes medical coverage guidelines for chiropractic services. To obtain a copy of the guidelines applicable to chiropractic services, contact the CBA at the number listed in the front of this book or go to www.ashcompanies.com. Also, if the BSA provides or administers benefits under your plan, the BSA may establish medical coverage guidelines for services covered through the benefits it administers. Contact the BSA at the number listed at the front of this book for a copy of coverage guidelines maintained by the BSA.

"Member" or "You" means an individual, employee, participant or dependent covered under a benefit plan.

"Per diem" means a method of reimbursement based on a negotiated rate per day for payment of covered services provided to a patient in a facility.

"Pharmacy Coverage Guidelines" means BCBSAZ 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 BCBSAZ determine whether a medication or other products such as medical devices or supplies are eligible for benefits under a member's retail or mail order benefit. Pharmacy Coverage Guidelines are available by going to www.azblue.com under Prescription Medications and then Pharmacy Coverage Guidelines. Guidelines are also available by calling the number listed for the Prescription Benefit Unit listed in the front of this book.

"Physician," for purposes of classifying benefits and member cost-shares in this benefit plan, means a properly licensed M.D., D.O., D.P.M., or D.C.

"Primary Care Provider (PCP)" means a health care professional who is contracted with BCBSAZ as a PCP and generally specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, pediatrics or any other classification of provider approved as a PCP by BCBSAZ. Your benefit plan does not require you to have a PCP or to have a PCP authorize specialist referrals.

"Provider" means any properly licensed, certified or registered person or facility furnishing medical care to you, such as a doctor, hospital, laboratory or other health professional.

"Service" means a generic term referencing some type of health care treatment, test, procedure, supply, medication, technology, device or equipment.

"Specialist" means either a physician or other health care professional who practices in a specific area other than those practiced by primary care providers, or a properly licensed, certified or registered individual health care provider whose practice is limited to rendering mental health services. This definition of "specialist" does not apply to dentists. BCBSAZ does not require you to obtain an authorization or referral to see a specialist.

UNDERSTANDING THE BASICS

Your Responsibilities

Read your benefit materials. Before you receive any services you need to understand what is covered and excluded under your benefit plan, your cost-sharing obligations and the steps you can take to minimize your out-of-pocket costs. You need to carefully review this book, your SBC and other materials that BCBSAZ has provided to you.

Review your explanation of benefits (EOB) forms, other claim-related information and available claims history. Notify BCBSAZ of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

Tell us about changes. We need current information to correctly process your claims, update you on changes to your benefits and explain how we are administering your benefit plan. Check the BCBSAZ customer service section at the front of this book for information on contacting Membership Services. Tell us right away about any changes in the following:

- Individuals being added to the benefit plan: Spouse, newborns, adopted children, children placed for adoption, stepchildren
- Eligibility of you or your dependents for Medicare during the term of this contract
- Your mailing address or phone number
- Other medical coverage that you or your dependents add or lose, including any changes in benefits
- Eligibility of you or your dependents for Arizona Health Care Cost Containment System (AHCCCS) coverage during the term of this contract
- Individuals removed from the benefit plan due to divorce or death
- A disabled dependent age 26 or older who is no longer disabled

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

BCBSAZ ID Card

Your ID card has basic eligibility and cost-sharing information: Contract holder and dependent names, group number, ID number, card issue date and certain cost-sharing amounts.

- Bring your ID card with you each time you seek health care services.
- Have your ID card available for reference when you contact BCBSAZ for information.

Benefit Maximums

Some benefits may have a specific benefit maximum or limit based on dollar amount, number of days or visits, type, timeframe (calendar year or benefit plan), age, gender or other factors. If you reach a benefit maximum, any further services are not covered under that benefit and you may have to pay the provider's billed charges for those services. However, if you reach the benefit maximum on a particular line of a claim, you will be responsible for paying only up to the allowed amount for the remaining charges on that line of the claim.

All benefit maximums are included in the applicable benefit description.

Coverage Changes

Your benefits and coverage can change while this benefit plan is in effect. You will be notified of any changes as required by law.

Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available.

Covered Services

To be covered a service must be all of the following:

- A benefit of this plan;
- Medically necessary as determined by BCBSAZ;
- Not excluded;
- Not experimental or investigational as determined by BCBSAZ;
- Precertified where precertification is required;
- Provided while this benefit plan is in effect and while the person claiming benefits is eligible for benefits; **and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ.

Experimental or Investigational Services

BCBSAZ, in its sole and absolute discretion, decides whether a service is experimental or investigational. A service is considered experimental or investigational unless it meets all of the following criteria:

- The service must have final approval from the appropriate governmental regulatory bodies if applicable;
- The scientific evidence must permit conclusions concerning the effect of the service on health outcomes;
- The service must improve the net health outcome;
- The service must be as beneficial as any established alternative; **and**
- The improvement resulting from the service must be attainable outside the investigational setting.

In addition to classifying a service as experimental or investigational using the above criteria, BCBSAZ may also classify the service as experimental or investigational if any one or more of the following apply:

- The service 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 is submitted for precertification or rendered;
- The provider rendering the service documents that the service is experimental or investigational; **or**
- Published reports and articles in authoritative (peer-reviewed) medical and scientific literature show that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, appropriate selection, efficacy or efficacy as compared with the standard treatment for the diagnosis.

Medically Necessary

BCBSAZ, in its sole and absolute discretion, decides whether a service is medically necessary based on the following definition:

A medically necessary service is a service that meets all of the following requirements:

- Is consistent with the diagnosis or treatment of a symptom, illness, disease or injury;
- Is not primarily for the convenience of a member or a provider;
- Is the most appropriate site, supply or service level that can safely be provided; **and**
- Meets BCBSAZ's medical necessity guidelines and criteria in effect when the service is precertified or rendered. If no such guidelines or criteria are available, BCBSAZ will base its decision on the judgment and expertise of a BCBSAZ medical professional or medical consultant retained by BCBSAZ.

Medical Necessity Guidelines and Criteria

Listed below are some sources and criteria that BCBSAZ uses to make medical necessity decisions. BCBSAZ does not rely on each of these sources for every decision. Information on how to obtain a copy of the Medical Coverage Guidelines is in the BCBSAZ customer service section at the front of this book.

- Medical Coverage Guidelines (local medical policy)
- InterQual ® Clinical Decision Support Criteria
- Medical Policy Reference Manual (MPRM) of the Blue Cross Blue Shield Association
- Medicare Guidelines
- Pharmacy Coverage Guidelines
- Technology Evaluation Center (TEC) of the Blue Cross Blue Shield Association

BCBSAZ contracts with a behavioral services administrator (BSA) and a chiropractic benefits administrator (CBA) to administer some or all of these types of benefits for some plans. The BSA and CBA also make medical necessity determinations based on their own medical necessity criteria, which are also available to you on request.

BCBSAZ's decision about medical necessity may differ from your provider's opinion. A provider may prescribe, order, recommend or approve a service that BCBSAZ decides is not medically necessary and therefore is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered.

In addition, not all medically necessary services will be covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A service may be medically necessary and still excluded from coverage.

Provider Eligibility and Network Status

Check your provider's eligibility and network status before you receive services. Not all medical professionals are eligible providers, and not all eligible providers are contracted with BCBSAZ. If you don't know your provider's status with BCBSAZ, check our online provider directory at www.azblue.com or call BCBSAZ customer service.

Summary of Benefits and Coverage (SBC)

BCBSAZ gives you an SBC that shows applicable copays, access fees, coinsurance percentages, deductible amounts, other cost-sharing amounts; and other important information. Please keep your current SBC with your benefit book.

MEMBER COST-SHARING

Members pay part of the costs for benefits received under this plan. Depending on your particular benefit plan, the service you receive and the provider you choose, you may have an access fee, balance bill, coinsurance, copay, deductible or some combination of these payments. Each cost-share type is explained below. This section, the benefit descriptions in this book and your SBC will explain which cost-share types apply to each benefit.

If the allowed amount is calculated based upon a fee schedule, a change to the fee schedule may result in higher member cost-share.

BCBSAZ uses your claims to track whether you have met some cost-share obligations. We apply claims based on the order in which we process the claims and not based on date of service.

Access Fee

An access fee is a fixed fee you pay to a provider for certain covered services, usually at the time of service. If an access fee applies to a particular service, you must pay the access fee in addition to any other applicable cost-share for the service. Access fees do not count toward meeting your calendar-year deductible.

Balance Bill

The balance bill refers to the amount you may be charged for the difference between a noncontracted provider's billed charges and the allowed amount.

In-network providers will accept the allowed amount for covered services. They will not charge you for the difference between their billed charges and the allowed amount.

Noncontracted providers have no obligation to accept the allowed amount. You are responsible to pay a noncontracted provider's billed charges, even though BCBSAZ will reimburse your claims based on the allowed amount. Depending on what billing arrangements you make with a noncontracted provider, the provider may charge you for full billed charges at the time of service or seek to balance bill you for the difference between billed charges and the amount that BCBSAZ reimburses you on a claim.

Any amounts paid for balance bills do not count toward deductible, coinsurance or the out-of-pocket maximum.

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for covered services each calendar year (January through December) before the benefit plan begins to pay for covered services. The deductible applies to every covered service unless the specific benefit section says it does not apply.

Each individual member has a calendar-year deductible. If you have family coverage, there is also a calendar-year deductible for the family. Amounts counting toward an individual's calendar-year deductible will also count toward any family deductible. When the family satisfies its calendar-year deductible, it also satisfies the deductible for all the individual members.

Your benefit plan has two different deductibles, a deductible that applies to services received from in-network providers and a separate deductible that applies to services received from out-of-network providers. Amounts applied to the in-network deductible will also apply to meet the out-of-network deductible. However, the amounts applied to the out-of-network deductible **do not** apply to meet the in-network deductible. Deductible amounts are shown on your SBC.

The family deductible must be met on a family policy before the Plan will pay for covered services for any individuals covered through that policy.

The deductible is calculated based on the allowed amount.

Amounts you pay for copays and access fees do not count toward the deductible.

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for covered services after meeting any applicable deductible. BCBSAZ subtracts any applicable access fees or precertification charges from the allowed amount before calculating coinsurance. Coinsurance applies to every covered service unless the specific benefit section says it does not apply. In most cases, your coinsurance percentage is higher when you use an out-of-network provider.

BCBSAZ normally calculates coinsurance based on the allowed amount. **There is one exception.** If a hospital provider's billed charges are less than the hospital's DRG reimbursement, BCBSAZ will calculate your coinsurance based on the lesser billed charge.

Copay

A copay is a specific dollar amount you must pay to the provider for some covered services. If a copay applies to a covered service you must pay it when you receive services. You may have different copays for various covered services. See your SBC for specific amounts. If a copay does not apply to a service, you pay the applicable deductible and coinsurance, unless otherwise specified within the benefit provision.

Out-of-Pocket Maximum (Individual & Family)

An out-of-pocket maximum is the amount each member must pay each year before the Plan begins paying 100 percent of the allowed amount on covered services, for the remainder of the calendar year. The payments listed below do not count toward the out-of-pocket maximum. You must keep paying them even after you reach your out-of-pocket maximum:

- Amounts above a benefit maximum
- Any amounts for balance billing
- Any amounts for noncovered services
- Any charges for lack of precertification

If you have family coverage, there is an out-of-pocket maximum 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.

Precertification Charges

If your out-of-network provider does not obtain precertification from BCBSAZ for a service that requires it, you are subject to a precertification charge or complete loss of benefit. Applicable precertification charges are shown on your SBC.

Amounts applied as precertification charges do not count toward the calendar-year deductible or out-of-pocket maximum.

The SBC sent with your member ID card shows the actual cost-share amounts for your plan (for example copay amounts, coinsurance percentage, deductible). Some of these amounts are also shown on your ID card.

PROVIDERS

Eligible Providers

Eligible providers include the properly licensed, certified or registered providers listed below, when acting within the scope of their practice. Benefits may also be available from other health care professionals whose services are mandated by Arizona state law or federal law or who are accepted as eligible by BCBSAZ. The fact that a service is rendered by an eligible provider does not mean that the service will be covered. Eligible providers are not necessarily contracted with BCBSAZ. For information on a provider's status as an eligible or network provider, check our online provider directory at www.azblue.com, or call BCBSAZ customer service, before you receive services.

Eligible providers include the following:

Professional	Facility Ancillary
• Board Certified Applied Behavioral Analyst (BCABA) • Certified Nurse First Assist (CRNFA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Doctor of chiropractic (D.C.) • Doctor of dental surgery (D.D.S.) • Doctor of medical dentistry (D.M.D.) • Doctor of medicine (M.D.) • Doctor of optometry (O.D.) • Doctor of osteopathy (D.O.) • Doctor of podiatry (D.P.M.) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner • Licensed professional counselor • Physician Assistant (PA) • Psychologist (Ph.D., Ed.D. and Psy.D.) • Perfusionist • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational or physical therapist • Surgical Assist (SA) • Surgical Technician (ST)	• Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long Term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Rehabilitation Treatment Centers (substance abuse centers) • Retail, mail order and specialty pharmacies • Skilled Nursing Facility • Specialty Laboratory • Sleep Lab • Urgent Care

Choosing a Provider

Please call BCBSAZ customer service before you receive services if you have any questions about a provider's eligibility or network participation with BCBSAZ.

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

In-Network Providers (Contracted)

In-network providers are the following: (1) health care providers who have a contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ members); and (2) out-of-state providers licensed in the United States who have a PPO contract with a Host Blue plan. In-network providers will file your claims with BCBSAZ or the Host Blue plan with which they are contracted. The provider's contract generally prohibits the provider from charging more than the allowed amount for covered services. However, when there is another source of payment, such as liability insurance, all providers may be entitled to collect their balance bill from the other source, or from proceeds received from the other source. The provider's contract does allow the provider to charge you up to the provider's billed charges for non-covered services. We recommend that you discuss costs with the provider before you obtain non-covered services.

BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan directly reimburse in-network providers for your benefit plan's portion of the allowed amount for covered services. **You are responsible to pay your member cost-share directly to the provider.**

In-network providers must be licensed in the United States. Except for emergencies, in-network providers must render covered services in the United States in order for covered services to be considered in-network and subject to in-network member cost-share. If an in-network provider renders covered services outside the United States, the covered services will be considered out-of-network and subject to out-of-network member cost-share, including balance bills (except for emergencies).

Out-of-Network Providers (Contracted and Noncontracted)

Out-of-network providers are: (1) Providers who are contracted with a Host Blue plan as "Participating" only providers; (2) Eligible providers who have no contract with BCBSAZ or a Host Blue plan (Noncontracted providers); and (3) Providers who are contracted with the BlueCard Worldwide program.

- **Participating-Only Providers**

  Participating-only providers are contracted with a Host Blue plan as "Participating" and are not contracted as PPO or Preferred providers. Participating-only providers are out-of-network providers. Participating-only providers will submit your claims to the Host Blue plan with which they are contracted. If you receive covered services from a Participating-only provider, you will pay out-of-network deductible and coinsurance and access fees. However, you will not have to pay the balance bill because the provider is contracted.

- **Noncontracted Providers**

  Eligible providers who have no provider participation agreement with BCBSAZ or any Host Blue plan are noncontracted providers. Noncontracted providers are out-of-network providers.

  If you receive covered services from an eligible noncontracted provider, you will pay out-of-network deductible and coinsurance, access fees and the balance bill. Noncontracted providers may bill you up to their full billed charges. The difference between the noncontracted provider's billed charges and payment under this benefit plan may be substantial. Please check with the noncontracted provider regarding the amount of your financial responsibility before you receive services.

  BCBSAZ does not send claim payments to noncontracted providers. BCBSAZ will send payment to you for whatever benefits are covered under your benefit plan. You are responsible for paying the noncontracted provider. A noncontracted provider will not receive a copy of your explanation of benefits (EOB) and will not know the amount this benefit plan paid you for the claim.

- **Providers Contracted with the BlueCard Worldwide Program**

  Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. For covered services from these providers, you will pay out-of-network deductible and coinsurance and access fees (except for emergency services), plus the balance bill.

Provider Status and Payment – Summary Table

Provider contract status	Network status and applicable cost share	Provider required to file claim on member's behalf	Accept BCBSAZ Allowed Amount[1] and do not Balance Bill	Payee for Reimbursement
Providers contracted with BCBSAZ	In-network[2]	Yes	Yes	BCBSAZ reimburses the **provider** the allowed amount, less any member cost-share
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue") as PPO providers	In-network[2]	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share

Providers contracted with Host Blue as Participating only providers	Out-of-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share
Providers contracted with Blue Card World Wide Program	Out-of-network	Yes	No	Blue Card Worldwide reimburses the **provider** the allowed amount less any member cost share
Noncontracted providers (in Arizona and out-of-state) (must be eligible providers)	Out-of-network	No (provider may elect to do so as courtesy to member)	No. May charge up to full billed charges. Difference between billed charges and BCBSAZ member reimbursement may be substantial[3]	BCBSAZ reimburses the **member** the allowed amount, less any member cost-share. Provider does not get copy of member's EOB or know reimbursement amount.

[1] See "Definitions" section for basis of allowed amount computation.

[2] In-network providers must be licensed in the United States. Except for emergencies, in-network providers must render covered services in the United States in order for covered services to be considered in-network and subject to in-network member cost-share. If an in-network provider renders covered services outside the United States, the covered services will be considered out-of-network and subject to out-of-network member cost-share, plus balance bills.

[3] **Please check with the noncontracted provider regarding the amount of your financial responsibility before you receive services.**

All providers may charge you up to full billed charges for non-covered services. We recommend that you discuss costs with the provider before you obtain non-covered services.

Differences in Financial Responsibility

The following **example** shows how out-of-pocket expenses can differ depending on the provider you choose. This example is provided for demonstration purposes only. Your savings may vary depending on your benefit plan and your chosen provider.

In this example, the member has already satisfied the calendar-year deductible and has a 20 percent coinsurance for an in-network provider and 40 percent coinsurance for an out-of-network provider.

Billed Charges	**Allowed Amount**	**Financial Responsibility**	**In-Network Providers 20% coinsurance**	**Out-of-Network (noncontracted) Providers 40% coinsurance**
$1,000	$400	BCBSAZ pays:	$320	$240
		You pay:	$ 80 coinsurance amount	$160 coinsurance +600 balance bill $760

Locating an In-Network Provider

Check the BCBSAZ provider directory to locate an in-network provider who offers the services you are seeking and contact the provider for an appointment.

If you cannot get an appointment with the in-network provider, you may either call BCBSAZ or ask an in-network provider with whom you have an existing treatment relationship for help in getting an appointment or locating another provider.

Precertifications for Out-of-Network Providers

BCBSAZ does not guarantee that every specialist or facility will be in our network. Not all providers will contract with health insurance plans. If you believe or have been told there is no in-network provider available to render covered services that you need, you may ask your treating provider to request precertification of in-network cost-share for services from an out-of-network provider. BCBSAZ will not issue this precertification if we find that an in-network provider is available to treat you. The section on precertification explains how to make this request.

Continuing Physician Care from an Out-of-Network Physician (M.D., D.O.)

You may be able to receive benefits at the in-network level for services from an out-of-network Arizona physician, under the circumstances described below. Continuity of care benefits are subject to all other applicable provisions of your benefit plan.

Continuity of care only applies to otherwise covered services rendered by doctors of medicine and osteopathy who are located in Arizona. Continuity of care is not available for facility services. If the hospital or other facility at which your physician practices is not an in-network facility, the out-of-network provisions of coverage will apply to covered facility services.

New Members	Current Members
A new member may continue an active course of treatment with an out-of-network Arizona physician 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 thirty (30) days from the effective date of coverage; **or** 2. Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; **and**	A current member may continue an active course of treatment with an out-of-network Arizona physician if BCBSAZ terminates the physician from the network for reasons other than medical incompetence or unprofessional conduct if: The member has: 1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of the physician's termination; **or** 2. Entered the third trimester of pregnancy on the effective date of the physician's termination, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; **and**
The member's physician agrees in writing to do all of the following: 1. Accept the BCBSAZ allowed amount applicable to covered services as if provided by an in-network physician, subject to the deductible, coinsurance and copay requirements of this benefit plan; 2. Provide BCBSAZ with any necessary medical information related to your care; **and** 3. Comply with BCBSAZ's policies and procedures, as applicable, including precertification, network referral, claims processing, quality assurance and utilization review.	

Information on requesting continuity of care is listed in the BCBSAZ customer service section at the front of this book.

Out-of-Area Services

BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Plans referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Arizona, but inside the United States (not BlueCard Worldwide), the claims for those services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between BCBSAZ and other Blue Cross and/or Blue Shield Plans. National Account arrangements are contractual agreements between BCBSAZ and other Blue Cross and/or Blue Shield Plans regarding reimbursement for covered services provided to members of certain self-funded group health plans by providers contracted with the other Blue Cross and/or Blue Shield Plans.

Typically, when accessing care outside Arizona but inside the United States (not BlueCard Worldwide), you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Plan in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-contracted healthcare providers. BCBSAZ's payment practices in both instances are described in this benefit plan book.

BlueCard Program

Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for fulfilling BCBSAZ's contractual obligations.

However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Arizona but inside the United States (not BlueCard Worldwide) and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed charges for your covered services; **or**
- The negotiated price that the Host Blue makes available to BCBSAZ.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSAZ uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Precertification requirements and other benefit plan limitations apply to services received outside Arizona. You must make sure the provider obtains any required precertification. Otherwise, BCBSAZ may deny your benefits or require you to pay a precertification charge.

For assistance in locating a local BCBS network provider in another state, call (800) 810-BLUE (2583) or check the "BlueCard Doctor & Hospital Finder" online at www.bcbs.com.

See the "Provider" section and the definition of "Allowed Amount" in this benefit book for information regarding payment for services provided by non-contracted providers outside Arizona.

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue. The amount you pay for covered healthcare services under a National Account arrangement will be calculated based on either: (1) the negotiated price made available to BCBSAZ by the Host Blue; or (2) the lesser of the provider's billed charges or the negotiated price made available to BCBSAZ by the Host Blue.

BlueCard Outside the United States (BlueCard Worldwide)

Always go directly to the nearest hospital in the event of an emergency. Emergency services are covered outside the United States. In-network member cost-sharing will apply to covered Emergency Services. See the Emergency Services section of this benefit book.

The BlueCard Worldwide program helps Blue Cross and/or Blue Shield members arrange medical services when they are outside the United States. BlueCard Worldwide works differently than BlueCard inside the United States.

If you need to locate a doctor or hospital or need medical assistance services outside the United States, call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Except for emergencies, you cannot obtain services at the in-network cost-share from providers located outside the United States. Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. If you receive covered services from a provider who is contracted with the BlueCard Worldwide program, you will pay out-of-network deductible and coinsurance and BCBSAZ access fees, plus the balance bill (except for emergency services).

- **Inpatient Services**

  In most cases, hospitals contracted with the BlueCard Worldwide program will not require you to pay for covered inpatient hospital services, except for your member cost-share (out-of-network deductible and coinsurance and BCBSAZ access fees). In such cases, the BlueCard Worldwide hospital will submit your claim for processing. **You must still contact BCBSAZ to obtain precertification for non-emergent inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the United States are generally not contracted with the BlueCard Worldwide program and will require you to pay for services in full at the time of service. Complete a BlueCard Worldwide claim form and send the claim form with the provider's bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claim processing. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide.

Services Received on Cruise Ships

If you receive health care services while on a cruise ship, you will pay in-network cost-share, and the allowed amount will be based on billed charges. A cruise ship claim is not considered an out-of-country claim. Claims should be submitted and processed through BCBSAZ, not through the BlueCard Worldwide program. Please call the BCBSAZ Customer Service department at the phone number listed in the front of this book for more information, or mail copies of your receipts to the BCBSAZ general correspondence address listed at the front of this book.

PRECERTIFICATION

Precertification

Precertification is the process BCBSAZ uses to determine eligibility for benefits.

When Is Precertification Required and What Happens If You Don't Obtain It

Not all services require precertification. Each benefit description in this booklet tells you whether precertification is required for that benefit. If it is required, your provider must obtain it on your behalf before rendering services.

Notwithstanding any other language in this benefit book, BCBSAZ may change the services that require precertification at any time. If the benefit description does not indicate that precertification is required, and you or your provider are unsure, go to www.azblue.com for a listing of medications and services that require precertification or call the Customer Service number listed in the front of this book.

If precertification is required, but not obtained, the consequences vary by benefit. The benefit description section in this book tells you which consequences will apply to specific benefits including:

- Your benefits may be denied
- You may have to pay a precertification charge
- Your cost-sharing payments may be substantially higher

How to Obtain Precertification

Ask your provider to contact BCBSAZ for precertification before you receive services. Your provider must contact BCBSAZ because he or she has the information and medical records we need to make a benefit determination. BCBSAZ will rely on information supplied by your provider. If that information is inaccurate or incomplete, it may affect the decision on your claim. You are responsible for checking with your provider to make sure that the provider has obtained any required precertification.

Factors BCBSAZ Considers in Evaluating a Precertification Request for Services or Medications

- Applicability of other benefit plan provisions (limitations, exclusions and benefit maximums);
- If the treating provider or location of service is in-network;
- Whether the service is medically necessary or investigational; **and**
- Whether your coverage is active.

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

Prescription Medication Exception

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

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

If there is no in-network provider available to deliver covered services, your treating provider may contact BCBSAZ and ask BCBSAZ to precertify the in-network cost-share for services from an out-of-network provider. BCBSAZ will evaluate whether there is an in-network alternative. If BCBSAZ determines that an in-network provider is available to treat you, BCBSAZ will not precertify in-network cost-share for services from your out-of-network provider of choice.

Precertification of in-network cost-share for services from an out-of-network provider is a process separate from precertification of services. If you want an out-of-network provider to render services that require precertification, and you also want to be eligible for the in-network cost-share, you must ensure that your

provider makes two separate precertification requests: one for the service itself and one for use of the out-of-network provider. The benefit descriptions in this book refer only to your obligation to obtain precertification for the service. If BCBSAZ precertifies you for the in-network cost-share, your services will be subject to the in-network cost-share. You will still be responsible for any balance bill, plus your in-network cost-share.

If BCBSAZ Precertifies Your Service

- Precertification is not a pre-approval or a guarantee of payment. Precertification made in error by BCBSAZ is not a waiver of BCBSAZ's right to deny payment for noncovered services.
- You and your provider will receive a letter explaining the scope of the precertification.

If BCBSAZ Denies Your Precertification Request

Denial of precertification is an adverse benefit determination. As explained in the next section on Claims, BCBSAZ will send you a notice explaining the reason for the denial, and your right to appeal the BCBSAZ decision. Information on where to file an appeal is in the BCBSAZ Customer Service section at the front of this book.

If your request for precertification of a service is denied because BCBSAZ decides that the service is not medically necessary, remember that BCBSAZ's interpretation of medical necessity is a benefits determination made in accordance with the provisions of this plan. Your provider may recommend services or treatment not covered under this plan. You and your provider should decide whether to proceed with the service or procedure if BCBSAZ denies precertification.

DESCRIPTION OF BENEFITS

Please review this section for an explanation of covered services and benefit-specific limitations and exclusions. Also be sure to review *"What is Not Covered"* for general exclusions and limitations that apply to all benefits.

To be covered and eligible for benefits, a service must be:

- A benefit of this plan;
- Medically necessary as determined by BCBSAZ;
- Not excluded;
- Not experimental or investigational as determined by BCBSAZ;
- Precertified if precertification is required;
- Provided while this benefit plan is in effect and while the person claiming benefits is an eligible member; **and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ.

BCBSAZ does not determine whether a service is covered under this benefit plan until after services are provided and BCBSAZ receives a complete claim describing the services actually rendered.

Most diagnosis, management and treatment of behavioral health conditions that are eligible for benefits, including medication management, are covered under your behavioral and mental health benefit. Depending on how your provider submits a claim and the scope of services provided, certain services involving both behavioral health and medical diagnoses may be covered under the behavioral and mental health benefit, and cost-shares for behavioral and mental health services will apply.

Benefits are listed in alphabetical order:

A. AMBULANCE SERVICES

Precertification: Not required.

Your Cost-Share: The Plan pays 100 percent of the allowed amount.

Benefit Description: Ground ambulance transportation from the site of an emergency, accident or acute illness to the nearest facility capable of providing appropriate treatment; **or**

Interfacility ground or air ambulance transfer for admission to an acute care facility, extended active rehabilitation facility or skilled nursing facility when the transferring facility is unable to provide the level of service required; **or**

Air ambulance transportation to the nearest facility capable of providing appropriate treatment when the emergency, accident or acute illness occurs in an area inaccessible by ground vehicles or transport by ground ambulance would be harmful to the member's medical condition.

Benefit-Specific Exclusion: All other expenses for travel and transportation are not covered, except for the limited travel benefits described in *"Transplant Travel and Lodging."*

B. BEHAVIORAL AND MENTAL HEALTH SERVICES (including chemical dependency or substance abuse treatment)

B.1.1 Inpatient Hospital

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share:

In-Network Facility and Professional Services: You pay in-network deductible and coinsurance.

Out-of-Network Facility and Professional Services: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for:

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

B.1.2 Inpatient Subacute Hospitalization - Behavioral Health Facility Services

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share:

In-Network Facility and Professional Services: You pay in-network deductible and coinsurance.

Out-of-Network Facility and Professional Services: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description:

Benefits are available for:

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

Benefits are available for inpatient behavioral and mental health services that meet all the following criteria:

- The facility is licensed to provide behavioral health services to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time.
- The facility's designated medical director is a physician or registered nurse practitioner and provides direction for physical health services provided at the facility;
- A physician or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- The facility's designated clinical director is a behavioral health professional and provides direction for the behavioral health services provided at the facility;
- The facility has 24/7 onsite registered nursing coverage; **and**
- The facility has sufficient behavioral or mental health professional staff to provide appropriate treatment.

Changing Types of Inpatient Care (applicable to B.1.1 and B.1.2 above): Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient subacute and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit-Specific Exclusions (applicable to B.1.1 and B.1.2 above):

- Custodial Care
- Medications dispensed at the time of discharge from a hospital

- Private Duty Nursing
- Respite Care

B.2 Behavioral and Mental Health Services (Outpatient Facility and Professional Services)

Precertification: Required for partial hospitalization. Not required for other outpatient services. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share:

BSA: Your cost-share is waived.

Non-BSA (in-network): You pay in-network deductible and coinsurance.

Non-BSA (out-of-network): You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Non-emergency outpatient behavioral and mental health services are available either through BSA providers or from non-BSA providers. Those services include psychotherapy, outpatient therapy for chemical dependency or substance abuse, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, intensive outpatient services, counseling for personal and family problems, electroconvulsive therapy (ECT) and partial hospitalization.

B.3 Behavioral Therapy Services For The Treatment Of Autism Spectrum Disorder

Precertification: Not required.

Your Cost-Share:

BSA: Your cost-share is waived.

Non-BSA (in-network): You pay in-network deductible and coinsurance.

Non-BSA (out-of-network): You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definitions:

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

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

Benefit Description: Behavioral therapy services for the treatment of Autism Spectrum Disorder are available for members who have been diagnosed with Autism Spectrum Disorder. Services are available either through the BSA or from non-BSA providers. Covered behavioral therapy services must be delivered by a provider who is licensed or certified as required by law.

Benefit-Specific Exclusions (applicable to all Behavioral and Mental Health Services):

- Activity therapy, milieu therapy and any care primarily intended to assist an individual in the activities of daily living
- Biofeedback and hypnotherapy
- Development of a learning plan and treatment and education for learning disabilities (such as reading and arithmetic disorders)
- Inpatient and outpatient facility charges for services provided by the following facilities: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes.

- IQ testing
- Lifestyle education and management services
- Neurofeedback
- Neuropsychological and cognitive testing
- Sensory integration, LOVAAS therapy and music therapy
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

C. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

Precertification: Not required.

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

Benefit Description: Benefits are available for outpatient Phase I and II cardiac rehabilitation programs and pulmonary rehabilitation services.

D. CATARACT SURGERY

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance for the cataract surgery and any associated services. The cost-share amount will depend on the provider's network status and the place you receive services. In addition, you pay any amounts above the $250 maximum per member, per six (6) month period, for eyeglasses. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: There is a maximum benefit of $250 per member, per six (6) month period for eyeglasses following cataract surgery.

Benefit Description: Benefits are available for the removal of cataracts, including placement of a single intraocular lens at the time of the cataract removal. Benefits are also available for the first pair of eyeglasses post-cataract surgery or external contact lenses for treatment of keratoconus. The eyeglasses or external contact lenses must be prescribed and purchased within six (6) months of the surgery.

Benefit-Specific Exclusion: Procedures associated with cataract surgery that are not included in the benefit description, including replacement, piggyback or secondary intraocular lenses and any other treatments or devices for refractive correction.

E. CHIROPRACTIC SERVICES

Precertification: Not required.

Your Cost-Share:

In-Network: You pay in-network deductible and coinsurance.

Out-of-Network: You pay out-of-network deductible and coinsurance for services rendered by an out-of-network provider. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: There is a chiropractic visit limit of twenty (20) visits per member, per calendar year. In- and out-of-network visits count toward the twenty (20) visit limit. Physical therapy and occupational therapy services provided and billed by a chiropractor will apply towards the twenty (20) visit limit.

Benefit Description: Benefits are available for chiropractic services.

Benefit-Specific Exclusions:

- Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Spinal decompression or vertebral axial decompression therapy

F. CLINICAL TRIALS FOR TREATMENT OF CANCER AND OTHER LIFE-THREATENING DISEASES

Precertification: Required for services directly associated with a clinical trial for treatment of cancer or other life-threatening diseases or conditions. Precertification will be issued in accordance with the requirements of applicable law, regardless of whether the clinical trial would otherwise be considered investigational. See specific benefit provisions for precertification charges.

Precertification of covered services directly associated with an eligible clinical trial is not a guarantee of coverage, assurance that the clinical trial satisfies the requirements of applicable law or evidence of any determination that the service provided through the clinical trial is safe, effective or appropriate for any member.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: A "life-threatening disease or condition" is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefit Description: Benefits are available for covered services directly associated with a member's participation in a clinical trial meeting all requirements specified by applicable Arizona and/or federal law. Benefits are limited to those services eligible for coverage under this plan that would be required if you received standard, non-investigational treatment. If you have any questions about whether a particular service will be covered, please contact BCBSAZ customer service. You or your provider must inform BCBSAZ that you are enrolled in a clinical trial, that the trial meets the requirements of applicable law, and that the services to be rendered are directly associated with the trial. Otherwise, BCBSAZ will administer your benefits according to the other terms of your benefit plan, which may result in a denial of benefits.

Benefit-Specific Exclusions:

- Investigational medications (except as stated in *"Prescription Medications for the Treatment of Cancer")* and devices
- Any item, device or service that is the subject of the clinical study, or which is provided solely to meet the need for data collection and analysis
- Costs and services customarily paid for by government, biotechnical, pharmaceutical and medical device industry sources
- Costs to manage the clinical trial research
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services not otherwise covered under this plan

G. DENTAL SERVICES BENEFIT

Not all dentists who are contracted with BCBSAZ are contracted to provide medical-related dental services. Call BCBSAZ customer service with questions.

1. Dental Accident Services

Precertification: Not required.

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

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

A "sound tooth" is a tooth that is:

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

Benefit Description: Benefits are only available for the following services to repair or replace sound teeth damaged or lost by an accidental dental injury:

Covered Services:

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

Benefit-Specific Exclusions:

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

2. Dental Services Required for Medical Procedures

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

Benefit Description: Benefits are available for dental services which are required in order to perform the medical services listed in this benefit. These dental services may either be part of the medical procedure or may be performed in conjunction with and made medically necessary solely because of the medical procedure.

Benefits are available for the following:

- Diagnostic services prior to planned organ or stem cell transplantation 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

Benefit-Specific Exclusions:

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

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

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

- Children 5 years or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office
- Malignant hypertension
- Mental retardation
- Senility or dementia
- Unstable cardiovascular condition
- Uncontrolled seizure disorder

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

Precertification: Not required.

Your Cost-Share: The Plan pays 100 percent of the allowed amount for services received from in-network providers. You pay out-of-network deductible and coinsurance for services received from out-of-network providers. In addition, your cost-share is waived for one FDA-approved manual or electric breast pump and breast pump supplies per female member, per calendar year when received from in-network providers. If you receive services from a noncontracted provider, you also pay the balance bill.

1. Durable Medical Equipment (DME)

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

- Be designed for repeated medical use in the home setting;
- Be specifically designed to improve or support the function of a body part;
- Cannot be primarily useful to a person in the absence of an illness or injury; **and**
- Intended to prevent further deterioration of the medical condition for which the equipment has been prescribed.

Benefits are available for DME rental up to the purchase price of the item, as determined by BCBSAZ, and for DME repair or replacement due to normal wear and tear caused by use of the item in accordance with the manufacturer's instructions or due to growth of a child.

Benefits are limited to the allowed amount for the DME item base model. BCBSAZ will determine what is covered as the base model. Deluxe or upgraded DME items may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusions: The following services or charges are not covered:

- Charges for continued rental of a DME item after the purchase price is reached
- Repair costs that exceed the replacement cost of the DME item
- Repair or replacement of DME items lost or damaged due to neglect or use that is not in accordance with the manufacturer's instructions or specifications

2. **Medical Supplies**

Benefit Description: Benefits are available for the following medical supplies:

- Any device or supply required by applicable law or as otherwise permitted under the Medical Coverage Guidelines
- Blood glucose monitors
- Blood glucose monitors for the legally blind and visually impaired
- Diabetic injection aids and drawing-up devices
- Diabetic syringes and lancets
- Ostomy and urinary catheter supplies
- Peak flow meters
- Supplies associated with oxygen or respiratory equipment
- Test strips for glucose monitors and urine test strips
- Volume nebulizers

Benefits are limited to the allowed amount for the medical supply base model. BCBSAZ will determine what is covered as the base model. Deluxe or upgraded medical supplies may be eligible for coverage based upon BCBSAZ medical necessity criteria.

3. **Prosthetic Appliances and Orthotics**

Benefit Description: Benefits are available for the following:

- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- Prosthetic appliances to replace all or part of the function of an inoperative or malfunctioning body organ or to replace an eye or limb lost as a result of trauma or disease
- Orthotics (such as foot orthotics, collars, braces, molds) to protect, restore or improve impaired bodily function
- Wig(s) for individuals diagnosed with alopecia (absence of hair) resulting from illness or injury (up to a maximum benefit of $300 per member, per calendar year)
- Orthopedic shoes that are:
    - attached to a brace;
    - therapeutic shoes (depth inlay or custom-molded) along with inserts, for individuals with diabetes; or
    - covered in accordance with BCBSAZ medical necessity criteria.

Benefits are limited to the allowed amount for the prosthetic appliance or orthotic base model. BCBSAZ will determine what is covered as the base model. Deluxe or upgraded prosthetic appliances or orthotics may be eligible for coverage based upon BCBSAZ medical necessity criteria.

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

- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, corsets, cushions, dentures, diatherapy machines, disposable hygienic items, dressing aids and devices, elastic/support/compression stockings except TED hose, elevators, exercise equipment, foot stools, garter belts, grab bars, health spas, hearing aid batteries, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment,

mineral baths, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas and vehicle or home modifications.
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for help in daily living, socialization, personal comfort, convenience or other nonmedical reasons
- Manual and electric breast pumps and supplies for male members
- Replacement of external prosthetic devices due to loss or theft
- Strollers of any kind
- Supplies used by a provider during office treatments
- Tilt or inversion tables or suspension devices
- Wig(s), when hair loss results from male or female-pattern baldness or natural or premature aging

I. EDUCATION AND TRAINING

Precertification: Not required.

Your Cost-Share: See descriptions under subheadings.

1. Diabetes and Asthma Education and Training

Your Cost-Share: Waived.

Benefit Description: Benefits are available for diabetes and asthma education and training that meet the following criteria:

- An in-network provider delivers the education and training;
- Education and training are provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Training is conducted in person; **and**
- Your health care provider prescribes the training as part of a comprehensive plan of care related to your condition to enhance therapy compliance and improve self-management skills and knowledge.

Benefit-Specific Exclusion: Diabetes and asthma education and training provided by an out-of-network provider.

2. Nutritional Counseling and Training

Your Cost-Share: Cost-share is waived for services from in-network providers. You pay out-of-network deductible and coinsurance for services from an out-of-network provider. If you receive services from a noncontracted provider, you pay the balance bill.

Benefit Description: Nutritional counseling and training is available only for members diagnosed with the following conditions:

- Coronary Artery Disease
- Heart Failure
- High Cholesterol
- Hypertension
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

3. Lifestyle Education and Management Services, Biofeedback and Hypnotherapy

Your Cost-Share: Your cost-share is waived for services provided through the BSA. If you are referred to a BCBSAZ or community resource, you may be responsible for additional fees. Check with the provider regarding fees before obtaining services.

Benefit Description:

- Lifestyle education and management services, which are designed to provide members with information, skills and social support to maximize health

- Biofeedback
- Hypnotherapy

Lifestyle education and management services, biofeedback and hypnotherapy services are available only through the BSA. **BSA services are available only in Arizona.**

J. EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)

Precertification: Not required.

Your Cost-Share: For emergency services, you will pay your in-network cost share, even for services from out-of-network providers.

Emergency Room: You pay one access fee per member, per facility, per day plus in-network deductible and coinsurance. Covered ancillary services provided on the same day as the emergency room visit are paid at 100 percent of the allowed amount.

Admission to the Hospital from the Emergency Room: The emergency room access fee is waived if you are admitted to the hospital. Following admission, you pay in-network deductible and coinsurance for all other hospital and professional services related to the emergency.

If you receive emergency services from a noncontracted facility or professional provider, BCBSAZ will base the allowed amount used to calculate your cost-share on billed charges.

For all non-emergency services following the emergency treatment and stabilization, you pay applicable deductible, coinsurance, copays and access fees. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which may be substantial.

Benefit Description: Benefits are available for services needed to treat an emergency.

Teletrauma Services:

If a member is receiving covered emergency services, benefits may be available for teletrauma consultations between providers at the facility where the member is being treated and providers at certain Level 1 trauma centers. In order for teletrauma services to be covered, the member must be receiving emergency treatment in a facility that is not equipped to handle that member's medical condition and the treating providers must need the consultation to appropriately treat or stabilize the member. A teletrauma consultation may include telephonic or electronic communications between providers and video presentation of the member's condition. Both facilities must have certain equipment to facilitate the teletrauma communications.

For purposes of this benefit, "trauma" is defined as a physical wound or injury that results from a sudden accident or violent cause and which, if not immediately treated, is likely to result in death, permanent disability or severe pain.

K. EOSINOPHILIC GASTROINTESTINAL DISORDER

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and 25 percent of the Cost of amino-acid based formula ('Formula").

Benefit-Specific Definitions: "Cost" is defined as either billed charges, if the Formula is purchased from an out-of-network provider, or the allowed amount, if purchased from an in-network provider.

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

- At risk of mental or physical impairment if deprived of the Formula;
- Diagnosed with eosinophilic gastrointestinal disorder; **and**
- Under the continuous supervision of a physician or a registered nurse practitioner.

L. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share:

Implanted Devices: Your cost-share is waived for professional charges for implantation and/or removal of FDA-approved implanted contraceptive devices for female members when the purpose of the procedure is contraception, as documented by your provider on the claim, and the device is inserted and/or removed in an in-network physician office. You pay applicable deductible, and coinsurance when the location of service is outside an in-network physician office. If you receive services from a noncontracted provider, you also pay the balance bill.

Sterilization Procedures: Your cost-share is waived for professional and facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim. You pay out-of-network deductible and coinsurance for professional and facility charges from out-of-network providers for FDA-approved sterilization procedures provided to female members. You pay applicable deductible and coinsurance for professional and facility charges from in- and out-of-network providers for FDA-approved sterilization procedures provided to male members. If you receive services from a noncontracted provider, you also pay the balance bill.

Hormonal Contraceptive Methods: (includes oral contraceptives, patches, rings and contraceptive injections). See the *"Physician Services"* section and the *"Prescription Medications Obtained From a Retail or Mail Order Pharmacy"* section for benefits and cost-share.

Emergency Contraception: FDA-approved over-the-counter emergency contraception is covered when prescribed by a physician or other provider. See the *"Prescription Medications Obtained From a Retail or Mail Order Pharmacy"* section for benefits and cost-share.

Barrier Contraceptive Methods: (includes diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides). See the *"Physician Services"* section and the *"Prescription Medications Obtained From a Retail or Mail Order Pharmacy"* section for benefits and cost-share.

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

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.

M. FERTILITY AND INFERTILITY SERVICES

Precertification: Not required.

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

Benefit Description: Benefits are available to diagnose infertility or to treat the underlying medical condition causing the infertility.

Benefit-Specific Exclusion: Services to improve or achieve fertility (ability to conceive) or to treat infertility (inability to conceive).

N. HOME HEALTH AND HOME INFUSION - MEDICATION ADMINISTRATION THERAPY

Precertification: Required for certain medications covered under this benefit. Go to www.azblue.com for a listing of medications that require precertification or call the customer service number listed in the front of this book. If you fail to obtain precertification for these medications, they will not be covered.

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

Benefit Description: Benefits are available for the following services:

- Home infusion medication administration therapy, including:
  - Blood and blood components
  - Hydration therapy
  - Intravenous catheter care
  - Intravenous, intramuscular or subcutaneous administration of medication
  - Specialty injectable medications, as defined by BCBSAZ
  - Total parenteral nutrition
- Enteral nutrition (tube feeding) when it is the sole source of nutrition. Sole source of nutrition is defined as the inability to orally receive more than 30 percent of daily caloric needs.
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition and other services that require skilled nursing care.

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

- A licensed home health agency must provide the services;
- A health care provider must order the services pursuant to a specific plan of home treatment;
- Services must be provided in the member's residence;
- The health care provider must regularly review the appropriateness of the services ("regularly" means at least every thirty (30) days or more frequently if appropriate under the treatment plan); and
- The services must be provided by a licensed practical nurse (L.P.N.) or a registered nurse (R.N.) or another eligible provider.

Benefit-Specific Exclusions:

- Continuous home health services or shift nursing, including 24 hour continuous nursing care
- Custodial care
- Respite care

O. HOSPICE SERVICES

Precertification: Not required for inpatient hospice admissions. Required for non-emergency inpatient admissions not related to hospice services. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

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

Benefit Description: When a member elects to use the hospice benefit, it is in lieu of other medical benefits available under this plan, except for care unrelated to the terminal illness or related complications.

The hospice agency determines the required level of care, which is subject to the medical necessity provision of the benefit plan. Once the member selects the hospice benefit, the hospice agency coordinates all of the member's health care needs related to the terminal illness.

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

Benefits are available for the following:

- ***Continuous Home Care:*** 24-hour skilled care provided by an RN or LPN during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- ***Inpatient Acute Care:*** Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- ***Respite Care:*** Admission of the member to an approved facility to provide rest to the member's family or primary caregiver
- ***Routine Care:*** Intermittent visits provided by a member of the hospice team

P. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

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

Q. INPATIENT HOSPITAL

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

For bariatric surgeries received from in- and out-of-network providers, you pay applicable deductible and 50 percent of the allowed amount. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share is waived for facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim.

Please note: You pay in-network cost-share for services received from in- and out-of-network anesthesiologists only when services are received in-network.

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

Benefit Description:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including radiology and laboratory services
- 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, except in conjunction with a noncovered transplant
- Room and board in a semi-private room, unless the hospital only has private rooms. If the hospital only has private rooms, only standard private rooms are covered (not deluxe).

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

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

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance. If you receive services at a noncontracted provider, you also pay the balance bill, in addition to applicable deductible and coinsurance.

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

Benefit Description: An intense therapy program provided in a facility licensed to provide extended active rehabilitation. This care is for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

S. LONG-TERM ACUTE CARE (INPATIENT)

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill, in addition to applicable deductible and coinsurance.

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

Benefit Description: Specialized acute, medically complex care for patients provided in a facility licensed to provide long-term acute care. This care is for patients who require hospitalization on an extended basis in a facility offering specialized treatment programs and aggressive clinical and therapeutic interventions.

Benefit-Specific Exclusions:

- Custodial Care
- Private Duty Nursing
- Respite Care

T. MATERNITY

Precertification: Not required

Your Cost-Share:

In-Network: You pay in-network deductible and coinsurance for the delivering provider's Global Charge and for any other services.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided in the member's home must be rendered by an eligible provider. Your cost-share will vary depending on the type of provider and the provider's network status.

Applicable deductible and coinsurance are waived for maternity services covered under the "*Preventive Services*" benefit and delivered by an in-network provider. If you receive these services from an out-of-network provider, the services will be covered through your maternity benefit and you will pay the out-of-network cost-share. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share obligations may be affected by the automatic addition of a newborn or adopted child, as described in the **Plan Administration** section of this book. If you have coverage only for yourself and no dependents, automatic addition of a child will result in a change from individual coverage to family coverage. If you currently have a per person deductible and out-of-pocket maximum, when a child is added to your plan, you will also be required to meet a family deductible and out-of-pocket maximum, and you may be required to pay additional premium.

Benefit-Specific Definition:

Global Charge: A fee charged by the delivering provider that may include certain prenatal, delivery and postnatal services.

Benefit Description:

Maternity benefits are available for covered services related to pregnancy. This includes certain screening tests such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases and others as determined by BCBSAZ. Certain tests, including some genetic screening, may not be covered. For a complete listing of covered prenatal screening, please call BCBSAZ customer service at the numbers listed in the front of this benefit book.

Maternity benefits are available for the expense incurred by a birth mother (who is not a member) for the birth of any child legally adopted by a member, if all of the following requirements are met:

- The member adopts the child within one year of birth;
- The member is legally obligated to pay the costs of birth; **and**
- The member has provided notice to BCBSAZ within sixty (60) days of the member's acceptability to adopt children.

This adopted child maternity benefit is secondary to any other coverage available to the birth mother. Contact Membership Services at the number listed in the front of this book to receive a BCBSAZ adoption packet.

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

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

U. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and 50 percent of the Cost of Medical Foods.

Benefit-Specific Definitions: "Cost" is defined as either billed charges, if the member buys the Medical Foods from an out-of-network provider or the allowed amount, if the member buys the Medical Foods from an in-network provider.

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

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

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

- Administered for the medical and nutritional management of a member who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation;
- Essential to the member's optimal growth, health and metabolic homeostasis;
- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an M.D. or D.O. physician or a registered nurse practitioner;
- Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs (metabolic formula only); **and**
- Processed or formulated to contain less than one gram of protein per unit of serving (modified low protein foods only).

Benefit Description: Benefits are available for Medical Foods to treat Inherited Metabolic Disorders.

Benefit-Specific Exclusions:

- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available for purchase without a prescription or order from an M.D. or D.O. physician or registered nurse practitioner
- Foods and formulas that do not require supervision by an M.D. or D.O. physician or a registered nurse practitioner
- Medical food benefits are not available for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia

- Spices and flavorings

Claim submission for Medical Foods

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

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

Please contact BCBSAZ at the Supply Line number listed at the front of this book to request copies of the Medical Foods Claim Form. To obtain reimbursement for Medical Foods you purchased directly, please submit the Medical Foods Claim Form and the dated receipt to the address for claims submission at the front of this book.

Medical Foods also may be covered under the *"Home Health and Home Infusion—Medication Administration Therapy"* benefit. Medical Foods are not covered under *the "Prescription Medications Obtained from a Retail or Mail Order Pharmacy"* or the "*Specialty Self-Injectable Medications"* benefits.

V. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Precertification: Not required.

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

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

W. OUTPATIENT SERVICES

Precertification: Not required.

Your Cost-Share: Outpatient services are often available in multiple settings, and generally result in separate charges for professional and facility services. Your cost-share will vary depending on the type of outpatient service, the location of the service, and the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

For bariatric surgeries received from in- and out-of-network providers, you pay applicable deductible and 50 percent of the allowed amount. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share is waived for facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception as documented by your provider on the claim.

Please note: You pay in-network cost-share for services received from in- and out-of-network anesthesiologists only when services are received in-network.

Diagnostic Laboratory Services

- ***In-Network Physician's Office:*** You pay in-network deductible and coinsurance (cost-share is waived if you receive only covered laboratory services during your visit).
- ***In-Network Clinical Laboratory and Hospital Outpatient Laboratory Department:*** Your cost-share is waived.
- ***In-Network Inpatient Laboratories:*** You pay applicable deductible and coinsurance.

- ***Out-of-Network Physician's Office, Clinical Laboratory or Hospital Outpatient Laboratory Department:*** You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Radiology Services: The Plan pays 100 percent of the allowed amount for ultrasounds and basic x-rays. You pay applicable deductible and coinsurance for any other in-network radiology service. You pay out-of-network deductible and coinsurance for services received from out-of-network providers. If you receive services from a noncontracted provider, you also pay the balance bill.

MRI, MRA, Nuclear Medicine, Radiation Therapy, PET and CT Scans: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided by a radiologist or pathologist, including a dermapathologist, are always subject to applicable deductible and coinsurance, even when the services are provided in a physician's office.

Benefit Description: Benefits are available for the following outpatient services:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including laboratory and radiology services
- Outpatient surgery, which is defined as operative procedures and other invasive procedures such as epidural injections for pain management and various scope procedures, such as arthroscopies and colonoscopies.
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant

X. PHARMACY BENEFIT

Precertification (Prior Authorization): Required for certain medications. Contact the Pharmacy Benefit Customer Service number listed in the front of this book for a list of medications that require precertification. If you do not obtain precertification for medications that require precertification, the medications will not be covered.

Information About This Benefit

Contact the Pharmacy Benefit Customer Service number listed in the front of this book to request any of the following:

- A list of covered medications that require precertification;
- A list of covered vaccines;
- An exception to BCBSAZ prescription medication limitations;
- Information on the assigned cost-share Level of a covered medication; or
- Other information about this Pharmacy Benefit.

Your Cost-Share:

In-Network:

Medications Obtained From Retail/Mail Order Pharmacies: You pay a Level 1, 2 or 3 prescription copay for most medications. You pay the greater of the Level 3 copay or 50 percent coinsurance for compounded medications.

Your cost-share is based on the Level to which BCBSAZ has assigned the medication at the time the prescription is filled. **No exceptions will be made regarding the assigned Level of a medication.** BCBSAZ may change the Level of a medication at any time without notice.

Your cost-share is waived for preventive medications and for covered vaccines. BCBSAZ will determine which medications are considered preventive and for which your cost-share is waived. BCBSAZ also determines which vaccines are covered and for which your cost-share is waived.

Your cost-share is waived for the following contraceptive methods when prescribed by your provider and obtained from an in-network pharmacy:

- FDA-approved diaphragms, cervical caps and cervical shields
- FDA-approved emergency contraception for female members of any age
- FDA-approved generic oral, patch, vaginal ring and injectable contraceptives
- FDA-approved brand oral, patch, vaginal ring and injectable contraceptives with no generic equivalent components
- Female condoms
- Sponges and spermicides for female members

Contraceptives must be prescribed for or include the purpose of contraception and not be prescribed solely for some other medical reason to be covered with no member cost-share.

Out-of-Network: You pay your in-network cost-share amount plus the balance bill.

Benefit-Specific Definitions:

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

"PBM" means the independent pharmacy benefit manager that contracts with BCBSAZ to administer the prescription medication benefits covered under this benefit plan.

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

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

You may obtain prescription medications covered under this benefit from retail pharmacies or the in-network mail order pharmacy. Compounded medications are eligible for coverage only when purchased through retail pharmacies.

Covered medications are subject to limitations, including but not limited to, quantity, age, gender, dosage, and frequency of refills. BCBSAZ and/or the PBM determines which medications are subject to limitations. **Medication limitations are subject to change at any time without prior notice.**

The following medical devices are covered under this benefit: diabetic test strips, lancets, diabetic syringes/needles for insulin and spacer devices for asthma medications. Certain vaccines are covered when obtained from in-network retail pharmacies and administered by a certified, licensed pharmacist.

Benefit-Specific Exclusions:

- Abortifascient medications
- Administration of a covered medication
- All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms
- Biologic serums
- Certain categories of injectable medications
- Compounded medications obtained from a mail order pharmacy
- Formula for Eosinophilic Gastrointestinal Disorder
- Medications, devices, equipment and supplies lawfully obtainable without a prescription, except as stated in this benefit plan
- Medical devices, except as stated in this benefit
- Medical Foods
- Medication delivery implants

- Medications designated as clinic packs
- Medications dispensed to a member who is an inpatient in any facility
- Medications for athletic performance
- Medications for lifestyle enhancement
- Medications labeled "Caution - Limited by Federal Law to Investigational Use" or words to that effect and any experimental medications as determined by BCBSAZ and/or the PBM, except as stated in this benefit plan
- Medications obtained from an out-of-network mail order pharmacy
- Medications packaged with one other or multiple other prescription products
- Medications packaged with over-the-counter medications, supplies, medical foods, vitamins or other excluded products
- Medications that exceed BCBSAZ and/or the PBM's limitations, including, but not limited to, quantity, age, gender and refill limits.
- Medications used for any cosmetic purpose, including but not limited to, Tretinoin for members age 26 and older
- Medications used to treat a condition not covered under this plan
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging or name
- Prescription medications dispensed in unit-dose packaging, unless that is the only form in which the medication is available
- Prescription refills for medications that are lost, stolen, spilled, spoiled or damaged
- Medications designed for weight gain or loss, including but not limited to, Xenical® and Meridia®, regardless of the condition for which it is prescribed
- Medications to improve or achieve fertility or treat infertility
- Specialty self-injectble medications
- Transsexual medications

X. PHYSICAL THERAPY (PT) - OCCUPATIONAL THERAPY (OT) - SPEECH THERAPY (ST)

Precertification: Not required.

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

Benefit-Specific Maximum: You have a combined in- and out-of-network maximum of sixty (60) PT, OT, and ST visits per member, per calendar year.

Benefit Description: Benefits are available for physical therapy, occupational therapy and speech therapy services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience, except for limited hospice benefits
- Cognitive therapy
- Computer speech training and therapy programs and devices
- Custodial Care
- Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines
- Physical or occupational therapeutic services performed in a group setting of 2 or more individuals
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Strength training, cardiovascular endurance training, fitness programs, strengthening programs and other services designed primarily to improve or increase strength

Y. PHYSICIAN SERVICES

Precertification: Not required.

Your Cost-Share:

In-Network: You pay in-network deductible and coinsurance for office, home and walk-in clinic visits and for non-preventive physician services provided in locations other than an office, home or walk-in clinic, including but not limited to, inpatient and outpatient facilities. If you receive preventive physician services that are billed separately from inpatient or outpatient facility charges, your cost-share for those services may be waived as described in the *"Preventive Services"* section of this benefit book.

Your cost-share will be waived for the following services, when the purpose of the procedure is contraception as documented by your provider on the claim:

- Professional physician services for FDA-approved sterilization procedures provided to female members, regardless of the location of service.
- Professional physician services for fitting, implantation and/or removal of FDA-approved contraceptive devices in female members provided during a physician office, home or walk-in clinic visit.
- FDA-approved implanted contraceptive devices in female members
- The following FDA-approved prescription hormonal and barrier contraceptive methods and devices for female members: patches, rings, contraceptive injections, diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides

If you receive preventive physician services from an in-network physician, your cost-share may be waived, as described in this benefit section and in the *"Preventive Services"* section of this benefit book. You pay in-network deductible and coinsurance for physician services for sterilization procedures provided to male members.

Allergy injections: The Plan pays 100 percent of the allowed amount for allergy injections received from in-network providers. You pay in-network deductible and coinsurance if an office visit is billed or a serum is mixed.

Out-of-Network: You pay out-of-network deductible and coinsurance for services rendered by an out-of-network physician. If you receive services from a noncontracted provider, you also pay the balance bill.

See the *"Emergency"* section for cost-share for emergency professional services.

Professional services provided by a radiologist or pathologist, including a dermapathologist, are always subject to applicable deductible and coinsurance, even when the services are provided in a physician's office.

Benefit Description: Benefits are available for the following:

- General surgical procedures (including assistance at surgery) provided outside a physician's office. Only certain surgical assistants are eligible providers. Call BCBSAZ customer service at the numbers listed in the front of this book to verify that the surgical assistant chosen by your physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your physician are in-network providers.
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics)
- Inpatient medical visits
- Second surgical opinions
- FDA-approved patches, rings and contraceptive injections for female members
- FDA-approved diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides for female members
- FDA-approved emergency contraception
- Professional physician services for FDA-approved sterilization procedures
- Professional physician services for fitting, implantation and/or removal of FDA-approved contraceptive devices in female members
- FDA-approved implanted contraceptive devices for female members
- Abortifacient medications, including oral medications as described in the BCBSAZ Medical Coverage Guidelines.

Multiple surgical procedures may be performed during a single operative session. In general, covered secondary procedures are reimbursed at reduced levels. Noncontracted providers may balance bill you for secondary, incidental or mutually exclusive procedures, in addition to the primary surgical procedure.

You may receive services in a physician's office that incorporate services or supplies from a provider other than your physician. If those services or supplies are rendered and billed by a provider other than your physician, you will pay the cost-share applicable to the billing provider, in addition to the cost-share for your office visit. Examples of services or supplies from another provider include durable medical equipment from a medical supply company, specialty injectable medications provided by a pharmacy, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.

Z. POST-MASTECTOMY SERVICES

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

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

AA. PREGNANCY, TERMINATION

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

The treating provider certifies in writing the abortion is medically necessary in order to save the life of the mother or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.

Benefits are also available for abortifacient medications, including some oral medications as described in the BCBSAZ Medical Coverage Guidelines.

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

BB. PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER

Precertification: May be required depending on the medication received. A list of medications that require precertification is available online at www.azblue.com or you or your provider may contact BCBSAZ at the numbers listed in the front of this book. This list is subject to change at any time without prior notice. If you fail to obtain precertification for medications that require precertification, the medications will not be covered.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

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

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

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

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

DD. PREVENTIVE SERVICES

Precertification: Not required.

Your Cost-Share:

All preventive services listed in this benefit section, except for mammography, foreign travel immunizations and certain services cross-referenced in other benefit sections, must be received from in-network providers or the services will not be covered. For services listed in this benefit section and cross-referenced in other benefit sections, see the cross-referenced benefit section to determine whether services from out-of-network providers are covered and, if applicable, cost-share for those services from out-of-network providers.

Your cost-share is waived, regardless of the location where services are provided, if:

- You receive services from an in-network provider;
- you receive one of the services listed in the Benefit Description subsection of this Preventive Services section; and
- the procedure code, the diagnosis code or the combination of procedure codes and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive.

Please note: You pay in-network cost-share for services received from in- or out-of-network anesthesiologists, when associated with a colonoscopy screening.

Out-of-Network Mammography Services: Deductible is waived. You pay out-of-network coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Out-of-Network Foreign Travel Immunizations: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

For more information on the foreign travel immunizations covered under this benefit, go to the Medical Coverage Guidelines available at www.azblue.com/member, or call BCBSAZ Customer Service at the number listed in the front of this book.

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

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

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

- Preventive physical examination, i.e. routine physical examination, including the following services when done for screening purposes only:
    - resting electrocardiogram (EKG)
    - lung function test (spirometry)
    - vision and hearing screening (this may include newborn audiological evaluation in the hospital)
    - fecal occult blood test
    - general health laboratory panel (bilirubin, calcium, carbon dioxide, chloride, creatinine, alkaline phosphatase, potassium, total protein, sodium, ALT, SGPT, AST, SGOT, BUN, TSH)
    - thyroid function testing (TSH)
    - complete blood count (CBC)
    - lipid panel (cholesterol panel and triglycerides)
    - fasting glucose (blood sugar)
    - urinalysis
    - blood lead
    - sexually transmitted disease (STD) testing
    - prostate specific antigen (PSA) testing
    - TB testing
- Aspirin prescribed for prevention of cardiovascular disease for men ages 45 to 79 and women ages 55 to 79. See the "Pharmacy Benefit" section.
- Behavioral intervention to promote breast-feeding for women
- Bone density testing for osteoporosis
- Counseling and behavioral interventions to promote sustained weight loss for obese adults
- Counseling (annually) for HIV infection for all sexually active women
- Counseling (annually) on sexually transmitted infections for all sexually active women
- Counseling for female members who are at increased risk for breast cancer about medications to reduce the risk of breast cancer. For female members at increased risk of breast cancer and at low risk of adverse medication effects, coverage of risk-reducing medications, such as tamoxifen or raloxifene
- Counseling for members ages 10-24 regarding minimizing the risk of UV radiation exposure to reduce the risk of skin cancer
- Counseling for tobacco cessation and augmented pregnancy counseling for members who use tobacco
- Counseling on contraceptive methods for all women with reproductive capacity
- FDA-approved contraceptive methods for female members, as prescribed. See the "Family Planning", "Physician Services" and "Pharmacy Benefit" sections.
- FDA-approved sterilization procedures for female members, as prescribed. See the "Family Planning" and "Physician Services" benefit sections.
- Folic acid supplementation prescribed for females. See the "Pharmacy Benefit" section.
- Interventions, including counseling and education, to prevent initiation of tobacco use in school-aged children and adolescents
- Lactation support counseling during pregnancy and/or in the post-partum period
- Mammogram

- Oral fluoride supplementation prescribed for children ages 6 months through 5 years who live in areas where the water service is deficient in fluoride
- Physical therapy or exercise for members age 65 and older living in community dwellings to minimize falls
- Rental or purchase of manual or electric breast pumps and breast pump supplies when obtained from in-network durable medical equipment (DME) providers. See the "Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics" benefit section.
- Repeated antibody testing for unsensitized Rh(D)-negative pregnant women at 24-28 weeks gestation, unless the biological father is known to be Rh(D) negative
- Routine gynecologic exam including Pap test and other cervical cancer screening test
- Routine immunizations and immunizations for foreign travel, as determined by BCBSAZ
- Routine iron supplementation prescribed for asymptomatic children ages 6 months through 12 months who are at increased risk for iron deficiency anemia
- Screening and counseling (annually) for interpersonal and domestic violence
- Screening (annually) for lung cancer with low-dose computed tomography (LDCT) for members age 55-80 with a 30 year or more year history of smoking and who currently smoke or have quit smoking within the past 15 years. Screenings will be discontinued if the member (1) has not smoked for 15 years or more; (2) develops a health problem that limits life expectancy; or (3) is unwilling to have curative lung surgery.
- Screening, counseling and intervention for obesity
- Screening for abdominal aortic aneurysm for men ages 65 to 75 who have ever smoked
- Screening for alcohol misuse and behavioral counseling interventions for pregnant women
- Screening for asymptomatic bacteriuria for pregnant women at 12-16 weeks gestation or at first prenatal visit, if later
- Screening for depression for members age 18 and older
- Screening for gestational diabetes mellitus (GDM) at (1) the first prenatal visit (2) prior to 24 weeks of gestation based upon risk factors for type 2 diabetes, such as obesity, family history of type 2 diabetes or fetal macrosomia during a previous pregnancy; and (3) after 24 weeks of gestation.
- Screening for Hepatitis B virus infection for pregnant women at their first prenatal visit
- Screening for Hepatitis C virus infection for persons at high risk for infection
- Screening for Hepatitis C virus infection for adults born between 1945 and 1965 (one-time screening)
- Screening for iron deficiency anemia for asymptomatic pregnant women
- Screening for major depressive disorders for members ages 12 through 18
- Screenings for newborns as required by Arizona and federal law
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Screening sigmoidoscopy or colonoscopy
- Smoking cessation medications and devices, as prescribed
- Vision screenings for children under age 5
- Vitamin supplementation for members age 65 and older living in community dwellings to minimize falls
- Any other preventive service required by federal or state law to be covered

For information on the foreign travel immunizations covered under this benefit, go to the Medical Coverage Guidelines available at www.azblue.com/member, or call BCBSAZ Customer Service at the number listed in the front of this book.

Benefit-Specific Exclusions:

- Abortifascient medications
- All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.
- Any service or test not specifically listed in this benefit description or in another section of this benefit book, such as chest X-rays, will not be covered when performed for preventive or screening purposes
- Except as stated in this benefit book, preventive services provided by an out-of-network provider.

Services or tests listed under this benefit and provided to a member with a specific diagnosis, signs or symptoms of a condition or disease for which the test is being performed may be covered through another benefit section of this plan. Certain maternity services covered under this benefit are also available through the "Maternity" benefit.

EE. RECONSTRUCTIVE SURGERY AND SERVICES

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

Benefit Description: Benefits are available for reconstructive surgery, which is surgery performed to improve or restore the impaired function of a body part or organ resulting from one of the following:

- Congenital defects;
- Illness and disease;
- Injury and trauma;
- Surgery; **or**
- Therapeutic intervention

Benefit-Specific Exclusion: Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy in accordance with state and federal law.

FF. SKILLED NURSING FACILITY (SNF)

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance. If you receive SNF services at a noncontracted provider, you also pay the balance bill, in addition to applicable deductible and coinsurance.

Benefit-Specific Maximum: You have a combined in- and out-of-network maximum of 240 days per member, per calendar year.

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

Benefit Description: Benefits are available for inpatient skilled nursing facility services provided in a facility licensed to offer skilled nursing services and meeting BCBSAZ's definition of skilled nursing care. Skilled nursing services are provided by and under the supervision of qualified and licensed professionals, such as a licensed practical nurse (L.P.N.) or registered nurse (R.N.) and provided at a level of complexity and sophistication requiring assessment, observation, monitoring and/or teaching or training to achieve the medically desired outcome.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ]

GG. SPECIALTY SELF-INJECTABLE MEDICATIONS

Precertification: Required for all specialty self-injectable medications. If you fail to obtain precertification, these medications will not be covered.

Your Cost-Share: You pay a Level A, B, C or D copay. Copays do not apply to deductibles.

If a member obtains a specialty self-injectable medication from an eligible provider other than a pharmacy contracted with BCBSAZ for the specialty self-injectable medications benefit ("specialty pharmacy"), the medication is excluded from coverage under this benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

Additional Information About Medication Levels

Copays are based on the Level to which BCBSAZ has assigned the medication at the time the prescription is filled. BCBSAZ may change the Level of a medication at any time without notice. Go to www.azblue.com to view a list of contracted specialty pharmacies and the specialty self-injectable medication list. To confirm the status and Level of a particular specialty self-injectable medication, you may also call the BCBSAZ Prescription Benefits Unit at the number listed in the front of this book.

No exceptions will be made concerning the assigned Level of a medication or the copay that will apply, regardless of the medical reasons requiring use of the medication. This means if you are taking a Level B, C or D medication, you pay the applicable copay for that Level even if there is no equivalent medication on a lower Level or you are unable to take a medication on the lower Level for any reason.

The assignment of a medication to any particular Level is not a recommendation on the use of a medication.

Benefit Description: Benefits are available for specialty self- injectable medications obtained from a specialty pharmacy contracted with BCBSAZ. Go to www.azblue.com to view a list of contracted

specialty pharmacies and the specialty self-injectable medication list. To confirm the status and level of a particular specialty self-injectable medication, you may also call the BCBSAZ Prescription Benefits Unit at the number listed in the front of this book. Coverage of specialty self-injectable medications is determined by the Medical Coverage Guidelines and Pharmacy Coverage Guidelines and subject to change without notice.

Specialty self-injectable medications are subject to limitations contained in the Medical Coverage Guidelines and Pharmacy Coverage Guidelines and may change at any time without prior notice.

Benefit-Specific Exclusions:

- All benefit-specific exclusions listed under *"Prescription Medications Obtained from a Retail or Mail Order Pharmacy,"* except for the exclusion for specialty self-injectable medications
- Medications obtained from a pharmacy not specifically contracted with BCBSAZ as a specialty pharmacy

HH. TRANSPLANTS - ORGAN - TISSUE - BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES

Precertification: Required prior to any organ, tissue or bone marrow transplant or stem cell procedure. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

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

If both a donor and a transplant recipient are covered by a BCBSAZ plan or a plan administered by BCBSAZ, the transplant recipient pays the cost-share related to the transplant.

BCBSAZ is contracted with certain facilities to provide covered transplants to BCBSAZ members. Not all such facilities are contracted to provide services related to a covered transplant, such as pre-transplant testing, certain types of chemotherapy and radiation therapy and other services covered under this plan. If you receive pre-transplant testing or other services associated with the transplant from a facility that is not contracted with BCBSAZ or a Host Blue to provide those services, you will pay your out-of-network cost-share, plus the balance bill.

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

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

Benefit Description: The following transplants are eligible for coverage if they meet the Medical Coverage Guidelines:

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

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

- Inpatient and outpatient facility and professional services
- Air and ground transportation of a medical team to and from the site in the contiguous states of the United States to obtain tissue that is subsequently transplanted into a member
- Bone marrow search and procurement of a suitable bone marrow donor when a member is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
- Chemotherapy or radiation therapy associated with transplant procedures
- Harvest and reinfusion of stem cells or bone marrow
- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ. Covered donor expenses include complications and medically necessary follow-up care related to the donation for up to six (6) months post transplant, as long as the recipient's BCBSAZ coverage remains in effect.
- Pre-transplant testing and services

Benefit-Specific Exclusions:

- Expenses related to a noncovered transplant
- Expenses related to donation of an organ to a recipient who is not covered by BCBSAZ
- Transplants that do not meet the Medical Coverage Guidelines

II. TRANSPLANT TRAVEL AND LODGING

Precertification: Not required.

Your Cost-Share: Not applicable.

Benefit Maximum: Benefits are limited to $10,000 per member, per transplant. Covered expenses incurred by a donor, recipient or caregiver accumulate toward the member's $10,000 per transplant maximum.

Benefit-Specific Definition: "Caregiver" is the individual primarily responsible for providing daily care, basic assistance and support to a member or donor who is eligible for transport lodging and reimbursement. Caregivers may perform a wide variety of tasks to assist the member or donor in his

or her daily life, such as preparing meals, assisting with doctors' appointments, giving medications or assisting with personal care and emotional needs.

Benefit Description: Coverage is available for reimbursement of travel and lodging expenses, as listed below, that are incurred by a member receiving a covered transplant, a donor donating for a covered transplant and a caregiver for the donor or recipient member. Total reimbursement will not exceed actual expenses, up to a maximum of $200 per day. The daily maximum is an aggregate amount, not a per person amount, for the member receiving a covered transplant, donor and caregiver.

To qualify for reimbursement, all the following criteria must be met:

- BCBSAZ has precertified the transplant procedure;
- The distance from the member's, donor's or caregiver's residence must be more than seventy-five (75) miles from the transplant facility;
- The member is receiving a covered solid organ, bone marrow or stem cell transplant;
- The member must receive the transplant from a provider contracted with BCBSAZ, a provider contracted with the local Blue Cross and/or Blue Shield plan where services are rendered or a Blue Distinction Centers for Transplants (BDCT) facility;
- The member or donor must be receiving medically necessary pre and post-operative treatments, including without limitation, treatment of complications related to the covered transplant or routine follow-up care for a covered transplant or a transplant that occurred while the member was covered by another insurance plan; **and**
- The expenses are for any of the following:
    - Meal expenses;
    - Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; bus; train or air fare; **and**
    - Room charges from hotels, motels and hostels or apartment rental.

Benefit-Specific Exclusions:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of $200 per day per covered member
- All travel and lodging expenses in excess of the $10,000 per member, per transplant maximum
- Ambulance transportation (ground or air)
- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with noncovered transplant services or any follow-up care, including treatment of complications
- Expenses for travel or lodging related to evaluation, consultation or medical testing to determine if a member is a candidate for transplantation
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Travel and lodging expenses for transplants other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service
- Travel and lodging expenses for members, donors or caregivers when the member, donor or caregiver does not travel more than seventy-five (75) miles for an authorized transplant or transplant related services, including follow-up care and treatment of complications
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement

To request reimbursement of eligible transplant travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to BCBSAZ. The address for claims submission and phone number for requesting claim forms are listed in the BCBSAZ customer service section at the front of this book.

JJ. URGENT CARE

Precertification: Not required.

Your Cost-Share: You pay in-network deductible and coinsurance for services from a provider who is contracted with BCBSAZ to render urgent care services. You pay applicable cost-share if you receive urgent care services from an in-network provider who is not specifically contracted for urgent care services. You pay out-of-network deductible and coinsurance if you receive services from an out-of-network urgent care provider. If you receive services from a noncontracted provider, you also pay the balance bill.

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

Benefit Description: BCBSAZ has contracted with certain free-standing urgent care providers to render these services to its members. These providers are listed in your provider directory and on the BCBSAZ Web site at www.azblue.com under "Urgent Care Centers."

Please be aware that the BCBSAZ network includes some providers, such as hospitals, that offer urgent care services, but are not specifically contracted with BCBSAZ as urgent care providers. No matter what the circumstances, if you obtain urgent care services at a hospital or a hospital's on-site urgent care department, you will be responsible for the applicable emergency room access fee, plus in-network deductible and coinsurance.

KK. VISION EXAMS (ROUTINE)

Precertification: Not required.

Your Cost-Share:

For Members Under Age 5: Applicable deductible, coinsurance and copays are waived for services from an in-network provider. For services from an out-of-network vision care provider, you pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

For Members Age 5 and Older: You pay applicable deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

If a medical condition is identified during your routine vision exam, you will be responsible for additional cost-sharing.

Benefit-Specific Definition: A "routine vision exam" is an exam generally performed to determine the need for corrective lenses.

Benefit Description: Benefits are available for routine vision exams. Routine vision exam services do not have to meet the medical necessity requirement.

Benefit-Specific Exclusions:

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

WHAT IS NOT COVERED

NOTWITHSTANDING ANY OTHER PROVISION IN THIS PLAN, NO BENEFITS WILL BE PAID FOR EXPENSES ASSOCIATED WITH THE FOLLOWING:

Abortions, except as stated in this plan

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

Acupuncture

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

Bariatric Surgeries excluded by the BCBSAZ Medical Coverage Guidelines

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

Biofeedback and hypnotherapy, except as may be available through the BSA

Blood Administration for the purpose of general improvement in physical condition

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

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

Care required by state or federal 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. Inpatient and outpatient facility charges for services provided by residential treatment facilities are not covered except for certain very limited situations based upon BCBSAZ medical necessity criteria. All other inpatient and outpatient services provided by residential treatment facilities are not covered.

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

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

Complications of Noncovered Services – Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under this plan.

Computer Speech Training, Therapy Programs and Devices

Consumable Medical Supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as stated in this plan

Cosmetic Services and any Related Complications – Surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy.

Cosmetics and health and beauty aids

Counseling – Counseling and behavioral modification services, except as stated in this plan

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

Custodial Care

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

Dietary and Nutritional Supplements – All dietary, caloric and nutritional supplements, such as specialized formulas for infants, children or adults or other special foods or diets, even if prescribed, except as stated in this plan

Expenses for services that exceed benefit limitations

Expenses incurred for or in connection with an injury or illness, arising out of, or in the course of, any employment for wage or profit

Experimental or Investigational Services

Fees - Associated with the collection or donation of blood or blood products

Fees – Fees other than for medically appropriate, in-person, direct member services, except as stated in this plan

Fees – Fees for concierge medicine services

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, except arch supports may be covered when medically necessary for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

Foot Care – Services for foot care, including trimming of nails or treatment of corns and calluses, except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

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

Genetic and Chromosomal Testing, Screening and Therapy – Genetic and chromosomal testing, screening and therapy for an individual who is asymptomatic, unaffected or not displaying signs or symptoms of a disorder for which the test, screening or therapy is performed

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

Growth Hormone – Growth hormone, except as specified in the Medical Coverage Guidelines. Growth hormone to treat Idiopathic Short Stature (ISS) is expressly excluded.

Hearing Services and Devices, except as stated in this plan

Inpatient or Outpatient Long Term Care

Lifestyle education and management services, except as stated in this plan

Lodging and Meals – Lodging and meals, except as stated in this plan

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

Manipulation of the Spine Under Anesthesia

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

Massage Therapy – Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines

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

Medications – Medications which are:

- Not FDA approved
- Not required by the FDA to be obtained with a prescription, except as stated in this plan
- Not used in accordance with the Medical Coverage Guidelines or Pharmacy Coverage Guidelines
- Used to treat a condition not covered by BCBSAZ
- Off-label, unlabeled and orphan medications, except as stated in this plan

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

Membership Costs or Fees associated with health clubs and weight loss programs.

Neurofeedback

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

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

Over-the-Counter Items – Medications, devices, equipment and supplies that are lawfully obtainable without a prescription, except as stated in this plan

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

Phase 3 Cardiac Rehabilitation

Private Duty Nursing

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

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

Respite Care, except as stated in this plan

Reversal of Sterilization

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

Sensory Integration, LOVAAS Therapy and Music Therapy

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

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 Weight Loss and Gain, except as stated in this plan

Services from a Family Member – Services delivered by an eligible provider who is a member of your immediate family or a member of a Dependent's immediate family. "Immediate family" members are: parents, siblings, children, stepparents, stepchildren, spouses, domestic partners, grandparents, grandchildren and any of the preceding individuals related to the member by marriage. When a provider is also the covered person, services rendered by that provider for himself or herself are also excluded from coverage

Services from Ineligible Providers

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

Services Paid for By Other Organizations -- Services customarily paid for by an employer, such as worksite or ergonomic evaluations; the government; a school; biotechnical, pharmaceutical or medical device industry sources; or other individuals and organizations

Services Prior to Member's Coverage Effective Date

Services Provided After the Member's Coverage Termination Date, except as stated in this plan

Services Related to or Associated with Noncovered Services

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

Sexual Dysfunction – Services for sexual dysfunction, regardless of the cause

Smoking Cessation, except as stated in this plan

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, except as stated in this plan

Telemedicine Services, except as stated in this plan

Telephonic and Electronic Consultations -- Telephonic and electronic consultations, except as stated in this plan

Therapy Services, except as stated in this plan

Therapy to Improve General Physical Condition including, but not limited to, inpatient and outpatient routine long term care

Training and Education – Training and education, except as stated in this plan

Transportation – Transport services and travel expenses, except as stated in this plan

Transsexual Treatment, Surgery, Medications and Related Services

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; vision examinations for fitting of eyeglasses and contact lenses, except as stated in this plan

Vitamins – All vitamins, minerals and trace elements that are lawfully obtainable without a prescription, except as stated in this plan

Workers' Compensation – Illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election

CLAIMS INFORMATION

Filing Claims

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

Time Limit for Claim Filing

A complete claim, as described below, must be filed within one year from the date of service. Any claim not filed within one year of the date of service may be denied.

Claim Forms

Claim forms are available from BCBSAZ. Go to the "Forms" section of the "Member" area of www.azblue.com or call the Supply Line telephone number listed at the front of this book.

Complete Claims

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

- Billed charges
- Date of service(s)
- Diagnosis code
- Group number
- Member ID number
- Member name
- Name of provider
- Patient name
- Patient's birth date
- Procedure code
- Provider ID number
- Signature of provider who rendered services

BCBSAZ may reject claims that are filed without complete information needed for processing. If BCBSAZ rejects a submitted claim due to lack of information, BCBSAZ will notify you or the provider who submitted the claim. Lack of complete information may also delay processing.

Medical Records and Other Information Needed to Process a Claim

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

Explanation of Benefits (EOB) Form

After your claim is processed, BCBSAZ will send you an EOB. The CBA or BSA will send you an EOB for any claim for chiropractic or behavioral health benefits, as applicable.

Your BCBSAZ EOBs also will be available through the member portal on www.azblue.com. An EOB shows services billed, whether the services are covered or not covered, the allowed amount and the application of cost-sharing amounts. BCBSAZ, the CBA or the BSA will also send your in-network provider the information that appears on your EOB. BCBSAZ and the CBA do not send EOBs to out-of-network providers. Out-of-network providers do not receive any written information on how much BCBSAZ or the CBA paid on a claim or the reasons for how the claim processed. Save the EOB for your personal records. BCBSAZ, the CBA or the BSA may charge a fee for duplication of claims records. Carefully review your EOB for any discrepancies or inconsistencies with the amounts your provider actually collects from you or bills to you.

Monthly Statement

Some EOBs may be consolidated and sent to you in the form of a monthly statement rather than single EOBs.

Concurrent Care Decisions

BCBSAZ may require that your provider submit a plan of care. Based on that plan, BCBSAZ may precertify a certain number of visits or services over a certain period of time. You may request precertification for additional periods of care as long as your request is made at least seventy-two (72) hours prior to the expiration of an existing plan of care. BCBSAZ will make a determination as soon as possible in accordance with medical exigencies, but no later than seventy-two (72) hours after receipt of the request. If that precertification is denied, you may appeal that denial in the same way you appeal any other coverage denial.

Notice of Determination

If your claim is filed properly and your claim is then denied in whole or in part, you will receive notice of an adverse benefit determination that will:

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

Pharmacy Prescriptions; Submission of Claims by Members

When you submit a prescription to either a retail or mail order pharmacy, the prescription is not considered to be a claim. If you have any concerns about fulfillment of the prescription, you must submit a claim to BCBSAZ for the prescription. Send BCBSAZ a claim in the following circumstances:

- The pharmacy tells you that you are not eligible for coverage
- Coverage for the prescription was denied in whole or in part
- You feel that you paid the wrong copay or other cost-sharing amount for the prescription
- You were required to pay other amounts you feel you are not required to pay
- Other dispute or discrepancy regarding your prescription medication coverage

If the pharmacy tells you that you are not eligible for coverage and you are unable to purchase a temporary supply of medication that is needed immediately, please contact BCBSAZ member services immediately by calling the number on the back of your identification card.

Time Period for Claim Decisions:

Post-Service Claims

Within thirty (30) days of receiving your claim for a service that was already rendered, BCBSAZ will send you an Explanation of Benefits (EOB) adjudicating the claim, or a notice that BCBSAZ has requested records needed to make a decision on your claim.

If BCBSAZ cannot make a decision on your claim within thirty (30) days, BCBSAZ may extend the initial processing time by fifteen (15) days by notifying you, within the initial 30-day period, of the need for an extension and the date by which a determination can be expected. If the extension is necessary to obtain additional information, the extension notice will describe the information needed. You or your provider will have at least forty-five (45) days to submit the information.

Pre-Service Claims

When you request coverage for a service that has not yet been rendered (precertification), BCBSAZ will make a precertification decision within a reasonable time period considering the medical circumstances, but not later than ten (10) business days from receipt of the precertification request.

If BCBSAZ requires more time to make a precertification decision, BCBSAZ may extend the time by an additional fifteen (15) days by notifying you, within the initial 10-day period of need for an extension and the date by which a determination can be expected. If the extension is necessary to obtain additional information, the extension notice will describe the information needed. You and your provider will have at least forty-five (45) days to submit the information.

Urgent Claims

Federal law defines an "urgent" medical situation as the following: (a) one in which application of the "non-urgent" time periods could seriously jeopardize the member's life, health or ability to regain maximum function or (b) one which, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

When you request coverage for an urgent care claim, a determination will be made as soon as possible in accordance with medical exigencies, but no later than twenty-four (24) hours after receipt of the request.

PLAN ADMINISTRATION

Coordination of Benefits

The Group Master Contract between the group and BCBSAZ contains a coordination of benefits provision that prevents duplication of payments. Under the provision, if you are eligible for benefits under any other group health insurance, the combined benefit payments from all coverages will not exceed 100 percent of the billed charges. In addition, BCBSAZ's payment will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If your other group health insurance does not include a coordination of benefits provision, that coverage pays first. If your other group health insurance provides for coordination of benefits, the following rules will be used to determine which coverage will pay first:

- If the person is an inpatient on the day this benefit plan becomes effective and benefits are payable under the person's prior health care coverage for the inpatient stay, the prior health care coverage pays first.
- If the person who received care is covered as an active employee under one benefit plan and as a dependent under another, the employee coverage pays first.
- If the person who receives care is covered as an active employee under one benefit plan and as an inactive employee under another, the coverage through active employment pays first.
- If the person who receives care is a dependent child, then the plan benefits of the parent whose birthday occurred earlier in a calendar year shall cover the child first.
- If both parents have the same birthday, the benefits of the plan that covered a parent longer shall cover a dependent child first.
- If one of the plans determines the order of benefits based upon the gender of a parent and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rule shall determine the order of benefits.
- If the dependent child's parents are legally separated or divorced, the following applies:
    - If a court decree specifies the parent who is financially responsible for the child's health care expenses, that parent's coverage pays first.
    - If there is no applicable court decree, the custodial parent's coverage pays first. If the custodial parent has remarried, the stepparent's coverage pays second. The non-custodial parent's coverage pays last.
    - If the parents have joint custody, the plan benefits of the parent whose birthday occurred earlier in a calendar year pays first.

When none of the above applies, the coverage you have had for the longest continuous period of time pays first (see *"Non-Duplication of Benefits"*).

BCBSAZ does not coordinate benefits for services covered by the retail and mail order pharmacy benefit. For this benefit, BCBSAZ will pay primary, without regard to the member's other coverage.

Non-Duplication of Benefits

If services are covered under this benefit plan and one or more other group benefit plans that are issued or administered by BCBSAZ, the rules described above in *"Coordination of Benefits"* will be used to determine which coverage pays first. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If services are covered under this benefit plan and one or more BCBSAZ individual contracts, benefits will be paid first under the individual contract. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed 100 percent of the amount BCBSAZ would have paid if you had no other coverage. BCBSAZ does not coordinate benefits with non-group coverage provided by an insurance plan other than BCBSAZ.

BCBSAZ does not coordinate benefits for services covered by the retail and mail order pharmacy benefit. For this benefit, BCBSAZ will pay primary, without regard to the member's other coverage.

Definitions Related to Eligibility and Administration

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

- **"Disabled Dependent Child"** is a child who has reached age 26 and who meets criteria for coverage under this plan described in "Eligibility Requirements," below.

- **"Employee/Retiree"** refers to the person eligible for this benefit plan because of his/her employment relationship or former employment relationship or affiliation to the group. An employee is also the contract holder under this plan.

- **"Group"** refers to the employer or other entity to which a Group Master Contract is issued and under which the contract holder and dependents become entitled to health coverage.

- **"Group Master Contract"** refers to the agreement between the group and BCBSAZ. The Group Master Contract controls the administration of the group coverage and is on file with the group. The coverage described in this book will terminate when the Group Master Contract terminates. The group is responsible to notify members if the group terminates the Group Master Contract or if the Group Master Contract is terminated for non-payment of premiums. BCBSAZ will notify members if the Group Master Contract is terminated for any other reason.

- **"Open Enrollment"** is an annual period during which the contract holder and dependents are eligible to enroll for coverage or change benefit plan options. The benefit plan administrator will notify the contract holder if the group has established such an open enrollment period. Contract holders and dependents can change benefit plans only during an open enrollment period, except as set forth in this benefit book.

Eligibility Requirements

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

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

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

  - Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;
  - Is continuously incapable of self-sustaining employment because of mental or physical disability on the date the dependent reaches age 26; **and**
  - Is dependent on the contract holder for maintenance and support, as determined by BCBSAZ criteria.

  Medical reports, acceptable to BCBSAZ, must substantiate the incapacity and must be submitted by the contract holder within thirty-one (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 review by BCBSAZ.

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

- **Retiree** – Please see your benefit plan administrator to determine eligibility requirements for a retiree and his/her eligible dependents.

Effective Date of Coverage

- **Contract Holder** – A contract holder's effective date of coverage will be either the date the contract holder becomes eligible to enroll or the first billing date after the contract holder becomes eligible to enroll as determined by the Group, as long as the contract holder completes the application process within thirty-one (31) days of becoming eligible. See your SBC for contract holder effective date.

- **Dependent** – Dependent coverage is available only if an eligible contract holder has enrolled for coverage. Eligible dependents will have the same effective date as the contract holder if they are included on the application at the time the contract holder first enrolls. If the contract holder and/or dependents do not enroll when first eligible, the contract holder and/or dependents may only apply for coverage at the group's annual open enrollment period, except as stated in *"Special Enrollment Provisions"* or if court-ordered. The effective date of coverage for an application made during an open enrollment period is the group's anniversary date following that open enrollment period.

- **Spouse** – The effective date for a new spouse will be the date of marriage, as long as the contract holder completes an application within thirty-one (31) days of that date; otherwise, the spouse may not enroll until the next open enrollment period, unless he or she qualifies under *"Special Enrollment Provisions."*

- **Newborn/Adopted Child/Child Placed for Adoption** – A child is eligible for coverage under this benefit plan following birth or adoption, so long as: (1) the parent or guardian covered under this benefit plan remains eligible for coverage; and (2) the parent or guardian covered under this benefit plan submits the appropriate enrollment documentation to the group to enroll the child for coverage within thirty-one (31) days following the date of birth, adoption or placement for adoption. No claims will be paid until the child is enrolled in this benefit plan and BCBSAZ receives notification from the group that indicates the child has been enrolled in this benefit plan. If the parent or guardian covered under this benefit plan does not enroll the child within thirty-one (31) days following the date of birth, adoption or placement for adoption, the parent or guardian covered under this benefit plan must wait until the next open enrollment period to enroll the child.

  Contact Membership Services at the number listed in the front of this benefit book to receive a BCBSAZ adoption packet.

- **Other Children** – The effective date for a dependent child who is not a newborn child, adopted child or a child placed for adoption (as described above) shall be the date the child becomes an eligible dependent, as long as the contract holder completes an application to add the child within thirty-one (31) days of that date. If an application is not completed within thirty-one (31) days, the child may not enroll until the next open enrollment period, unless the child qualifies under *"Special Enrollment Provisions."*

- **Retiree** – Please see your benefit plan administrator to determine effective dates of coverage for a retiree and his/her eligible dependents.

Loss of Eligibility

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

Some groups have up to thirty-one (31) days to notify BCBSAZ that a contract holder or dependent has become ineligible. Until BCBSAZ receives notice and processes the termination of eligibility, BCBSAZ may quote benefits, give precertification or pay claims that ultimately will be recouped from members or providers, if it is later determined the member was ineligible on the date services were received. Such benefit quotations or precertifications become null and void, regardless of whether the group has notified the contract holder that eligibility terminated.

Contract holder eligibility ends on the following days:

- The end of the month in which the contract holder was entitled to receive compensation from the group, regardless of the date such compensation is actually paid.

- The end of the month in which an approved leave of absence expires, if the contract holder fails to return to active employment.

- The date of death.

- The end of the month in which the Group and/or Contractholder fails to pay any amounts due and any grace period available under Arizona law is exhausted.

Dependent eligibility ends on the following days:

- For a dependent spouse and any children of that spouse who are not the birth or adopted children of the contract holder, the end of the month during which the divorce decree becomes final.
- The end of the month in which the child turns age 26, if the child is not a disabled dependent child.
- The end of the month in which the disability or dependency ceases for a disabled dependent child over age 26.
- The end of the month in which a child covered by a medical support order is no longer eligible under the court order or administrative order.
- The end of the month in which the contract holder's death occurs or as might otherwise be provided in the Group Master Contract.
- The surviving dependent spouse, and any eligible dependent children of any employee killed in the line of duty or in the course and scope of City Employment are covered until the end of the month in which the spouse remarries or attains Medicare eligibility; or to the end of the month in which the eligible dependent child turns age 26.

Retiree eligibility:

Please see your benefit plan administrator for information regarding loss of retiree's eligibility and termination dates of coverage and the dates for a retiree's dependents.

Date of Termination of Coverage

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

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

Contract holders' and/or dependents' coverage ends no later than the date the Group Master Contract terminates.

When a contract holder's coverage terminates, coverage for all dependents also terminates. Members may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Members may also be eligible for individual portability coverage or may apply to BCBSAZ for an individual conversion contract.

BCBSAZ will issue a certificate of creditable coverage upon receipt of notice of the contract holder's termination. Members may request a certificate of creditable coverage at anytime up to twenty-four (24) months after termination of coverage.

Special Enrollment Provisions

A special enrollment period is available for the following qualifying events, as applicable to the individual seeking coverage when such individual requests coverage under this benefit plan by completing an application within thirty-one (31) days of the loss of other coverage:

- A person loses minimum essential coverage, as that term is defined in applicable law
- A person gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption
- The death of the covered employee
- A person has coverage through his or her spouse and the spouse dies
- A person has coverage through his or her spouse and a divorce or legal separation occurs

- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of the covered employee's employment
- The divorce or legal separation of the covered employee from the covered employee's spouse
- The covered employee becomes entitled to Medicare
- A dependent child ceases to be a dependent child under the generally applicable requirement of the plan
- A proceeding in a case under title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time
- Exhaustion of a person's COBRA coverage;
- Termination of the employer's contribution toward coverage
- Termination of the covered employee's eligibility for coverage
- The covered employee's employer terminates coverage
- The covered employee is employed by an employer that offers multiple health benefit plans and the covered employee elects a different plan during open enrollment
- A person loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- A person received notice that he or she is eligible for a Medicaid or CHIP premium assistance subsidy
- A person exhausts a lifetime maximum on all benefits under the other policy or plan (qualifying event is denial of claim due to operation of a lifetime maximum;
- A person no longer lives, resides or works in the other plan's service area and no other benefit plan is available to that person
- Any other special enrollment rights available under applicable state or federal law

Leave of Absence

If a Contract holder takes a leave of absence, the group may continue coverage for the Contract holder and covered dependents for up to the length of the approved absence, subject to payment of applicable premiums.

BCBSAZ will also continue coverage for members during any leave of absence the group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 and any amendments or successor provisions. If the Contract holder returns to active employment by the end of the leave of absence period, coverage under this benefit plan will continue for the Contract holder and covered dependents, so long as the group maintains coverage with BCBSAZ. If not, the Contract holder will cease to be eligible and coverage for the Contract holder and dependent(s) will terminate as described in *"Termination of Coverage."*

Medical Support Orders

Coverage is available to a child of the contract holder in accordance with any court order or administrative order issued by a court of competent jurisdiction, that requires the contract holder to provide health benefits coverage for such child.

The order must clearly specify the name of the contract holder, the name and birth date of each child covered by the order and the time period to which the order applies.

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

Termination of Coverage

Benefits After Termination

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

Continuation of Coverage

Under federal law it is the group's responsibility, as plan administrator, to inform employees and dependents of the availability, terms and conditions of continuation of coverage available under COBRA.

COBRA requires most employers who have twenty or more employees and sponsor a group health plan to offer employees and their covered dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Continuation of coverage is available when an employee is absent from employment by reason of service in the uniformed services, as defined by applicable federal law. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Disability Extension of Benefits

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

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

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

If your group discontinues coverage, you are eligible for this extension of benefits whether covered as an active employee, the dependent of an active employee or a qualified COBRA beneficiary on the date the group discontinues coverage through BCBSAZ.

If you are eligible for an extension of benefits because of an individual termination as described above and you elect continuation coverage under COBRA, the extension of benefits shall run concurrently with your continuation coverage under COBRA, until the 12-month extension of benefits period is exhausted. Because these provisions run concurrently, please contact your employer before making any changes to or terminating your COBRA continuation coverage.

Individual Portability Coverage

You are eligible for certain individual coverage with no medical underwriting or pre-existing condition waiting periods if you meet **all** of the following criteria:

- You have eighteen (18) months of prior continuous creditable coverage; the most recent coverage must be with a group, government or church plan, **and**
- You are no longer eligible for a group plan, Medicare or Medicaid, **and**
- Coverage was not terminated for non-payment of premium or fraud, **and**
- You elected and exhausted COBRA continuation coverage (or other similar coverage) if this coverage was available to you, **and**
- You apply for individual portability coverage within sixty-three (63) days of the date your group (or COBRA) coverage ends.

Please contact BCBSAZ for information on individual portability coverage.

Transfer Coverage

Each Blue Cross and Blue Shield (BCBS) plan is required to offer a transfer policy to members of other BCBS plans who are under age 65.

If you cease to be a member under this benefit plan (for any reason other than the group changing insurance plans) and you move to an area served by another Blue Cross and/or Blue Shield plan, you may be eligible to enroll for transfer coverage with the BCBS plan serving your new address.

Transfer coverage available to you from the other BCBS plan may be very different from the coverage under this plan.

If you do not wish to enroll in the transfer coverage, you may be eligible for other policies issued by other BCBS plans.

Benefit-Specific Eligibility

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

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

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

GENERAL PROVISIONS

Appeal and Grievance Process

Members may participate in BCBSAZ's appeals and grievances processes, which are described in detail in the Health Coverage Appeal Information Packet, a separate document provided to you. You may ask BCBSAZ for another copy of the Health Coverage Appeal Information Packet at any time by submitting a request through www.azblue.com or by calling the BCBSAZ Supply Line telephone number listed in the front of this book.

You do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ. To appeal a denial of precertification for urgently needed services you have not yet received, please call the BCBSAZ Precertification Denial Appeals telephone number listed in the front of this book.

Billing Limitations and Exceptions

When there is another source of payment such as a liability insurer, in-network providers may be entitled to collect any difference between the allowed amount and the provider's billed charges from the other source or from proceeds received from the other source, pursuant to A.R.S. § 33-931.

A.R.S. § 33-931 may give providers medical lien rights independent of this benefit plan or any contract with BCBSAZ. BCBSAZ is not a party to any collection dispute that may arise under the provisions of A.R.S. § 33-931.

Blue Cross and Blue Shield Association

You hereby expressly acknowledge and agree to the following:

i. This benefit plan constitutes a contract between the group and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSAZ to use the Blue Cross and/or Blue Shield service marks in the State of Arizona;
ii. BCBSAZ is not contracting as the agent of the Association;
iii. In accepting the benefits of this plan, you are not relying on any representations by the Association or any other Blue Cross or Blue Shield plan, other than BCBSAZ; **and**
iv. You will not seek to hold the Association or any Blue Cross and Blue Shield plan other than BCBSAZ, accountable or liable for BCBSAZ's obligations herein.

Broker Commissions

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

Claim Editing Procedures

In order to process claims accurately, BCBSAZ uses a computer system to verify benefits, eligibility, claims accuracy and compliance with BCBSAZ coding guidelines and the Medical Coverage Guidelines. BCBSAZ uses claims coding and editing logic to process professional and outpatient facility claims for surgery, laboratory, radiology, maternity and dental services. This system logic is designed to identify the following: procedure unbundling (billing multiple procedure codes to represent a procedure that can be described with a more comprehensive code), separate billing for included (incidental) services, procedures not usually performed together (mutually exclusive) procedures, correct use of coding guidelines, member's age and sex edits. The system logic does not audit the diagnosis code to change or modify the intensity of service of office visit (evaluation and management) codes. BCBSAZ periodically updates its computer system claim edits.

Confidentiality and Release of Information

BCBSAZ takes confidentiality very seriously. We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with state and federal law. If you wish to authorize someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from www.azblue.com or call BCBSAZ customer service and request a hard copy of the CIRF form.

Court or Administrative Orders Concerning Dependent Children

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

Access to Information Concerning Dependent Children

BCBSAZ is not a party to domestic disputes. Parental disputes over dependent coverage and information must be resolved between the parents of the dependent child. Under Arizona law, both parents have equal rights of access to information about their children, unless there is a court order denying such access. Absent a copy of such order and subject to the confidentiality provisions described above, BCBSAZ provides equal parental access to information.

Discretionary Authority

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

Provider Treatment Decisions and Disclaimer of Liability

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

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

Lawsuits against BCBSAZ

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

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

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

Failure to comply with these provisions may result in dismissal of the lawsuit.

A member must complete all applicable levels of appeal before bringing a lawsuit other than a suit filed pursuant to the Health Care Insurer Liability Act. Failure to complete the mandatory levels of the appeal process may result in dismissal of the lawsuit for failure to exhaust BCBSAZ's administrative remedies.

By providing this notice BCBSAZ does not waive, but expressly reserves all applicable defenses available under Arizona and federal law.

Legal Action and Applicable Law

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

This benefit book and the contract between BCBSAZ and the sponsor of your group health plan were issued in Arizona to a group headquartered in Arizona. The only state law governing the benefit book and the contract is the law of the state of Arizona. This benefit plan may not provide all benefits required by other state laws.

Jurisdiction and Venue

Maricopa County, Arizona shall be the site of jurisdiction and venue for any legal action or other proceeding that arises out of or relates to the contract or this benefit plan.

Lawsuits by BCBSAZ

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

Non-Assignability of Benefits

The benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against BCBSAZ and imposes no duty or obligation on BCBSAZ. BCBSAZ will not honor any such purported sale, assignment, pledge, transfer or grant.

Medicaid Reimbursement

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

Member Notices and Communications

BCBSAZ sends notices and other communications to members by U.S. mail to the last address on file with BCBSAZ Membership Services. BCBSAZ may also elect to send some notices and communications electronically if the member has consented to electronic receipt. Notice is deemed complete when sent to the member's last address of record, as follows: (1) on delivery, if hand-delivered; (2) if mailed, on the earlier of the day actually received by the member or 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.

Payments Made in Error

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

Plan Amendment

There is no guarantee of continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted or changed upon notice to the group and/or contract holder or as required to comply with state or federal laws. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available. Please review and retain this book, any replacement books, SBCs, all riders and amendments and other communications concerning your coverage.

Retroactive Changes

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

Prescription Medication Rebates and Medication Level Assignments

BCBSAZ enters into contracts with pharmaceutical manufacturers to receive rebate payments based on the volume and/or market share of pharmaceutical products utilized by BCBSAZ subscribers. These rebate contracts are subject to renegotiation and/or termination from time to time at BCBSAZ's sole discretion. BCBSAZ's rebate contracts with pharmaceutical manufacturers generally work as follows: BCBSAZ submits data regarding utilization of specific medication(s) to the pharmaceutical manufacturer. The pharmaceutical manufacturer compares the data to the utilization level and/or market share required by the applicable rebate contract. If the utilization and/or market share meets the requirements of the rebate contract, the manufacturer issues a rebate payment to BCBSAZ after receipt of the data. As utilization and/or market share increases, the amount of the rebate payable to BCBSAZ may increase.

Rebates may be paid on medications that are covered under the pharmacy benefits of this benefit plan. The BCBSAZ Pharmacy and Therapeutics (P&T) Committee decides which medications to place on which levels of the tiered pharmacy benefit. The P&T Committee is comprised of pharmacists, BCBSAZ employees and other members as needed. The community physician members of the P&T Committee are not informed of potential rebate contracts or rebate payments when deciding which medications to place on certain levels. Certain BCBSAZ employees are aware of the potential rebate contracts or rebate payments. The P&T Committee decisions are not binding and can be overridden by BCBSAZ.

The rebates BCBSAZ receives are not reimbursable to you. Your employer receives either: (a) a credit against administrative costs/fees or (b) the prescription medication rebate dollar amount attributable to your employer group.

Rebates received by BCBSAZ may result in the overall cost of a particular medication falling below the amount you pay for such medication pursuant to the coverage described in this benefit plan. Other discount programs offered by a pharmacy may result in members of the public paying a lower cost for some medications than you pay under this benefit plan.

Provider Contractual Arrangements

The BCBSAZ allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors such as type and location of provider and other relevant information. For that reason, BCBSAZ network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate.

Release of Records

Subject to Arizona or federal law, the member agrees that BCBSAZ may obtain, from any provider, insurance company or third party, all records or information relating to the member's health, condition, treatment, prior health insurance claims or health benefit program.

Rescission of Coverage

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

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

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

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. In-network providers generally cannot charge you for providing BCBSAZ with health records needed to process claims, grievances or appeals. Noncontracted providers have no contractual obligation to provide records to BCBSAZ free of charge. If you receive services from a noncontracted provider who charges for record preparation, costs or copies, you will need to make arrangements with your provider to obtain any records required by BCBSAZ and pay any applicable fees.

Statement of ERISA Rights

(Does Not Apply to Government Plans, Church Plans or Other Non-ERISA Qualified Plans)

As a member of a group health insurance benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

For purposes of ERISA, your employer is the "Plan Administrator." BCBSAZ is not the Plan Administrator.

ERISA provides that all members shall be entitled to:

- **Receive information about your plan and benefits**

  Under ERISA, you are entitled to examine, without charge, at the Plan Administrator's office and other locations, such as worksites and union halls, all documents governing the Plan that are available from the Plan Administrator, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Upon written request to the Plan Administrator, you may obtain copies of the Plan documents, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may charge you for the copies.

- **Continue group health plan coverage**

  COBRA is the abbreviation for a federal law that regulates continuation of health care coverage for you, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Unless you have an agreement with your employer to pay your COBRA premiums, you or your dependents will be responsible for full payment of the premium to continue coverage under your group plan. Review your benefit book and talk to your benefits administrator about your COBRA continuation coverage rights.

- **Receive credit for pre-existing condition waiting periods**

  If you have creditable coverage from one health plan, you may receive credit toward meeting the pre-existing condition waiting period of another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ends. You must request such a certificate before losing coverage or within 24 months of losing your coverage.

  Without evidence of creditable coverage, you may be subject to a pre-existing condition waiting period of 11 months from your effective date (or 18 months, if you are a late enrollee in your group plan).

- **Prudent actions by plan fiduciaries**

  In addition to creating certain rights for group members, ERISA also imposes certain duties on the "plan fiduciaries," those responsible for administration of the health plan. The plan fiduciaries have a duty to operate the plan prudently and in the interest of you and other members.

- **Enforce your rights**

  No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

  If your claim for a benefit is denied in whole or in part, you have a right to know why it was denied, obtain copies of documents related to the decision (at no charge) and appeal any denial, all within the time periods required by ERISA.

  Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with your Questions**

  If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Third-Party Beneficiaries

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

Your Right to Information

You have the right to inspect and copy your information and records maintained by BCBSAZ, with some limited exceptions required by law. This right is described in the Notice of Privacy Practices provided to you at the time of enrollment and available by request from BCBSAZ. If you choose to review your medical records in person, BCBSAZ will require a reasonable amount of time to research and retrieve the records before scheduling a time with you to review the records.

Subrogation

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") that provides its employees and their dependents ("Participants") with health care coverage.

BCBSAZ performs claims administration for the Plan and now also provides subrogation recovery services for the Plan as described in this section.

Here is the way subrogation works. Sometimes you and/or your dependent ("you") require hospital and/or medical services due to an injury in an accident or due to a condition caused by another person's negligence. In such cases, the person causing the accident ("third party") is responsible for payment of your hospital and medical expenses. The Plan, who pays for your covered hospital and medical services, has the right to recover these payments from the third party or from you if you have recovered from the third party. When the Plan exercises its rights to be reimbursed, the process is known as subrogation, recovery and/or reimbursement ("subrogation").

During the subrogation process, BCBSAZ, on behalf of the Plan, will continue to pay your covered hospital and medical services on behalf of the Plan just as it always has. However, if a third party is legally obligated to pay for your expenses, the Plan will then exercise its rights to be reimbursed for 100 percent of what the Plan paid without any reduction for attorneys' fees and/or court costs and regardless of whether you were made whole. In addition, the Plan has first priority from any judgment, payment or settlement.

The Plan's rights apply to any settlement of a claim regardless of whether anyone has started litigation. Any right a Participant might have to be "made whole",(i.e., to be fully compensated for his/her injuries prior to any right the Plan has to recover its cost) is superseded by the Plan's subrogation rights. The Plan may subrogate against all money that you or anyone recovers regardless of the source of the money and regardless of where the money is located and/or regardless of how it is held. The Plan will also have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of recovery or settlement.

You must promptly execute and deliver any documents relating to settlement of claims, settlement negotiations or litigation when the Plan asks you to so the Plan can exercise its subrogation rights. Also, you or your legal representative must (1) promptly notify the Plan in writing of any settlement negotiations before you enter into any settlement agreement, (2) disclose to the Plan any amount recovered from any person or entity that may be liable and (3) not make any distributions of settlement or judgment proceeds without the Plan's prior written consent. No waiver, release of liability or other documents executed by you without such written notice to the Plan shall be binding upon the Plan.

City of Chandler
HSA White Medical Option Benefit Plan

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") to provide its employees with health care coverage. The Plan is established by your employer and is maintained pursuant to a written document called a Plan Document.

Your employer has contracted with Blue Cross Blue Shield of Arizona ("BCBSAZ") to provide certain administrative claims processing and utilization management services for this PPO benefit plan. Benefits under the Plan are paid from the general assets of the Plan Sponsor*.

BCBSAZ, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BCBSAZ may also have a contract with your employer to provide stop-loss insurance to the Plan. The stop-loss insurance may be "aggregate" stop-loss, which reimburses the Plan whenever claims on all employees exceed a specified level in a Plan year, "specific" stop-loss, which reimburses the Plan whenever claims on any covered person exceeds a specified level; or a combination of both.

BCBSAZ is an independent contractor and shall not for any purpose be deemed an agent of your employer or the employer's Plan Administrator*, nor shall BCBSAZ and your employer be deemed partners, joint venturers or governed by any legal relationship other than that of independent contractor. In this book, BCBSAZ refers to the administrative services agreement and/or stop loss insurance agreement with your employer as a group master contract.

This benefit book describes the benefits for employees and their dependents that are eligible for and have elected coverage, under the PPO benefit plan. BCBSAZ may distribute a similar benefit book for insured employer groups and self-funded employer groups. This book by itself is not your employer's Summary Plan Description or a Plan Document. Your employer is responsible for providing those documents to you.

This PPO benefit plan gives you access to a network of providers that have agreed to negotiated discounts with BCBSAZ or a local Blue Cross and/or Blue Shield plan if covered services are rendered outside of Arizona.

Please note: Not all services are covered. As this is a self-funded employer health care plan, benefits provided in this PPO plan may not include all benefits required for those health care plans which are not self-funded. Read this benefit book carefully to understand the benefits and limitations of the PPO benefit plan.

*Plan Sponsor and Plan Administrator are terms defined under the Employee Retirement Income Security Act (ERISA). These parties are often your employer, but may be another entity, e.g., a trust or association sponsoring your Plan. Your Plan Document or Summary Plan Description names these parties for you.

CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact BCBSAZ at one of the departments listed below or call the phone number on the back of your ID card.

BlueNet

BCBSAZ also makes information available at www.azblue.com and you may wish to look there before calling. BlueNet is the member area on www.azblue.com that allows you to manage your health insurance plan from anywhere you have Internet access. Go to www.azblue.com/member for more information and to register for a BlueNet account. After you register for BlueNet, you can*:

View claims and benefits information
Track deductible, if applicable to your plan
Update account information
Verify enrollment status
Order ID cards

Search for providers
Compare hospitals
Research prescription benefits
Access HealthyBlue® - tools for a healthier life
Review Medical and Dental Coverage Guidelines

*Access to BlueNet links and services will vary based on benefit plan type.

BCBSAZ Customer and Membership Services

Phone service hours are Monday through Friday, 8:00 a.m. to 4:30 p.m. MST (except holidays).

	Customer Service: • **All General Questions & Information** • **Claim Issues**	**Membership Services:** • **Enrollment Questions** • **Dependent Changes** • **Premium Billing & Payment**	**Hearing Impaired (TDD) (Claim Information)**	**Spanish-Language Phone Service (en Español – preguntas sobre su solicitud, beneficios, reclamos, o pagos)**
Dedicated City of Chandler Customer Service	(866) 595-5993	(602) 864-4115	(602) 864-4823	(602) 864-4884
		(800) 232-2345, ext. 4115	(800) 232-2345, ext. 4823	(800) 232-2345, ext. 4884
Fax:		(602) 864-4041		
Mailing Address:	All Correspondence Except as Noted Below: Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466	Attn: Membership Services, Mail Stop: A102, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466		

Customer Walk-In Office Locations

Phoenix (main office):	2444 W. Las Palmaritas Drive, 85021-4883 (2 blocks north of Northern Avenue between the Black Canyon Freeway (I-17) and 23rd Avenue)
Tucson:	5285 E. Williams Circle, Suite 1000, 85711-7411 (East on Broadway Road, right on S. Williams Circle, left on E. Williams Circle)
Flagstaff:	1500 E. Cedar Avenue, Suite 56, 86004-1643 (Intersection of Cedar Avenue and West Street)
Chandler:	2121 W. Chandler Blvd., Suite 115, 85224-6576 (East of the 101 Freeway, West of Dobson Road)

Provider Locator & Benefit Vendor Information

BlueCard® Program (getting care outside of Arizona):	Blue Cross Blue Shield Association: (800) 810-2583 or website at www.bcbs.com
Chiropractic Benefits Administrator (CBA)	(800) 678-9133
Pharmacy Benefit Customer Service	(866) 325-1794
Provider Network Status	Check the online provider directory at www.azblue.com or call BCBSAZ Customer Service at the numbers listed above

Claim Submissions

Mail New Claims to:	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix, AZ 85062-2924
Claims for Transplant Travel and Lodging	Attention: Transplant Travel Claim Processor, Mail Stop: A225, 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 **All claims for services provided by a chiropractor must be sent to this address for processing by the CBA.**	Claims Administration, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001

Accessing Care

Clinical Trials (for information on services directly associated with a clinical trial or to obtain a copy of the requirements for clinical trials):	Maricopa County: (602) 864-5841 Statewide: (800) 232-2345, ext. 5841
Care Management and Disease Management Support Line (information on care management services, how to contact a care manager or how to make a referral and information on health management programs that support members with complex, catastrophic and/or chronic conditions):	(877) My-HBlue or (877) 694-2583
Continuity of Care Requests:	(877) My-HBlue or (877) 694-2583
Precertification (your doctor must contact BCBSAZ):	Maricopa County: (602) 864-4320 Statewide: (800) 232-2345, ext. 4320

Disputes

	Medical Appeals and Grievances (except as noted below)	**Precertification Denial Appeals** (you or your doctor may contact BCBSAZ)
Maricopa County:	(602) 544-4938	(602) 544-4938
Statewide:	(866) 595-5998	(866) 595-5998
Fax:	(602) 544-5601	(602) 544-5601
Mailing Address:	Attn: Medical Appeals and Grievances, Mail Stop: A116, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466	
For disputes over chiropractic care:	Appeals Coordinator, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001; Telephone (800) 678-9133; Fax (619) 209-6237	

Document and Form Requests

Medical Coverage Guidelines (request a copy of the Medical Coverage Guidelines):	Maricopa County: (602) 864-4614 Statewide: (800) 232-2345, ext. 4614 BlueNet members' area of www.azblue.com under Claims & Benefits/Health Benefits/Medical Coverage Guidelines
Requests for Transplant Travel and Lodging Claim Forms:	Maricopa County: (602) 864-4051 Statewide: (800) 232-2345, ext. 4051
Supply Line (provider directories, claim forms, Summaries of Benefits and Coverage, BCBSAZ Appeal and Grievance Guidelines, ID cards, Rx mail order packet):	Maricopa County: (602) 995-6960 Statewide: (800) 232-2345, ext. 6960

Social Media

Like us on Facebook: www.facebook.com/bcbsaz
Follow us on Twitter: www.twitter.com/bcbsaz
Email complaints and concerns to socialcares@azblue.com
iPhone and Android phone users can download our mobile application via Google Play or App Store

DEFINITIONS

"Allowed amount" means the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost-share payment.

BCBSAZ calculates deductible and coinsurance based on the allowed amount, less any precertification charges. BCBSAZ uses the allowed amount to accumulate toward any out-of-pocket maximum that applies to the member's benefit plan. The allowed amount does not include any balance bills from noncontracted providers. The allowed amount is neither tied to, nor necessarily reflective of, the amounts providers in any given area usually charge for their services.

If the allowed amount is based on a Fee Schedule, a change to the Fee Schedule may result in higher member cost-share.

The table below shows how BCBSAZ determines the allowed amount.

Type of Provider	Type of Claim	Basis for Allowed Amount
Providers contracted with BCBSAZ	Emergency and non-emergency	Lesser of the provider's billed charges or the applicable BCBSAZ fee schedule, with adjustments for any negotiated contractual arrangements and certain claim editing procedures
Providers contracted with a vendor	Emergency and non-emergency	Generally, the lesser of the provider's billed charges or the vendor's fee schedule, with adjustments for any negotiated contractual arrangements
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue")	Emergency and non-emergency	Lesser of the provider's billed charges or the price the Host Blue plan has negotiated with the provider
Noncontracted providers (in Arizona and out-of-state)	Non-emergency claims and emergency ground ambulance claims	Lesser of the provider's billed charges or the applicable BCBSAZ fee schedule, with adjustments for certain claim editing procedures. For emergency ground ambulance claims, the allowed amount is generally based upon the ambulance provider's billed charges.
Noncontracted providers (in Arizona and out-of-state)	Emergency	Billed charges

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

Blue Cross® Blue Shield® of Arizona is an independent licensee of the Blue Cross and Blue Shield Association.

BCBSAZ is a nonprofit 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 health care services organization as a line of business.

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

"Benefit book" means this document, which may also be referred to as benefit booklet or benefit plan booklet.

"Benefit plan" or "plan" means the document describing the benefits and terms of coverage that the sponsor of a group health plan provides to its group members and their Dependents. Your BCBSAZ plan includes this book and any SBC, your application for coverage, your ID card, any plan that is issued to replace this plan and any rider, amendment or modification to this plan, including but not limited to, any changes in deductible, coinsurance or copay amounts. **Changing deductible options within a product does not constitute a new plan.**

Many group health insurance plans (other than government plans, church plans, and certain other types of plans) must comply with the federal Employee Retirement Income Security Act of 1974 (ERISA). If your group health insurance plan is subject to ERISA, your plan sponsor must maintain a summary plan description and provide the summary plan description to you upon written request. While your plan sponsor may include this benefit book as part of its summary plan description, this benefit book is not a summary plan description.

"Billed charges" means:

- For a provider that has a participation agreement governing the amount of reimbursement, the amount the provider routinely charges for a service;
- For a provider that has no participation agreement governing the amount of reimbursement, the lowest amount that the provider is willing to accept as payment for a service.

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

"Contractholder" means the person to whom the benefit plan is issued. Any other person approved for coverage with the Contractholder under this plan is a Dependent. Under group coverage, the Contractholder is the member who is eligible for coverage because of his or her affiliation with a Group.

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

"Cost-share" means the member's financial obligation for a covered service. Depending on the plan type, cost-share may include one or more of the following: deductible, copay, coinsurance, pharmacy deductible, precertification charges, and balance bills.

"Custodial care" means health services and other related services that meet any one or more of the following criteria:

1. Are for comfort or convenience;
2. Do not seek to cure;
3. Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition or other self-care; **or**
4. Are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as an L.P.N., R.N. or licensed therapist.

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

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that failing to get immediate medical attention would result in serious jeopardy to the patient's life, health or ability to completely recover, serious impairment to a bodily function or part, or permanent disability.

"FDA" means the federal Food and Drug Administration.

"FDA-approved" means that a medication or device has been approved by the FDA.

"Fee Schedules" mean proprietary schedules of provider fees compiled by BCBSAZ or BCBSAZ's contracted vendors. BCBSAZ or BCBSAZ's contracted vendors develop proprietary schedules of fees based on annual reviews of information from numerous sources, including, but not limited to: Medicare fee schedules from the Centers for Medicare and Medicaid Services (CMS), BCBSAZ's or the contracted vendor's historical claims experience, pricing information that may be available to BCBSAZ or the vendor, information and comments from providers and negotiated contractual arrangements with providers. **BCBSAZ and/or BCBSAZ's contracted vendors may change their Fee Schedules at any time without prior notice to members. If the allowed amount is based on a Fee Schedule, a change to the Fee Schedule may result in higher member cost-share.**

"Group" means the employer, trust or other entity that sponsors the group benefit plan on behalf of its employees or participants.

"Group Master Contract" (sometimes referred to as "Agreement") means the legal agreement between the Group and BCBSAZ.

"Inpatient residential care" means medical or mental-behavioral care provided in a 24-hour facility licensed by the state in which it is located, and not licensed as a hospital, that offers integrated therapeutic services, educational services and activities of daily living. These services are part of a well-defined, individually tailored, medical or mental-behavioral treatment plan that is clinically appropriate based upon the individual's medical or mental-behavioral needs and is performed in a clinically appropriate facility.

"Medical Coverage Guidelines" means BCBSAZ medical, pharmaceutical, dental and administrative criteria that are developed from review of published, peer-reviewed medical, pharmaceutical and dental literature and other relevant information and used to help BCBSAZ determine whether a service, procedure, medical device or drug is eligible for benefits under a member's benefit plan. The Medical Coverage Guidelines also include prescription medication limitations. BCBSAZ periodically reviews and amends the Medical Coverage Guidelines in response to changes and advancements in medical knowledge and scientific study. Benefit determinations are based on the Medical Coverage Guidelines in effect at the time of service. You or your provider can review a specific guideline by going to the "Claims & Benefits" section on www.azblue.com and choosing "Health Benefits and Medical Coverage Guidelines." Specific Guidelines are also available by calling the number for requesting Medical Coverage Guidelines listed in the front of this book.

BCBSAZ contracted vendor(s) may establish medical coverage guidelines for services the vendor provides or administers pursuant to the vendor's contract with BCBSAZ.

"Member" or "You" means an individual, employee, participant or Dependent covered under a benefit plan.

"Per diem" means a method of reimbursement based on a negotiated rate per day for payment of covered services provided to a patient in a facility.

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

"Physician," for purposes of classifying benefits and member cost-shares in this benefit plan, means a properly licensed M.D., D.O., D.P.M., or D.C.

"Primary Care Provider (PCP)" means a health care professional who is contracted with BCBSAZ as a PCP and generally specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, pediatrics or any other classification of provider approved as a PCP by BCBSAZ. Your benefit plan does not require you to have a PCP or to have a PCP authorize specialist referrals.

"Provider" means any properly licensed, certified or registered person or facility furnishing medical care to you, such as a doctor, hospital, laboratory or other health professional.

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

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

"Service" means a generic term referencing some type of health care treatment, test, procedure, supply, medication, technology, device or equipment.

"Specialist" means either a physician or other health care professional who practices in a specific area other than those practiced by primary care providers, or a properly licensed, certified or registered individual health care provider whose practice is limited to rendering mental health services. For purposes of cost-share, this definition of "specialist" does not apply to dentists. BCBSAZ does not require you to obtain an authorization or referral to see a specialist.

"Summary of Benefits and Coverage" (SBC) means a federally required document in a specified template with information on applicable copays, coinsurance percentages, deductible amounts, other cost-sharing amounts, benefits, exclusions, limitations; and other important information. BCBSAZ generally sends SBCs with member ID cards. Please keep your current SBC with your benefit book.

UNDERSTANDING THE BASICS

Your Responsibilities

Before you get services:

- Read your benefit materials.
- Know your coverage.
- Know the limits and exclusions on coverage.
- Know how much cost-share you will have to pay.
- Check your provider's network status and know whether your provider is a network provider with BCBSAZ.

After you get services:

- Read your explanations of benefits (EOBs) and monthly health statements.
- Tell BCBSAZ if you see any differences between the amounts on your claims documents and what you actually paid.

BCBSAZ ID Card

BCBSAZ will mail you an ID card with basic information about your coverage:

- Who is covered (Contractholder and Dependent names)
- Identification numbers
- Cost-share amounts
- Important phone numbers and addresses
- Bring your ID card with you each time you seek health care services.
- Have your ID card available for reference when you contact BCBSAZ for information.

Coverage Changes

Your benefits and coverage can change while this benefit plan is in effect. You will be notified of any changes as required by law. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your Group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available.

Covered Services

To be covered, a service must be all of the following:

- A benefit of this plan;
- Medically or dentally necessary as determined by BCBSAZ or BCBSAZ's contracted vendor(s);
- Not excluded;
- Not experimental or investigational as determined by BCBSAZ or BCBSAZ contracted vendor(s);
- Precertified where precertification is required;
- Provided while this benefit plan is in effect and while the person claiming benefits is eligible for benefits; **and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ or BCBSAZ's contracted vendor(s).

Experimental or Investigational Services

BCBSAZ, in its sole and absolute discretion, decides whether a service is experimental or investigational. A service is considered experimental or investigational unless it meets <u>all</u> of the following criteria:

- The service must have final approval from the appropriate governmental regulatory bodies if applicable;
- The scientific evidence must permit conclusions concerning the effect of the service on health outcomes;
- The service must improve the net health outcome;
- The service must be as beneficial as any established alternative; **and**
- The improvement resulting from the service must be attainable outside the investigational setting.

In addition to classifying a service as experimental or investigational using the above criteria, BCBSAZ or its contracted vendor may also classify the service as experimental or investigational if any one or more of the following apply:

- The service 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 is submitted for precertification or rendered;
- The provider rendering the service documents that the service is experimental or investigational; **or**
- Published reports and articles in authoritative (peer-reviewed) medical and scientific literature show that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, appropriate selection, efficacy or efficacy as compared with the standard treatment for the diagnosis.

Health Savings Account (HSA)

This benefit plan is a high deductible health plan designed for use with an HSA, which is a tax-exempt trust or custodial account established with a qualified financial institution. A member uses the funds in the HSA to pay for qualified medical expenses and provide savings for the future.

You must satisfy certain criteria to be eligible to open an HSA. Enrolling in this plan does not automatically qualify you to open an HSA. Check with your tax or legal advisor regarding whether you satisfy these criteria. BCBSAZ is not an HSA trustee or custodian and does not provide tax, legal or investment advice about HSAs. You cannot set up an HSA with BCBSAZ. BCBSAZ does not make any contributions to the HSA. Federal and state regulations governing HSAs are subject to change.

Members with HSAs are responsible to tell BCBSAZ about any changes that apply to their health plan accruals. Sometimes members may have adjustments in their actual incurred expenses for services of which BCBSAZ is unaware. (For example, a provider may choose to discount all patients' cost-share by two percent if the patient pays cash on the day of service. Or, a member may have a discount coupon for the member's share of the cost of a drug.) If your out-of-pocket costs are reduced after your provider submits a claim, you must tell BCBSAZ about the reduction so BCBSAZ can properly credit amounts to your deductible and out-of-pocket maximum. If you do not tell us about these adjustments, it could result in inaccurate accumulations and jeopardize your status as an HSA-eligible individual.

Federal laws allow waiver of minimum deductible requirements applicable to qualified high deductible health plans for services and medications provided for a preventive purpose. If your deductible is waived for a service or item that is not provided for a preventive purpose, you may be ineligible to contribute or withdraw funds from your health savings account and you may be subject to a tax penalty on funds withdrawn from your health savings account. Contact BCBSAZ if your deductible is being waived for a service or item you are receiving for a non-preventive purpose.

Medically Necessary

BCBSAZ, or BCBSAZ's contracted vendor, in its sole and absolute discretion, decides whether a service is medically necessary based on the following definition:

A medically necessary service is a service that meets all of the following requirements:

- Is consistent with the diagnosis or treatment of a symptom, illness, disease or injury;
- Is not primarily for the convenience of a member or a provider;
- Is the most appropriate site, supply or service level that can safely be provided; **and**
- Meets BCBSAZ's medical necessity guidelines and criteria in effect when the service is precertified or rendered. If no such guidelines or criteria are available, BCBSAZ or its contracted vendor will base its decision on the judgment and expertise of a medical professional or medical consultant retained by BCBSAZ or the vendor.

Medical Necessity Guidelines and Criteria

BCBSAZ uses some of the sources and criteria listed below to make medical necessity decisions, but does not rely on each source for every decision. Information on how to obtain a copy of the Medical Coverage Guidelines is in the Customer Service section at the front of this book.

- Medical Coverage Guidelines (local medical policy)
- InterQual ® Clinical Decision Support Criteria

- Medical Policy Reference Manual (MPRM) of the Blue Cross Blue Shield Association
- Medicare Guidelines
- Pharmacy Coverage Guidelines
- Technology Evaluation Center (TEC) of the Blue Cross Blue Shield Association

Decisions about medical necessity may differ from your provider's opinion. A provider may prescribe, order, recommend or approve a service that BCBSAZ decides is not medically necessary and therefore is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered. Also, not all medically necessary services are covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A service may be medically necessary and still excluded from coverage.

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

PROVIDERS

Know your provider's network and eligibility status before you receive services.

Provider Directory

The BCBSAZ provider directory is available online at www.azblue.com. If you do not have Internet access, call BCBSAZ Customer Service to check a provider's eligibility and network status.

Provider Eligibility and Network Status

To be **eligible** for coverage, a service must be rendered by an eligible individual provider acting within his or her scope of practice, and, when applicable, performed at an eligible facility that is licensed or certified for the type of procedure and services rendered.

Eligible Providers

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

Benefits may also be available from other health care professionals whose services are mandated by Arizona state law or federal law or who are accepted as eligible by BCBSAZ. The following are examples of ineligible providers: acupuncturists and doctors of naturopathy and homeopathy. Other provider types may also be ineligible. The fact that a service is rendered by an eligible provider does not mean that the service will be covered. Not all eligible providers are contracted to participate in BCBSAZ networks.

ELIGIBLE PROVIDER LIST	
Professional	**Facility Ancillary**
• Board Certified Applied Behavioral Analyst (BCABA) • Certified Nurse First Assist (CRNFA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Doctor of chiropractic (D.C.) • Doctor of dental surgery (D.D.S.) • Doctor of medical dentistry (D.M.D.) • Doctor of medicine (M.D.) • Doctor of optometry (O.D.) • Doctor of osteopathy (D.O.) • Doctor of podiatry (D.P.M.) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner • Licensed professional counselor • Physician Assistant (PA) • Psychologist (Ph.D., Ed.D. and Psy.D.) • Perfusionist • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational or physical therapist • Surgical Assist (SA) • Surgical Technician (ST)	• Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long Term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Rehabilitation Treatment Centers (substance abuse centers) • Retail, mail order and specialty pharmacies • Skilled Nursing Facility • Specialty Laboratory • Sleep Lab • Urgent Care

Choosing a Provider

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

Network Status

In-Network Providers (Contracted)

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

- In-network providers will file your claims with BCBSAZ or the Host Blue plan with which they are contracted. The provider's contract generally prohibits the provider from charging more than the allowed amount for covered services. However, when there is another source of payment, such as liability insurance, all providers may be entitled to collect their balance bill from the other source, or from proceeds received from the other source. The provider's contract does allow the provider to charge you up to the provider's billed charges for noncovered services. We recommend that you discuss costs with the provider before you obtain noncovered services. BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan directly reimburse in-network providers for your benefit plan's portion of the allowed amount for covered services. **You are responsible to pay your member cost-share directly to the provider.**

- Except for emergencies, in-network providers must render covered services in the United States for the services to be considered in-network and subject to in-network member cost-share. If an in-network provider renders covered services outside the United States, the services will be considered out-of-network and subject to out-of-network member cost-share, including balance bills (except for emergencies).

Out-of-Network Providers (Contracted and Noncontracted)

- Out-of-network providers are: (1) Providers who are contracted with a Host Blue plan as "Participating" only providers; (2) Eligible providers who have no contract with BCBSAZ or a Host Blue plan (Noncontracted providers); and (3) Providers who are contracted with the BlueCard Worldwide program.

- **Participating-Only Providers**

  Participating-only providers are contracted with a Host Blue plan as "Participating" and are not contracted as PPO or Preferred providers. Participating-only providers are out-of-network providers. Participating-only providers will submit your claims to the Host Blue plan with which they are contracted. If you receive covered services from a Participating-only provider, you will pay out-of-network deductible and coinsurance. However, you will not have to pay the balance bill because the provider is contracted.

- **Noncontracted Providers**

  Eligible providers who have no provider participation agreement with BCBSAZ or any Host Blue plan are noncontracted providers. Noncontracted providers are out-of-network providers.

  If you receive covered services from an eligible noncontracted provider, you will pay out-of-network deductible and coinsurance, and the balance bill. Noncontracted providers may bill you up to their full billed charges. The difference between the noncontracted provider's billed charges and payment under this benefit plan may be substantial. Please check with the noncontracted provider regarding the amount of your financial responsibility before you receive services.

  BCBSAZ does not send claim payments to noncontracted providers. BCBSAZ will send payment to you for whatever benefits are covered under your benefit plan. You are responsible for paying the noncontracted provider. A noncontracted provider will not receive a copy of your explanation of benefits (EOB) and will not know the amount this benefit plan paid you for the claim.

- **Providers Contracted with the BlueCard Worldwide Program**

  Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. For covered services from these providers, you will pay out-of-network deductible and coinsurance, (except for emergency services), plus the balance bill.

Eligible Provider Status and Payment – Summary Table Subject to all terms and conditions noted in this section.				
Provider Contract Status	**Network Status and Applicable Cost-Share**	**Provider Required to File Claim on Member's Behalf**	**Accept BCBSAZ Allowed Amount and Do Not Balance Bill**	**Payee for Reimbursement**
Providers contracted with BCBSAZ	In-network	Yes	Yes	BCBSAZ reimburses the **provider** the allowed amount, less any member cost-share
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue") as PPO providers	In-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share
Providers contracted with Host Blue as Participating only providers	Out-of-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share
Providers contracted with Blue Card World Wide Program	Out-of-network	Yes	No	Blue Card Worldwide reimburses the **provider** the allowed amount less any member cost-share
Noncontracted providers (in Arizona and out-of-state) (must be eligible providers)	Out-of-network	No (provider may elect to do so as courtesy to member)	No. May charge up to full billed charges. Difference between billed charges and BCBSAZ member reimbursement may be substantial.	BCBSAZ reimburses the **member** the allowed amount, less any member cost-share. Provider does not get copy of member's EOB or know reimbursement amount.

Sample Differences in Financial Responsibility Based on Provider Choice

The following **example** shows how out-of-pocket expenses can differ depending on the provider you choose. This example is provided for demonstration purposes only. Your savings may vary depending on your benefit plan and your chosen provider.

In this example, the member has already satisfied the calendar-year deductible and has a 20 percent coinsurance for an in-network provider and 40 percent coinsurance for an out-of-network provider.

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

Locating an In-Network Provider

Check the BCBSAZ provider directory to locate an in-network provider who offers the services you are seeking and contact the provider for an appointment. If you cannot get an appointment with the in-network provider, you may either call BCBSAZ or ask an in-network provider with whom you have an existing treatment relationship for help in getting an appointment or locating another provider.

Precertifications for Out-of-Network Providers

BCBSAZ does not guarantee that every specialist or facility will be in our network. Not all providers will contract with health insurance plans. If you believe or have been told there is no in-network provider available to render covered services that you need, you may ask your treating provider to request precertification of in-network cost-share for services from an out-of-network provider. BCBSAZ will not issue this precertification if we find that an in-network provider is available to treat you. The section on precertification explains how to make this request.

Continuing Physician Care from an Out-of-Network Physician (M.D., D.O.)

You may be able to receive benefits at the in-network level for services from an out-of-network Arizona physician, under the circumstances described below. Continuity of care benefits are subject to all other applicable provisions of your benefit plan.

Continuity of care only applies to otherwise covered services rendered by doctors of medicine and osteopathy who are located in Arizona. Continuity of care is not available for facility services. If the hospital or other facility at which your physician practices is not an in-network facility, the out-of-network provisions of coverage will apply to covered facility services.

Information on requesting continuity of care is listed in the BCBSAZ Customer Service section at the front of this book.

New Members	**Current Members**
A new member may continue an active course of treatment with an out-of-network Arizona physician 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 thirty (30) days from the effective date of coverage; **or** 2. Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; **and**	A current member may continue an active course of treatment with an out-of-network Arizona physician if BCBSAZ terminates the physician from the network for reasons other than medical incompetence or unprofessional conduct if: The member has: 1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of the physician's termination; **or** 2. Entered the third trimester of pregnancy on the effective date of the physician's termination, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; **and**
The member's physician agrees in writing to do all of the following: 1. Accept the BCBSAZ allowed amount applicable to covered services as if provided by an in-network physician, subject to the cost-share requirements of this benefit plan; 2. Provide BCBSAZ with any necessary medical information related to your care; **and** 3. Comply with BCBSAZ's policies and procedures, as applicable, including precertification, network referral, claims processing, quality assurance and utilization review.	

Out-of-Area Services

BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Plans referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Arizona but inside the United States (not BlueCard Worldwide), the claims for those services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program.

Typically, when accessing care outside Arizona but inside the United States (not BlueCard Worldwide), you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Plan in that other geographic area ("Host Blue"). In some instances, you may obtain care from noncontracted healthcare providers. BCBSAZ's payment practices in both instances are described in this benefit plan book.

BlueCard Program

Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for fulfilling BCBSAZ's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Arizona but inside the United States (not BlueCard Worldwide) and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed charges for your covered services; **or**

- The negotiated price that the Host Blue makes available to BCBSAZ

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSAZ uses for your claim because they will not be applied retroactively to claims already paid.

Federal laws or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Precertification requirements and other benefit plan limitations apply to services received outside Arizona. You must make sure the provider obtains any required precertification. Otherwise, BCBSAZ may deny your benefits or require you to pay a precertification charge.

For assistance in locating a local BCBS network provider in another state, call (800) 810-BLUE (2583) or check the "BlueCard Doctor & Hospital Finder" online at www.bcbs.com.

See the "Provider" section and the definition of "Allowed amount" in this benefit book for information regarding payment for services provided by noncontracted providers outside Arizona.

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue. The amount you pay for covered healthcare services under a National Account arrangement will be calculated based on either: (1) the negotiated price made available to BCBSAZ by the Host Blue; or (2) the lesser of the provider's billed charges or the negotiated price made available to BCBSAZ by the Host Blue.

BlueCard Outside the United States (BlueCard Worldwide)

Always go directly to the nearest hospital in the event of an emergency. Emergency services are covered outside the United States. In-network member cost-sharing will apply to covered Emergency Services. See the Emergency Services section of this benefit book.

The BlueCard Worldwide program helps Blue Cross and/or Blue Shield members arrange medical services when they are outside the United States. BlueCard Worldwide works differently than BlueCard inside the United States.

If you need to locate a doctor or hospital or need medical assistance services outside the United States, call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Except for emergencies, you cannot obtain services at the in-network cost-share from providers located outside the United States. Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. If you receive covered services from a provider who is contracted with the BlueCard Worldwide program, you will pay out-of-network deductible and coinsurance and BCBSAZ access fees, plus the balance bill (except for emergency services).

- **Inpatient Services**

  In most cases, hospitals contracted with the BlueCard Worldwide program will not require you to pay for covered inpatient hospital services, except for your member cost-share (out-of-network deductible and coinsurance and BCBSAZ access fees). In such cases, the BlueCard Worldwide hospital will submit your claim for processing. **You must still contact BCBSAZ to obtain precertification for non-emergent inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the United States are generally not contracted with the BlueCard Worldwide program and will require you to pay for services in full at the time of service. Complete a BlueCard Worldwide claim form and send the claim form with the provider's bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claim processing. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide.

Services Received on Cruise Ships

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

PRECERTIFICATION

Precertification

Precertification is the process BCBSAZ uses to determine eligibility for benefits.

When Is Precertification Required and What Happens If You Don't Obtain It

Not all services require precertification. Each benefit description in this booklet tells you whether precertification is required for that benefit. If it is required, your provider must obtain it on your behalf before rendering services.

Notwithstanding any other language in this benefit book, BCBSAZ may change the services that require precertification at any time. If the benefit description does not indicate that precertification is required, and you or your provider are unsure, go to www.azblue.com for a listing of medications and services that require precertification or call the Customer Service number listed in the front of this book.

If precertification is required, but not obtained, the consequences vary by benefit and network status of the provider. The benefit description section in this book tells you which consequences will apply to specific benefits including:

- Your benefits may be denied
- You may have to pay a precertification charge
- Your cost-sharing payments may be substantially higher

How to Obtain Precertification

Ask your provider to contact BCBSAZ for precertification before you receive services. Your provider must contact BCBSAZ because he or she has the information and medical records we need to make a benefit determination. BCBSAZ will rely on information supplied by your provider. If that information is inaccurate or incomplete, it may affect the decision on your claim. You are responsible for checking with your provider to make sure that the provider has obtained any required precertification.

Factors BCBSAZ Considers in Evaluating a Precertification Request for Services or Medications

- Applicability of other benefit plan provisions (limitations, exclusions and benefit maximums);
- If the treating provider or location of service is in-network;
- Whether the service is medically necessary or investigational; **and**
- Whether your coverage is active.

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

Prescription Medication Exception

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

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

If there is no in-network provider available to deliver covered services, your treating provider may contact BCBSAZ and ask BCBSAZ to precertify the in-network cost-share for services from an out-of-network provider. BCBSAZ will evaluate whether there is an in-network alternative. If BCBSAZ determines that an in-network provider is available to treat you, BCBSAZ will not precertify in-network cost-share for services from your out-of-network provider of choice.

Precertification of in-network cost-share for services from an out-of-network provider is a process separate from precertification of services. If you want an out-of-network provider to render services that require precertification, and you also want to be eligible for the in-network cost-share, you must ensure that your

provider makes two separate precertification requests: one for the service itself and one for use of the out-of-network provider. The benefit descriptions in this book refer only to your obligation to obtain precertification for the service. If BCBSAZ precertifies you for the in-network cost-share, your services will be subject to the in-network cost-share. You will still be responsible for any balance bill, plus your in-network cost-share.

If BCBSAZ Precertifies Your Service

- Precertification is not a pre-approval or a guarantee of payment. Precertification made in error by BCBSAZ is not a waiver of BCBSAZ's right to deny payment for noncovered services.
- You and your provider will receive a letter explaining the scope of the precertification.

If BCBSAZ Denies Your Precertification Request

Denial of precertification is an adverse benefit determination. As explained in the next section on Claims, BCBSAZ will send you a notice explaining the reason for the denial, and your right to appeal the BCBSAZ decision. Information on where to file an appeal is in the BCBSAZ Customer Service section at the front of this book.

If your request for precertification of a service is denied because BCBSAZ decides that the service is not medically necessary, remember that BCBSAZ's interpretation of medical necessity is a benefits determination made in accordance with the provisions of this plan. Your provider may recommend services or treatment not covered under this plan. You and your provider should decide whether to proceed with the service or procedure if BCBSAZ denies precertification.

CLAIMS INFORMATION

Filing Claims

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

Time Limit for Claim Filing

A complete claim, as described below, must be filed within one year from the date of service. Any claim not filed within one year of the date of service may be denied.

Claim Forms

Claim forms are available from BCBSAZ. Go to the "Forms" section of the "Member" area of www.azblue.com or call the Supply Line telephone number listed at the front of this book.

Complete Claims

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

- Billed charges
- Date of service(s)
- Diagnosis code
- Group number
- Member ID number
- Member name
- Name of provider
- Patient name
- Patient's birth date
- Procedure code
- Provider ID number
- Signature of provider who rendered services

BCBSAZ may reject claims that are filed without complete information needed for processing. If BCBSAZ rejects a submitted claim due to lack of information, BCBSAZ will notify you or the provider who submitted the claim. Lack of complete information may also delay processing.

Medical and Dental Records and Other Information Needed to Process a Claim

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

Explanation of Benefits (EOB) Form

After your claim is processed, BCBSAZ and/or any contracted vendors that process claims will send you an EOB. Your BCBSAZ EOBs also will be available through the member portal on www.azblue.com. An EOB shows services billed, whether the services are covered or not covered, the allowed amount and the application of cost-sharing amounts. Carefully review your EOB for any discrepancies or inconsistencies with the amounts your provider actually collects from you or bills to you. BCBSAZ and/or any contracted vendors will also send your in-network provider the information that appears on your EOB. This information is not sent to out-of-network providers. Out-of-network providers do not receive any written information on how much was paid on a claim or the reasons for how the claim processed. Save the EOB for your personal records. BCBSAZ or any contracted vendor may charge a fee for duplication of claims records.

Monthly Statement

Some EOBs may be consolidated and sent to you in the form of a monthly statement rather than as single EOBs.

Notice of Determination

If your request for precertification is denied, or your claim is denied in whole or in part, you will receive a notice of adverse benefit determination. In most cases, your EOB or monthly statement will serve as the notice, and will:

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

Pharmacy Prescriptions; Submission of Claims by Members

When you submit a prescription to a retail, mail order or specialty pharmacy, the prescription is not considered to be a claim and will not result in an EOB. If you have any concerns about fulfillment of the prescription, you must submit a claim to BCBSAZ for the prescription. Send BCBSAZ a claim in the following circumstances:

- The pharmacy tells you that you are not eligible for coverage
- Coverage for the prescription was denied in whole or in part
- You feel that you paid the wrong copay or other cost-sharing amount for the prescription
- You were required to pay other amounts you feel you are not required to pay
- Other dispute or discrepancy regarding your prescription medication coverage

If the pharmacy tells you that you are not eligible for coverage and you are unable to purchase a temporary supply of medication that is needed immediately, please call the number on the back of your identification card.

Time Period for Claim Decisions:

Post-Service Claims

Within thirty (30) days of receiving your claim for a service that was already rendered, BCBSAZ will send you an EOB adjudicating the claim, or a notice that BCBSAZ has requested records needed to make a decision on your claim.

If BCBSAZ cannot make a decision on your claim within thirty (30) days, BCBSAZ may extend the initial processing time by fifteen (15) days by notifying you, within the initial 30-day period, of the need for an extension, the expected decision date, and any additional information that may be needed for the decision. You or your provider will have at least forty-five (45) days to submit any requested information.

Pre-Service Claims

When you request coverage for a service that has not yet been rendered (precertification), BCBSAZ will make a precertification decision within a reasonable time period considering the medical circumstances, but not later than ten (10) business days from receipt of the precertification request.

If BCBSAZ requires more time to make a precertification decision, BCBSAZ may extend the time by an additional fifteen (15) days by notifying you, within the initial ten (10)-day period of need for an extension, the expected decision date, and any additional information needed for the decision. You and your provider will have at least forty-five (45) days to submit any requested information.

Concurrent Care Decisions

BCBSAZ may require that your provider submit a plan of care. Based on that plan, BCBSAZ may precertify a certain number of visits or services over a certain period of time. You may request precertification for additional periods of care as long as your request is made at least seventy-two (72) hours prior to the

expiration of an existing plan of care. BCBSAZ will make a determination as soon as possible in accordance with medical exigencies, but no later than seventy-two (72) hours after receipt of the request. If that precertification is denied, you may appeal that denial in the same way you appeal any other coverage denial.

Urgent Claims

Federal law defines an "urgent" medical situation as the following: (a) one in which application of the "non-urgent" time periods could seriously jeopardize the member's life, health or ability to regain maximum function **or** (b) one which, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

When you request coverage for an urgent care claim, a determination will be made as soon as possible in accordance with medical exigencies, but no later than seventy-two (72) hours after receipt of the request.

GENERAL PROVISIONS

Appeal and Grievance Process

Members may participate in BCBSAZ's appeals and grievance processes, which are described in detail in the BCBSAZ Appeal and Grievance Guidelines, a separate document provided to you. You may obtain another copy of the BCBSAZ Appeal and Grievance Guidelines at any time by visiting us at www.azblue.comor by calling the BCBSAZ Supply Line telephone number listed in the front of this booklet.

You do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ. To appeal a denial of precertification for urgently needed services you have not yet received, please call the BCBSAZ Precertification Denial Appeals telephone number listed in the front of this booklet.

Billing Limitations and Exceptions

When there is another source of payment such as a liability insurer, in-network providers may be entitled to collect any difference between the allowed amount and the provider's billed charges from the other source or from proceeds received from the other source, pursuant to A.R.S. § 33-931.

A.R.S. § 33-931 may give providers medical lien rights independent of this benefit plan or any contract with BCBSAZ. BCBSAZ is not a party to any collection dispute that may arise under the provisions of A.R.S. § 33-931.

Blue Cross and Blue Shield Association

You hereby expressly acknowledge and agree to the following:

I. This benefit plan constitutes a contract between the Group and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSAZ to use the Blue Cross and/or Blue Shield service marks in the State of Arizona;
II. BCBSAZ is not contracting as the agent of the Association;
III. In accepting the benefits of this plan, you are not relying on any representations by the Association or any other Blue Cross or Blue Shield plan, other than BCBSAZ; **and**
IV. You will not seek to hold the Association or any Blue Cross and Blue Shield plan other than BCBSAZ, accountable or liable for BCBSAZ's obligations herein.

Broker Commissions

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

Claim Editing Procedures

In order to process claims accurately, BCBSAZ uses a computer system to verify benefits, eligibility, claims accuracy and compliance with BCBSAZ coding guidelines and the Medical Coverage Guidelines. BCBSAZ uses claims coding and editing logic to process professional and outpatient facility claims. This system logic is designed to identify the following: procedure unbundling (billing multiple procedure codes to represent a procedure that can be described with a more comprehensive code), separate billing for included (incidental) services, procedures not usually performed together (mutually exclusive) procedures, correct use of coding guidelines, member's age and sex edits. The system logic does not audit the diagnosis code to change or modify the intensity of service for office visit (evaluation and management) codes. BCBSAZ periodically updates its computer system claim edits.

Confidentiality and Release of Information

BCBSAZ takes confidentiality very seriously. We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with state and federal law. If you

wish to authorize someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from www.azblue.com or call BCBSAZ Customer Service and request a hard copy of the CIRF form.

Court or Administrative Orders Concerning Dependent Children

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

Access to Information Concerning Dependent Children

BCBSAZ is not a party to domestic disputes. Parental disputes over Dependent coverage and information must be resolved between the parents of the Dependent child. Under Arizona law, both parents have equal rights of access to information about their children, unless there is a court order denying such access. Absent a copy of such order and subject to the confidentiality provisions described above, BCBSAZ provides equal parental access to information.

Discretionary Authority

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

Provider Treatment Decisions and Disclaimer of Liability

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

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

Lawsuits against BCBSAZ

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

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

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

Failure to comply with these provisions may result in dismissal of the lawsuit.

A member must complete all applicable levels of appeal before bringing a lawsuit other than a suit filed pursuant to the Health Care Insurer Liability Act. Failure to complete the mandatory levels of the appeal process may result in dismissal of the lawsuit for failure to exhaust BCBSAZ's administrative remedies.

By providing this notice BCBSAZ does not waive, but expressly reserves all applicable defenses available under Arizona and federal law.

Legal Action and Applicable Law

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

This benefit book and the contract between BCBSAZ and the sponsor of your group health plan were issued in Arizona to a group headquartered in Arizona. The only state law governing the benefit book and the contract is the law of the state of Arizona. This benefit plan may not provide all benefits required by other state laws.

Jurisdiction and Venue

Maricopa County, Arizona shall be the exclusive site of jurisdiction and venue for any legal action or other proceeding that arises out of or relates to the contract or this benefit plan.

Lawsuits by BCBSAZ

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

Non-Assignability of Benefits

The benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against BCBSAZ and imposes no duty or obligation on BCBSAZ.BCBSAZ will not honor any such purported sale, assignment, pledge, transfer or grant.

Medicaid Reimbursement

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

Member Notices and Communications

BCBSAZ sends notices and other communications to members by U.S. mail to the last address on file with BCBSAZ Membership Services. BCBSAZ may also elect to send some notices and communications electronically if the member has consented to electronic receipt. Notice is deemed complete when sent to the member's last address of record, as follows: (1) on delivery, if hand-delivered; (2) if mailed, on the earlier of the day actually received by the member or 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.

Payments Made in Error

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

Plan Amendment

There is no guarantee of continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted or changed upon notice to the Group and/or Contractholder and/or participant or as required to comply with state or federal laws. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your Group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available. Please review and retain this book, any replacement books, any SBCs, all riders and amendments and other communications concerning your coverage.

Retroactive Changes

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

Prescription Medication Rebates

BCBSAZ enters into contracts with pharmaceutical manufacturers to receive rebate payments based on the volume and/or market share of pharmaceutical products utilized by BCBSAZ subscribers. These rebate contracts are subject to renegotiation and/or termination from time to time at BCBSAZ's sole discretion. BCBSAZ's rebate contracts with pharmaceutical manufacturers generally work as follows: BCBSAZ submits data regarding utilization of specific medication(s) to the pharmaceutical manufacturer. The pharmaceutical manufacturer compares the data to the utilization level and/or market share required by the applicable rebate contract. If the utilization and/or market share meets the requirements of the rebate contract, the manufacturer issues a rebate payment to BCBSAZ after receipt of the data. As utilization and/or market share increases, the amount of the rebate payable to BCBSAZ may increase.

Rebates may be paid on medications that are covered under the pharmacy benefits of this benefit plan. The BCBSAZ Pharmacy and Therapeutics (P&T) Committee decides which medications to place on which levels of the tiered pharmacy benefit. The P&T Committee is comprised of pharmacists, BCBSAZ employees and other members as needed. The community physician members of the P&T Committee are not informed of potential rebate contracts or rebate payments when deciding which medications to place on certain levels. Certain BCBSAZ employees are aware of the potential rebate contracts or rebate payments. The P&T Committee decisions are not binding and can be overridden by BCBSAZ.

The rebates BCBSAZ receives are not reimbursable to you. Your employer receives either: (a) a credit against administrative costs/fees or (b) the prescription medication rebate dollar amount attributable to your employer group.

Rebates received by BCBSAZ may result in the overall cost of a particular medication falling below the amount you pay for such medication pursuant to the coverage described in this benefit plan. Other discount programs offered by a pharmacy may result in members of the public paying a lower cost for some medications than you pay under this benefit plan.

Provider Contractual Arrangements

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

Release of Records

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

Rescission of Coverage

In the event of fraud or intentional misrepresentation of material fact, coverage for any person ineligible to be on the benefit plan as described in the Group Master Contract will be rescinded, that is, as never having been

in effect. Premiums paid for the coverage for the ineligible person will be refunded, minus any claims paid for that person. BCBSAZ is entitled to recover claim payments that exceed the amount of premium paid. Such rescission does not affect the coverage of those persons on the benefit plan who remain eligible for coverage.

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

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

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. In-network providers generally cannot charge you for providing BCBSAZ with health records needed to process claims, grievances or appeals. Noncontracted providers have no contractual obligation to provide records to BCBSAZ free of charge. If you receive services from a noncontracted provider who charges for record preparation, costs or copies, you will need to make arrangements with your provider to obtain any records required by BCBSAZ and pay any applicable fees.

Statement of ERISA Rights

(Does Not Apply to Government Plans, Church Plans or Other Non-ERISA Qualified Plans)

As a member of a group health insurance benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

For purposes of ERISA, your employer is the "Plan Administrator." BCBSAZ is not the Plan Administrator.

ERISA provides that all members shall be entitled to:

- **Receive information about your plan and benefits**

  Under ERISA, you are entitled to examine, without charge, at the Plan Administrator's office and other locations, such as worksites and union halls, all documents governing the Plan that are available from the Plan Administrator, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Upon written request to the Plan Administrator, you may obtain copies of the Plan documents, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may charge you for the copies.

- **Continue group health plan coverage**

  COBRA is the abbreviation for a federal law that regulates continuation of health care coverage for you, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Unless you have an agreement with your employer to pay your COBRA premiums, you or your Dependents will be responsible for full payment of the premium to continue coverage under your group plan. Review your benefit book and talk to your benefits administrator about your COBRA continuation coverage rights.

- **Prudent actions by plan fiduciaries**

  In addition to creating certain rights for group members, ERISA also imposes certain duties on the "plan fiduciaries," those responsible for administration of the health plan. The plan fiduciaries have a duty to operate the plan prudently and in the interest of you and other members.

- **Enforce your rights**

  No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you have a right to know why it was denied, obtain

copies of documents related to the decision (at no charge) and appeal any denial, all within the time periods required by ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with your questions**

  If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Third-Party Beneficiaries

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

Your Right to Information; Availability of Notice of Privacy Practices

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

The BCBSAZ "Notice of Privacy Practices" describes how BCBSAZ may use and disclose your information to administer your health plan. It also describes some of your individual rights and BCBSAZ's responsibilities under federal privacy regulations. BCBSAZ mails a copy of this Notice of Privacy Practices to your address shortly after you enroll for coverage with BCBSAZ.

You can also view the "Notice of Privacy Practices" by visiting the BCBSAZ website, www.azblue.com, and clicking on the Privacy Statement link at the bottom of the home page.

If you would like BCBSAZ to mail you another copy of the "Notice of Privacy Practices," please call the Customer Service telephone number listed on the back of your BCBSAZ identification card, or call (602) 864-4400 or (800) 232-2345 to make your request.

Subrogation

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") that provides its employees and their dependents ("Participants") with health care coverage.

BCBSAZ performs claims administration for the Plan and now also provides subrogation recovery services for the Plan as described in this section.

Here is the way subrogation works. Sometimes you and/or your dependent ("you") require hospital and/or medical services due to an injury in an accident or due to a condition caused by another person's negligence.

In such cases, the person causing the accident ("third party") is responsible for payment of your hospital and medical expenses. The Plan, who pays for your covered hospital and medical services, has the right to recover these payments from the third party or from you if you have recovered from the third party. When the Plan exercises its rights to be reimbursed, the process is known as subrogation, recovery and/or reimbursement ("subrogation").

During the subrogation process, BCBSAZ, on behalf of the Plan, will continue to pay your covered hospital and medical services on behalf of the Plan just as it always has. However, if a third party is legally obligated to pay for your expenses, the Plan will then exercise its rights to be reimbursed for 100 percent of what the Plan paid without any reduction for attorneys' fees and/or court costs and regardless of whether you were made whole. In addition, the Plan has first priority from any judgment, payment or settlement.

The Plan's rights apply to any settlement of a claim regardless of whether anyone has started litigation. Any right a Participant might have to be "made whole",(i.e., to be fully compensated for his/her injuries prior to any right the Plan has to recover its cost) is superseded by the Plan's subrogation rights. The Plan may subrogate against all money that you or anyone recovers regardless of the source of the money and regardless of where the money is located and/or regardless of how it is held. The Plan will also have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of recovery or settlement.

You must promptly execute and deliver any documents relating to settlement of claims, settlement negotiations or litigation when the Plan asks you to so the Plan can exercise its subrogation rights. Also, you or your legal representative must (1) promptly notify the Plan in writing of any settlement negotiations before you enter into any settlement agreement, (2) disclose to the Plan any amount recovered from any person or entity that may be liable and (3) not make any distributions of settlement or judgment proceeds without the Plan's prior written consent. No waiver, release of liability or other documents executed by you without such written notice to the Plan shall be binding upon the Plan.

MEMBER COST-SHARING

Members pay part of the costs for benefits received under this plan. Depending on your particular benefit plan, the service you receive and the provider you choose, you may have a balance bill, coinsurance, copay, deductible or some combination of these payments. Each cost-share type is explained below. This section, the benefit descriptions in this book and your SBC will explain which cost-share types apply to each benefit.

BCBSAZ uses your claims to track whether you have met some cost-share obligations. We apply claims based on the order in which we process the claims and not based on date of service.

Balance Bill

The balance bill refers to the amount you may be charged for the difference between a noncontracted provider's billed charges and the allowed amount.

Noncontracted providers have no obligation to accept the allowed amount. You are responsible to pay a noncontracted provider's billed charges, even though BCBSAZ will reimburse your claims based on the allowed amount. Depending on what billing arrangements you make with a noncontracted provider, the provider may charge you for full billed charges at the time of service or seek to balance bill you for the difference between billed charges and the amount that BCBSAZ reimburses you on a claim.

Any amounts paid for balance bills do not count toward deductible, coinsurance or the out-of-pocket maximum.

Benefit Maximums

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

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for covered services each January through December before the benefit plan begins to pay for covered services. The deductible applies to every covered service unless the specific benefit section says it does not apply.

If you have family coverage, there is also a calendar-year deductible for the family. Amounts counting toward an individual's calendar-year deductible will also count toward any family deductible. When the family satisfies its calendar-year deductible, it also satisfies the deductible for all the individual members.

The family deductible must be met on a family policy before the Plan will pay for covered services for any individuals covered through that policy.

The deductible is calculated based on the allowed amount. Amounts you pay for copays do not count toward the deductible.

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for certain covered services after meeting any applicable deductible. BCBSAZ subtracts any applicable precertification charges from the allowed amount before calculating coinsurance. Coinsurance applies to every covered service unless the specific benefit section says it does not apply.

BCBSAZ normally calculates coinsurance based on the allowed amount. There is one exception. If a hospital provider's billed charges are less than the hospital's DRG reimbursement, BCBSAZ will calculate your coinsurance based on the lesser billed charge.

Copay

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

Out-of-Pocket Maximum (Individual & Family)

An out-of-pocket maximum is the amount each member must pay each year before the plan begins paying 100 percent of the allowed amount on covered services, for the remainder of the calendar year. The payments listed below do not count toward the out-of-pocket maximum. You must keep paying them even after you reach your out-of-pocket maximum:

- Amounts above a benefit maximum
- Any amounts for balance billing
- Any amounts for noncovered services
- Any charges for lack of precertification

If you have family coverage, there is an out-of-pocket maximum for your family. Amounts applied to each member's out-of-pocket maximum also apply to the family out-of-pocket maximum. 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.

The family out-of-pocket maximum must be met on a family policy before the Plan will pay 100 percent of the allowed amount on covered services.

Precertification Charges

You must make sure that your out-of-network provider obtains precertification from BCBSAZ for any service that requires it. If your out-of-network provider does not obtain required precertification from BCBSAZ , you are subject to a precertification charge or complete loss of your benefit. Applicable precertification charges are shown on your SBC.

Amounts applied as precertification charges do **not** count toward the calendar-year deductible or out-of-pocket maximum.

The SBC sent with your member ID card shows the actual cost-share amounts for your plan (for example copay amounts, coinsurance percentage, deductible). Some of these amounts are also shown on your ID card.

DESCRIPTION OF BENEFITS

Please review this section for an explanation of covered services and benefit-specific limitations and exclusions. Also be sure to review *"What is Not Covered"* for general exclusions and limitations that apply to all benefits.

To be covered and eligible for benefits, a service must be:

- A benefit of this plan;
- Medically necessary as determined by BCBSAZ or BCBSAZ's contracted vendor;
- Not excluded;
- Not experimental or investigational as determined by BCBSAZ or BCBSAZ's contracted vendor;
- Precertified if precertification is required;
- Provided while this benefit plan is in effect and while the person claiming benefits is an eligible member; **and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ.

BCBSAZ does not determine whether a service is covered under this benefit plan until after services are provided, and BCBSAZ receives a complete claim describing the services actually provided.

The SBC sent with your member ID card shows the actual cost-share amounts for the cost-share types shown for each benefit, such as deductible amounts, copays, and coinsurance percentages.

A. AMBULANCE SERVICES

Precertification: Not required.

Your Cost-Share: You pay in-network deductible and coinsurance.

Benefit Description: Ground ambulance transportation from the site of an emergency, accident or acute illness to the nearest facility capable of providing appropriate treatment; **or**

Interfacility ground or air ambulance transfer for admission to an acute care facility, extended active rehabilitation facility or skilled nursing facility when the transferring facility is unable to provide the level of service required; **or**

Air ambulance transportation to the nearest facility capable of providing appropriate treatment when the emergency, accident or acute illness occurs in an area inaccessible by ground vehicles or transport by ground ambulance would be harmful to the member's medical condition.

Benefit-Specific Exclusion: All other expenses for travel and transportation are not covered, except for the benefits described in *"Transplant Travel and Lodging."*

B. BEHAVIORAL AND MENTAL HEALTH SERVICES (including chemical dependency or substance abuse treatment)

B.1.1 Inpatient Hospital

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance for inpatient facility and professional charges. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for:

- Diagnostic testing
- Intensive care units and other special care units
- Medications, biologicals and solutions
- Treatment and recovery rooms and equipment for covered services

- Room and board in a semi-private room or a private room if the hospital only has private rooms or if a private room is medically necessary. If the hospital only has private rooms or a private room is medically necessary, only standard private rooms are covered (not deluxe).

B.1.2 Inpatient Subacute Hospitalization - Behavioral Health Facility Services

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance for inpatient facility and professional charges. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for:

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

Benefits are available for inpatient behavioral and mental health services that meet all the following criteria:

- The facility is licensed to provide behavioral health services to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time.
- The facility's designated medical director is a physician or registered nurse practitioner and provides direction for physical health services provided at the facility;
- A physician or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- The facility's designated clinical director is a behavioral health professional and provides direction for the behavioral health services provided at the facility;
- The facility has 24/7 onsite registered nursing coverage; **and**
- The facility has sufficient behavioral or mental health professional staff to provide appropriate treatment.

Changing Types of Inpatient Care (applicable to B.1.1 and B.1.2 above): Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient subacute and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit-Specific Exclusions (applicable to B.1.1 and B.1.2 above):

- Custodial Care
- Medications dispensed at the time of discharge from a hospital
- Private Duty Nursing
- Respite Care

B.2 Behavioral and Mental Health Services (Outpatient Facility and Professional Services)

Precertification: Required for partial hospitalization. Not required for other outpatient services. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share:

In-Network: You pay in-network deductible and coinsurance.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Non-emergency outpatient behavioral and mental health services are available. Those services include psychotherapy, outpatient therapy for chemical dependency or substance abuse, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, intensive outpatient services, counseling for personal and family problems, electroconvulsive therapy (ECT) and partial hospitalization.

B.3 Behavioral Therapy Services For The Treatment Of Autism Spectrum Disorder

Precertification: Not required.

Your Cost-Share:

In-Network: You pay in-network deductible and coinsurance.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definitions:

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

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

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

Benefit-Specific Exclusions (applicable to all Behavioral and Mental Health Services):

- Activity therapy, milieu therapy and any care primarily intended to assist an individual in the activities of daily living
- Biofeedback and hypnotherapy
- Development of a learning plan and treatment and education for learning disabilities (such as reading and arithmetic disorders)
- Inpatient and outpatient facility charges for services provided by the following facilities: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes.
- IQ testing
- Lifestyle education and management services
- Neurofeedback
- Neuropsychological and cognitive testing
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

C. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

Precertification: Not required.

Your Cost-Share: You pay in-network deductible and coinsurance. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for outpatient Phase I and II cardiac rehabilitation programs and pulmonary rehabilitation services.

D. CATARACT SURGERY AND KERATOCONUS

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance for the cataract surgery and any associated services. The cost-share amount will depend on the provider's network status and the place you receive services. In addition, you pay any amounts above the $250 maximum per member, per six (6) month period, for eyeglasses. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: There is a maximum benefit of $250 per member, per six (6) month period for eyeglasses following cataract surgery.

Benefit Description: Benefits are available for the removal of cataracts, including placement of a single intraocular lens at the time of the cataract removal. Benefits are also available for the first pair of external contact lenses post-cataract surgery or for treatment of keratoconus. The eyeglasses or external contact lenses must be prescribed and purchased within six (6) months of the surgery.

Benefit-Specific Exclusion: Procedures associated with cataract surgery that are not included in the benefit description, including replacement, piggyback or secondary intraocular lenses and any other treatments or devices for refractive correction.

E. CHIROPRACTIC SERVICES

Precertification: Not required.

Your Cost-Share:

In-Network: You pay in-network deductible and coinsurance.

Out-of-Network: You pay out-of-network deductible and coinsurance for services rendered by an out-of-network provider. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: There is a chiropractic visit limit of twenty (20) visits per member, per calendar year. In- and out-of-network visits count toward the twenty (20) visit limit. Physical therapy and occupational therapy services provided and billed by a chiropractor will apply towards the twenty (20) visit limit.

Benefit Description: Benefits are available for chiropractic services.

Benefit-Specific Exclusions:

- Massage therapy
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Spinal decompression
- Vertebral axial decompression therapy (VAX-D)

F. CLINICAL TRIALS FOR TREATMENT OF CANCER AND OTHER LIFE-THREATENING DISEASES

Precertification: Required for services directly associated with a clinical trial for treatment of cancer or other life-threatening diseases or conditions. Precertification will be issued in accordance with the requirements of applicable law, regardless of whether the clinical trial would otherwise be considered investigational. See specific benefit provisions for precertification charges.

Precertification of covered services directly associated with an eligible clinical trial is not a guarantee of coverage, assurance that the clinical trial satisfies the requirements of applicable law or evidence of any determination that the service provided through the clinical trial is safe, effective or appropriate for any member.

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

Benefit-Specific Definition: A "life-threatening disease or condition" is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefit Description: Benefits are available for covered services directly associated with a member's participation in a clinical trial meeting all requirements specified by applicable Arizona and/or federal law. Benefits are limited to those services eligible for coverage under this plan that would be required if you received standard, non-investigational treatment. If you have any questions about whether a particular service will be covered, please contact BCBSAZ customer service. You or your provider must inform BCBSAZ that you are enrolled in a clinical trial, that the trial meets the requirements of applicable law, and that the services to be rendered are directly associated with the trial. Otherwise, BCBSAZ will administer your benefits according to the other terms of your benefit plan, which may result in a denial of benefits.

Benefit-Specific Exclusions:

- Investigational medications (except as stated in *"Prescription Medications for the Treatment of Cancer")* and devices
- Any item, device or service that is the subject of the clinical study, or which is provided solely to meet the need for data collection and analysis
- Costs and services customarily paid for by government, biotechnical, pharmaceutical and medical device industry sources
- Costs to manage the clinical trial research
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services not otherwise covered under this plan

G. DENTAL SERVICES BENEFIT - MEDICAL

Not all dentists who are contracted with BCBSAZ are contracted to provide medical-related dental services. Call BCBSAZ Customer Service with questions.

G.1 Dental Accident Services

Precertification: Not required.

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

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

A "sound tooth" is a tooth that is:

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

Benefit Description: Benefits are available only for the following services to repair or replace sound teeth damaged or lost by an accidental dental injury:

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

Benefit-Specific Exclusions:

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

G.2 Dental Services Required for Medical Procedures

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

Benefit Description: Benefits are available for dental services required to perform the medical services listed in this benefit. These dental services may either be part of the medical procedure or may be performed in conjunction with and made medically necessary solely because of the medical procedure:

- Diagnostic services prior to planned organ or stem cell transplantation 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

Benefit-Specific Exclusions:

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

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

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

Benefit Description: Benefits are available for facility and professional anesthesiologist charges incurred to perform dental services under anesthesia in an inpatient or outpatient facility for a patient having one or more of the following concurrent or co-morbid conditions:

- Children 5 years or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office
- Malignant hypertension
- Mental retardation
- Senility or dementia
- Unstable cardiovascular condition
- Uncontrolled seizure disorder

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

Precertification: Not required.

Your Cost-Share: You pay in-network deductible and coinsurance. Your cost-share is waived for one FDA-approved manual or electric breast pump and breast pump supplies per female member, per calendar year. You also pay the balance bill for services provided by noncontracted providers.

H.1 Durable Medical Equipment (DME)

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

- Be designed for repeated medical use in the home setting;
- Be specifically designed to improve or support the function of a body part;
- Cannot be primarily useful to a person in the absence of an illness or injury; **and**
- Intended to prevent further deterioration of the medical condition for which the equipment has been prescribed.

Benefits are available for DME rental up to the purchase price of the item, as determined by BCBSAZ, and for DME repair or replacement due to normal wear and tear caused by use of the item in accordance with the manufacturer's instructions or due to growth of a child. Benefits are limited to the allowed amount for the DME item base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded DME items may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusions:

- Charges for continued rental of a DME item after the purchase price is reached
- Repair costs that exceed the replacement cost of the DME item
- Repair or replacement of DME items lost or damaged due to neglect or use that is not in accordance with the manufacturer's instructions or specifications

H.2 Medical Supplies

Benefit Description: Benefits are available for the following medical supplies:

- A device or supply required by applicable law or as otherwise permitted under the Medical Coverage Guidelines
- Blood glucose monitors
- Blood glucose monitors for the legally blind and visually impaired
- Diabetic injection aids and drawing-up devices
- Diabetic syringes and lancets
- Insulin pumps and insulin pump supplies
- Ostomy and urinary catheter supplies
- Peak flow meters
- Supplies associated with oxygen or respiratory equipment
- Test strips for glucose monitors and urine test strips
- Volume nebulizers

Benefits are limited to the allowed amount for the medical supply base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded medical supplies may be eligible for coverage based upon BCBSAZ medical necessity criteria.

H.3 Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- Prosthetic appliances to replace all or part of the function of an inoperative or malfunctioning body organ or to replace an eye or limb lost as a result of trauma or disease
- Orthotics (such as foot orthotics, collars, braces, molds) to protect, restore or improve impaired bodily function
- Wig(s) for individuals diagnosed with alopecia (absence of hair) resulting from illness or injury (up to a maximum benefit of $300 per member, per calendar year)
- Orthopedic shoes that are:
  - attached to a brace; **and**
  - therapeutic shoes (depth inlay or custom-molded) along with inserts, for individuals with diabetes; **and**
  - covered in accordance with BCBSAZ medical necessity criteria.

Benefits are limited to the allowed amount for the prosthetic appliance or orthotic base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded prosthetic appliances or orthotics may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusions for all Durable Medical Equipment, Medical Supplies and Prosthetic Appliances and Orthotics:

- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, corsets, cushions, dentures, diatherapy machines, disposable hygienic items, dressing aids and devices, elastic/support/compression stockings except TED hose, elevators, exercise equipment, foot stools, garter belts, grab bars, health spas, hearing aid batteries except as stated in this plan, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, mineral baths, myoelectric limbs, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas and vehicle or home modifications.
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for help in daily living, socialization, personal comfort, convenience or other nonmedical reasons
- Manual and electric breast pumps and supplies for male members
- Replacement of external prosthetic devices due to loss or theft
- Strollers of any kind
- Supplies used by a provider during office treatments
- Tilt or inversion tables or suspension devices
- Wig(s), when hair loss results from male or female-pattern baldness or natural or premature aging

I. EDUCATION AND TRAINING

Precertification: Not required.

I.1 Diabetes and Asthma Education and Training

Your Cost-Share: You pay in-network deductible and coinsurance.

Benefit Description: Benefits are available for diabetes and asthma education and training from providers whose services are:

- Provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Conducted in person; **and**

- Prescribed by a patient's health care provider as part of a comprehensive plan of care to enhance therapy compliance and improve self-management skills and knowledge for a patient diagnosed with diabetes or asthma.

Benefit-Specific Exclusion: Diabetes and asthma education and training provided by out-of-network providers.

I.2 Nutritional Counseling and Training

Your Cost-Share: Applicable deductible and coinsurance are waived for services from an in-network provider. You pay out-of-network deductible and coinsurance for services from an out-of-network provider. If you receive services from a noncontracted provider, you pay the balance bill.

Benefit Description: Nutritional counseling and training is available for members diagnosed with one or more of the following conditions:

- Coronary Artery Disease
- Heart Failure
- High Cholesterol
- Hypertension
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

J. EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)

Precertification: Not required.

Your Cost-Share: You pay in-network deductible and coinsurance for emergency services, even for services from out-of-network providers. In addition, you pay in-network deductible, then the Plan pays 100 percent of the allowed amount for covered ancillary services provided on the same day as the emergency room visit.

If you receive emergency services from a noncontracted facility or professional provider, BCBSAZ will base the allowed amount used to calculate your cost-share on billed charges.

For all non-emergency services following the emergency treatment and stabilization, you pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive non-emergency services from a noncontracted provider, you also pay the balance bill. The balance bill may be substantial.

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

- The teletrauma consultation is between a provider at the facility where the member is physically located and being treated by one or more providers at certain Level 1 trauma centers.
- The member is receiving emergency treatment in a facility that is not equipped to handle the member's medical condition;
- The treating provider needs the consultation to appropriately treat or stabilize the member.

Benefit-Specific Definitions: "Teletrauma consultation" means telephonic or electronic communications between providers and video presentation of the member's condition between providers, where all consulting providers are located in facilities with the specialized equipment needed to facilitate teletrauma communications.

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

K. EOSINOPHILIC GASTROINTESTINAL DISORDER

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and 25 percent of the Cost of amino-acid based formula ('Formula").

Benefit-Specific Definition: "Cost" is defined as either billed charges, if the Formula is purchased from an out-of-network provider, or the allowed amount, if purchased from an in-network provider.

Benefit Description: Benefits are available for Formula for members who are:

- At risk of mental or physical impairment if deprived of the Formula;
- Diagnosed with eosinophilic gastrointestinal disorder; **and**
- Under the continuous supervision of a physician or a registered nurse practitioner.

L. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share:

In-Network:

Implanted Devices: Your cost-share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved implanted contraceptive devices for female members when the purpose of the procedure is contraception, as documented by your provider on the claim, and the device is inserted and/or removed in an in-network physician office. You pay applicable in-network cost-share when the location of service is outside an in-network physician office.

Sterilization Procedures: Your cost-share is waived for professional and facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim.

You pay applicable in-network cost-share for FDA-approved sterilization procedures provided to male members.

Hormonal Contraceptive Methods: Your cost-share is waived for oral contraceptives, patches, rings and contraceptive injections. See the "Physician Services" and "Pharmacy Benefit" sections for benefits.

Emergency Contraception: Your cost-share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a physician or other provider. See the "Physician Services" section for benefits.

Barrier Contraceptive Methods: Your cost-share is waived for diaphragms, cervical caps, cervical shields, female condoms and sponges and spermicides for female members. See the "Physician Services" and the "Pharmacy Benefit" sections for benefits.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for FDA-approved contraceptive methods and devices and sterilization procedures when prescribed by the member's provider.

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.

M. FERTILITY AND INFERTILITY SERVICES

Precertification: Not required.

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

Benefit Description: Benefits are available to diagnose infertility or to treat the underlying medical condition causing the infertility.

Benefit-Specific Exclusion: Services to improve or achieve fertility (ability to conceive) or to treat infertility (inability to conceive).

N. HOME HEALTH SERVICES

Precertification: Required for certain medications covered under this benefit. Go to www.azblue.com for a listing of medications that require precertification or call the Customer Service number listed in the front of this book. If you fail to obtain precertification for these medications, they will not be covered.

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

Benefit-Specific Definition: "Sole source of nutrition" is defined as the inability to orally receive more than 30 percent of daily caloric needs.

Benefit Description: Benefits are available for the following services:

- Home infusion medication administration therapy, including:
  - Blood and blood components
  - Hydration therapy
  - Intravenous catheter care
  - Intravenous, intramuscular or subcutaneous administration of medication
  - Specialty injectable medications, as defined by BCBSAZ
  - Total parenteral nutrition
- Enteral nutrition (tube feeding) when it is the sole source of nutrition.
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition and other services that require skilled nursing care.

Each service must meet all of the following criteria:

- A licensed home health agency must provide the service in the member's residence;
- A health care provider must order the service pursuant to a specific plan of home treatment;
- The health care provider must review the appropriateness of the service at least once every thirty (30) days or more frequently if appropriate under the treatment plan; **and**
- The service must be provided by a licensed practical nurse (L.P.N.) or a registered nurse (R.N.) or another eligible provider.

Benefit-Specific Exclusions:

- Continuous home health services or shift nursing, including 24-hour continuous nursing care
- Custodial Care
- Private Duty Nursing
- Respite Care

O. HOSPICE SERVICES

Precertification: Not required for inpatient hospice admissions. Required for non-emergency inpatient admissions not related to hospice services. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance. If you receive services from a noncontracted provider, you may pay the balance bill.

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

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

Benefit Description: When a member elects to use the hospice benefit, it is in lieu of other medical benefits available under this plan, except for care unrelated to the terminal illness or related complications.

The hospice agency determines the required level of care, which is subject to the medical necessity provisions of this benefit plan. Once the member selects the hospice benefit, the hospice agency coordinates all of the member's health care needs related to the terminal illness.

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

Benefits are available for the following services:

- ***Continuous Home Care:*** 24-hour skilled care provided by an R.N. or L.P.N. during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- ***Inpatient Acute Care:*** Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- ***Respite Care:*** Admission of the member to an approved facility to provide rest to the member's family or primary caregiver
- ***Routine Care:*** Intermittent visits provided by a member of the hospice team

P. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

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

Q. INPATIENT HOSPITAL

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

For bariatric surgeries received from in- and out-of-network providers, you pay applicable deductible and 50 percent of the allowed amount. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share is waived for facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim.

Please note: You pay in-network cost-share for services received from in- and out-of-network anesthesiologists only when services are received in-network.

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

Benefit Description:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including radiology and laboratory services
- 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, except in conjunction with a noncovered transplant
- Room and board in a semi-private room, unless the hospital only has private rooms. If the hospital only has private rooms, only standard private rooms are covered (not deluxe).

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

R. INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR)

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status.

If you receive services at a noncontracted provider, you also pay the balance bill, in addition to deductible and applicable coinsurance.

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

Benefit Description: Benefits are available for an intense therapy program provided in a facility licensed to provide extended active rehabilitation. This care must be for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

S. LONG-TERM ACUTE CARE (INPATIENT)

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status.

If you receive services from a noncontracted provider, you also pay the balance bill, in addition to deductible and applicable coinsurance.

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

Benefit Description: Benefits are available for specialized acute, medically complex care for patients who require extended hospitalization and treatment in a facility that is licensed to provide long term acute care and which offers specialized treatment programs and aggressive clinical and therapeutic interventions.

Benefit-Specific Exclusions:

- Custodial Care
- Private Duty Nursing
- Respite Care

T. MATERNITY

Precertification: Not required.

Your Cost-Share:

Inpatient Services: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Outpatient Services: You pay applicable deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided in the member's home must be rendered by an eligible provider. Your cost-share will vary depending on the type of provider and the provider's network status.

Applicable cost-share is waived for maternity services covered under the "*Preventive Services*" benefit and delivered by an in-network provider. If you receive these services from an out-of-network provider, the services will be covered through your maternity benefit and you will pay the out-of-network cost-share. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share obligations may be affected by the addition of a newborn or adopted child, as described in the **Plan Administration** section of this book. If you have coverage only for yourself and no Dependents, addition of a child will result in a change from individual coverage to family coverage. If you currently have a per person deductible and out-of-pocket maximum, when a child is added to your plan, you will also be required to meet a family deductible and out-of-pocket maximum, and you may be required to pay additional premium.

Benefit-Specific Definition:

Global Charge: A fee charged by the delivering provider that may include certain prenatal, delivery and postnatal services.

Benefit Description:

Maternity benefits are available for covered services related to pregnancy. This includes certain screening tests such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases and others as determined by BCBSAZ. Certain tests, including some genetic screening, may not be covered. For a complete listing of covered prenatal screening, please call BCBSAZ Customer Service at the numbers listed in the front of this benefit book.

Maternity benefits are available for the expense incurred by a birth mother (who is not a member) for the birth of any child legally adopted by a member, if all of the following requirements are met:

- The member adopts the child within one year of birth;
- The member is legally obligated to pay the costs of birth; **and**
- The member has provided notice to BCBSAZ within sixty (60) days of the member's acceptability to adopt children.

This adopted child maternity benefit is secondary to any other coverage available to the birth mother. Contact Membership Services at the number listed in the front of this book to receive a BCBSAZ adoption packet.

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

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

U. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and 50 percent of the Cost of Medical Foods.

Benefit-Specific Definitions:

"Cost" is defined as either billed charges, if the member buys the Medical Foods from an out-of-network provider or the allowed amount, if the member buys the Medical Foods from an in-network provider.

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

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

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

- Administered for the medical and nutritional management of a member who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation;
- Essential to the member's optimal growth, health and metabolic homeostasis;
- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an M.D. or D.O. physician or a registered nurse practitioner;
- Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs (metabolic formula only); **and**
- Processed or formulated to contain less than one gram of protein per unit of serving (modified low protein foods only).

Benefit Description: Benefits are available for Medical Foods to treat Inherited Metabolic Disorders.

Benefit-Specific Exclusions:

- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available for purchase without a prescription or order from an M.D. or D.O. physician or registered nurse practitioner
- Foods and formulas that do not require supervision by an M.D. or D.O. physician 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

Claim submission for Medical Foods

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

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

Medical Foods claim forms are available from BCBSAZ. Submit the completed Medical Foods Claim Form and the dated receipt to the address for claims submission at the front of this book.

Medical Foods also may be covered under the *"Home Health Services"* benefit. Medical Foods are not covered under the *"Pharmacy Benefit."*

V. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Precertification: Not required.

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

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

W. OUTPATIENT SERVICES

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

For bariatric surgeries received from in- and out-of-network providers, you pay applicable deductible and 50 percent of the allowed amount. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share is waived for facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim.

Please note: You pay in-network cost-share for services received from in- and out-of-network anesthesiologists only when services are received in-network.

Benefit Description: Benefits are available for the following outpatient services:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including laboratory and radiology services
- Outpatient surgery, which is defined as operative procedures and other invasive procedures such as epidural injections for pain management and various scope procedures, such as arthroscopies and colonoscopies
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant

X. PHARMACY BENEFIT

Precertification (Prior Authorization): Required for certain medications. Contact the Pharmacy Benefit Customer Service number listed in the front of this book for a list of medications that require precertification. If you do not obtain precertification for medications that require precertification, the medications will not be covered.

Information About This Benefit

Contact the Pharmacy Benefit Customer Service number listed in the front of this book to request any of the following:

- A list of covered medications that require precertification;
- A list of covered vaccines;
- An exception to BCBSAZ prescription medication limitations;
- Information on the assigned cost-share Level of a covered medication; or
- Other information about this Pharmacy Benefit.

Your Cost-Share:

In-Network:

Medications Obtained From Retail/Mail Order Pharmacies: You pay in-network deductible. After you satisfy the deductible, you pay a Level 1, 2, or 3 copay for most medications. After you satisfy the deductible, you pay the greater of the Level 3 copay or 50 percent coinsurance for compounded medications.

Your cost-share is waived for preventive medications and for covered vaccines. BCBSAZ will determine which medications are considered preventive and for which your cost-share is waived. BCBSAZ also determines which vaccines are covered and for which your cost-share is waived.

Your cost-share is waived for the following contraceptive methods when prescribed by your provider and obtained from an in-network pharmacy:

- FDA-approved diaphragms, cervical caps and cervical shields
- FDA-approved emergency contraception for female members of any age
- FDA-approved generic oral, patch, vaginal ring and injectable contraceptives
- FDA-approved brand oral, patch, vaginal ring and injectable contraceptives with no generic equivalent components

- Female condoms
- Sponges and spermicides for female members

Contraceptives must be prescribed for or include the purpose of contraception and not be prescribed solely for some other medical reason to be covered with no member cost-share.

Out-of-Network: You pay out-of-network deductible and coinsurance, plus the balance bill.

Benefit-Specific Definitions:

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

"PBM" means the independent pharmacy benefit manager that contracts with BCBSAZ to administer the prescription medication benefits covered under this benefit plan.

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

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

You may obtain prescription medications covered under this benefit from retail pharmacies or the in-network mail order pharmacy. Compounded medications are eligible for coverage only when purchased through retail pharmacies.

Covered medications are subject to limitations, including but not limited to, quantity, age, gender, dosage, and frequency of refills. BCBSAZ and/or the PBM determines which medications are subject to limitations. **Medication limitations are subject to change at any time without prior notice.**

The following medical devices are covered under this benefit: diabetic test strips, lancets, diabetic syringes/needles for insulin and spacer devices for asthma medications. Certain vaccines are covered when obtained from in-network retail pharmacies and administered by a certified, licensed pharmacist.

Benefit-Specific Exclusions:

- Abortifascient medications
- Administration of a covered medication
- All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms,
- Biologic serums
- Certain categories of injectable medications
- Compounded medications obtained from a mail order pharmacy
- Formula for Eosinophilic Gastrointestinal Disorder
- Medications, devices, equipment and supplies lawfully obtainable without a prescription, except as stated in this benefit plan
- Medical devices, except as stated in this benefit
- Medical Foods
- Medication delivery implants
- Medications designated as clinic packs
- Medications dispensed to a member who is an inpatient in any facility
- Medications for athletic performance
- Medications for lifestyle enhancement
- Medications labeled "Caution - Limited by Federal Law to Investigational Use" or words to that effect and any experimental medications as determined by BCBSAZ and/or the PBM, except as stated in this benefit plan
- Medications obtained from an out-of-network mail order pharmacy

- Medications packaged with one other or multiple other prescription products
- Medications packaged with over-the-counter medications, supplies, medical foods, vitamins or other excluded products
- Medications that exceed BCBSAZ and/or the PBM's limitations, including, but not limited to, quantity, age, gender and refill limits.
- Medications used for any cosmetic purpose, including but not limited to, Tretinoin for members age 26 and older
- Medications used to treat a condition not covered under this plan
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging or name
- Prescription medications dispensed in unit-dose packaging, unless that is the only form in which the medication is available
- Prescription refills for medications that are lost, stolen, spilled, spoiled or damaged
- Medications designed for weight gain or loss, including but not limited to, Xenical® and Meridia®, regardless of the condition for which it is prescribed
- Medications to improve or achieve fertility or treat infertility
- Specialty self-injectable medications
- Transsexual medications

Y. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), AND SPEECH THERAPY (ST) SERVICES

Precertification: Not required.

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

Benefit Maximum: You have a combined in- and out-of-network maximum of sixty (60) PT, OT, and ST visits per member, per calendar year.

Benefit Description: Benefits are available for PT, OT, and ST services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care meant to help an individual in the activities of daily living or for comfort and convenience
- Cognitive therapy
- Computer speech training and therapy programs and devices
- Custodial Care
- Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines
- Phase III cardiac rehabilitation programs
- Physical or occupational therapeutic services performed in a group setting of 2 or more individuals
- Rehabilitation services rendered after a member has met functional goals
- Rehabilitation services rendered when no objectively measurable improvement is reasonably anticipated
- Rehabilitation services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Strength training, cardiovascular endurance training, fitness programs, strengthening programs and other services designed primarily to improve or increase strength

Z. PHYSICIAN SERVICES

Precertification: Not required.

Your Cost-Share:

In-Network: You pay in-network deductible and coinsurance.

Out-of-Network: You pay out-of-network deductible and coinsurance for services rendered by an out-of-network physician. If you receive services from a noncontracted provider, you also pay the balance bill.

See the "Emergency" section for cost-share for emergency professional services.

Benefit Description: Benefits are available for the following:

- General surgical procedures (including assistance at surgery) provided outside a physician's office. Only certain surgical assistants are eligible providers. Call BCBSAZ Customer Service at the numbers listed in the front of this book to verify that the surgical assistant chosen by your physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your physician are in-network providers.
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics)
- Inpatient medical visits
- Second surgical opinions
- FDA-approved patches, rings and contraceptive injections for female members
- FDA-approved diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides for female members
- FDA-approved emergency contraception
- Professional physician services for FDA-approved sterilization procedures
- Professional physician services for fitting, implantation and/or removal (including follow-up care) of FDA-approved contraceptive devices in female members
- FDA-approved implanted contraceptive devices for female members

The following circumstances may impact member cost-share for physician services:

- If multiple surgical procedures are performed during a single operative session, the secondary procedures are usually reimbursed at reduced amounts. Noncontracted providers may bill the full amount for secondary, incidental or mutually exclusive procedures, in addition to the primary surgical procedure.

- You may receive services in a physician's office that incorporate services or supplies from a provider other than your physician. If the other provider submits a separate claim for those services or supplies, you will pay the cost-share for the other provider plus the cost-share for your office visit. Examples of services or supplies from another provider include durable medical equipment from a medical supply company, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.

AA. POST-MASTECTOMY SERVICES

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving the mastectomy-related benefits described above under "Benefit Description," coverage will be provided 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, as described in the "Member Cost-share" section of your SBC. If you would like more information on WHCRA benefits, call BCBSAZ Customer Service at the number listed in the front of this benefit book.

BB. PREGNANCY, TERMINATION

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

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

The treating provider certifies in writing the abortion is medically necessary in order to save the life of the mother or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.

Benefits are also available for abortifascient medications for the abortions covered under this plan, including some oral medications, as described in the BCBSAZ Medical Coverage Guidelines.

Benefit-Specific Exclusion: Abortions, except as stated in this benefit.

CC. PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER

Precertification: May be required depending on the medication received. **Contact the Pharmacy Benefit Customer Service number listed in the front of this book for a list of medications that require precertification.**

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

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

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

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

DD. PREVENTIVE SERVICES

Precertification: Not required.

Your Cost-Share:

All preventive services, except for mammography, foreign travel immunizations, nutritional counseling and training, and routine vision exams for members under age 5, must be received from in-network providers or the services will not be covered.

Your cost-share is waived, regardless of the location where services are provided, if:

- You receive services from an in-network provider;
- You receive one of the services listed in the Benefit Description subsection of this Preventive Services section; **and**
- The diagnosis codes, procedure codes, or combination of procedure and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive.

Out-of-Network Mammography Services: Deductible is waived. You pay out-of-network coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Out-of-Network Foreign Travel Immunizations: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

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

Benefit Maximum: Benefits are limited to one (1) manual or electric (not hospital grade) breast pump and breast pump supplies per female member, per calendar year.

Benefit Description: All preventive services listed in this benefit section, except for certain services cross-referenced in other benefit sections, must be received from in-network providers or the services will not be covered. For services listed in this benefit section and cross-referenced in other benefit sections, see the cross-referenced benefit section to determine whether services from out-of-network providers are covered and, if applicable, cost-share for those services from out-of-network providers.

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

- Preventive physical examination, i.e. routine physical examination, including the following services when done for screening purposes only:
  - resting electrocardiogram (EKG)
  - lung function test (spirometry)
  - vision and hearing screening (this may include newborn audiological evaluation in the hospital)
  - fecal occult blood test
  - general health laboratory panel (bilirubin, calcium, carbon dioxide, chloride, creatinine, alkaline phosphatase, potassium, total protein, sodium, ALT, SGPT, AST, SGOT, BUN, TSH)
  - thyroid function testing (TSH)
  - complete blood count (CBC)
  - lipid panel (cholesterol panel and triglycerides)
  - fasting glucose (blood sugar); HbA1c
  - urinalysis
  - blood lead
  - sexually transmitted disease (STD) counseling and testing, including HIV and HPV screening
  - prostate specific antigen (PSA) testing
  - TB testing

- Aspirin prescribed for prevention of cardiovascular disease for men ages 45 to 79 and women ages 55 to 79. See the "Pharmacy Benefit" section.
- Behavioral intervention to promote breast-feeding for women
- Bone density testing for osteoporosis
- Counseling and behavioral interventions to promote sustained weight loss for obese adults
- Counseling (annually) for HIV infection for all sexually active women
- Counseling (annually)on sexually transmitted infections for all sexually active women
- Counseling for female members who are at increased risk for breast cancer about medications to reduce the risk of breast cancer. For female members at increased risk of breast cancer and at low risk of adverse medication effects, coverage of risk-reducing medications, such as tamoxifen or raloxifene

- Counseling for members ages 10-24 regarding minimizing the risk of UV radiation exposure to reduce the risk of skin cancer
- Counseling for tobacco cessation and augmented pregnancy counseling for members who use tobacco
- Counseling on contraceptive methods for all women with reproductive capacity
- Developmental/Behavioral Assessments including developmental screening, Autism screening, developmental surveillance, and psychosocial/behavioral assessment for children from newborns through 21 years of age
- FDA-approved contraceptive methods for female members, as prescribed. See the "Family Planning", "Physician Services" and "Pharmacy Benefit" sections.
- FDA-approved sterilization procedures for female members, as prescribed. See the "Family Planning" and "Physician Services" benefit sections.
- Folic acid supplementation prescribed for females. See the "Pharmacy Benefit" section.
- Interventions, including counseling and education, to prevent initiation of tobacco use in school-aged children and adolescents
- Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease
- Lactation support counseling during pregnancy and/or in the post-partum period
- Mammogram
- Oral fluoride supplementation prescribed for children starting at age 6 months who live in areas where the water service is deficient in fluoride
- Physical therapy or exercise for members age 65 and older living in community dwellings to minimize falls
- Prophylactic ocular topical mediation for all newborns for the prevention of gonococcal ophthalmia neonatorum
- Rental or purchase of manual or electric breast pumps and breast pump supplies when obtained from in-network durable medical equipment (DME) providers. See the "Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics" benefit section.
- Repeated antibody testing for unsensitized Rh(D)-negative pregnant women at 24-28 weeks gestation, unless the biological father is known to be Rh(D) negative
- Routine gynecologic exam including Pap test and other cervical cancer screening test
- Routine immunizations and immunizations for foreign travel, as determined by BCBSAZ
- Routine iron supplementation prescribed for asymptomatic children ages 6 months through 12 months who are at increased risk for iron deficiency anemia
- Screening (annually) for lung cancer with low-dose computed tomography (LDCT) for members age 55 to 80 with a 30 year or more year history of smoking and who currently smoke or have quit smoking within the past 15 years. Screenings will be discontinued if the member (1) has not smoked for 15 years or more; (2) develops a health problem that limits life expectancy; or (3) is unwilling to have curative lung surgery.
- Screening and counseling (annually) for interpersonal and domestic violence
- Screening, counseling and behavioral intervention for obesity, including children age 6 and older
- Screening for high blood pressure in adults age 18 and older
- Smoking cessation medications and devices, as prescribed
- Screening for abdominal aortic aneurysm by ultrasonography for men ages 65 to 75 who have ever smoked
- Screening for alcohol misuse and behavioral counseling interventions for pregnant women
- Screening for alcohol and drug use/misuse in children age 11 years and older
- Screening for asymptomatic bacteriuria for pregnant women at 12-16 weeks gestation or at first prenatal visit, if later
- Screening for depression for members age 11 and older
- Screening for gestational diabetes mellitus (GDM) at (1) the first prenatal visit (2) prior to 24 weeks of gestation based upon risk factors for type 2 diabetes, such as obesity, family history of type 2 diabetes or fetal macrosomia during a previous pregnancy; and (3) after 24 weeks of gestation.
- Screening for Hepatitis B (HBV) virus infection for pregnant women at their first prenatal visit
- Screening for Hepatitis C virus infection for persons at high risk for infection
- Screening for Hepatitis C virus infection for adults born between 1945 and 1965 (one-time screening)
- Screening for HIV infection in adolescents and adults ages15-65, younger adolescents and older adults who are at increased risk of infection, and all pregnant women including those presenting in labor who are untested or whose HIV status is unknown.
- Screening for iron deficiency anemia for asymptomatic pregnant women
- Screening for major depressive disorders for members ages 12 through 18

- Screenings for newborns as required by Arizona and federal law
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Screening sigmoidoscopy or colonoscopy
- Screening women who have family members with breast, ovarian, tubal, or peritoneal cancer and for those women with positive screening results, provide genetic counseling and, if indicated after counseling, BRCA testing.
- Vision screenings for children under age 5
- Vitamin D supplementation for members age 65 and older living in community dwellings to minimize falls
- Any other preventive service required by federal or state law to be covered

For information on the foreign travel immunizations covered under this benefit, go to the Medical Coverage Guidelines available at www.azblue.com/member, or call BCBSAZ Customer Service at the number listed in the front of this book.

Benefit-Specific Exclusions:

- Abortifascient medications
- All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.
- Any service or test not specifically listed in this benefit description or in another section of this benefit book, such as chest X-rays, will not be covered when performed for preventive or screening purposes
- Except as stated in this benefit book, preventive services provided by an out-of-network provider.

Services or tests listed under this benefit and provided to a member with a specific diagnosis, signs or symptoms of a condition or disease for which the test is being performed may be covered through another benefit section of this plan. Certain maternity services covered under this benefit are also available through the "Maternity" benefit.

EE. RECONSTRUCTIVE SURGERY AND SERVICES

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

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

Benefit Description: Benefits are available for reconstructive surgery, which is surgery performed to improve or restore the impaired function of a body part or organ resulting from one of the following:

- Congenital defects;
- Illness and disease;
- Injury and trauma;
- Surgery; **or**
- Therapeutic intervention

Benefit-Specific Exclusion: Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy to the extent required by state and federal law.

FF. SKILLED NURSING FACILITY (SNF)

Precertification: Required. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status.

If you receive SNF services at a noncontracted provider, you also pay the balance bill, in addition to deductible and applicable coinsurance.

Benefit Maximum: You have a combined in- and out-of-network maximum of 240 days per member, per calendar year.

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

Benefit Description: Benefits are available for inpatient skilled nursing facility services provided in a facility licensed to offer skilled nursing services. Skilled nursing services must be provided by and under the supervision of qualified and licensed professionals, such as a licensed practical nurse (L.P.N.) or registered nurse (R.N.) and provided at a level of complexity and sophistication requiring assessment, observation, monitoring and/or teaching or training to achieve the medically desired outcome.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

GG. SPECIALTY SELF-INJECTABLE MEDICATIONS

Precertification: Required for all specialty self-injectable medications. If you fail to obtain precertification, these medications will not be covered.

Your Cost-Share: You pay in-network deductible and coinsurance.

If a member obtains a specialty self-injectable medication from an eligible provider other than a pharmacy contracted with BCBSAZ for the specialty self-injectable medications benefit ("specialty pharmacy"), the medication is excluded from coverage under this benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

Benefit Description: Benefits are available for specialty self- injectable medications obtained from a specialty pharmacy contracted with BCBSAZ. Coverage of specialty self-injectable medications and limitations on these medications are determined by the Medical Coverage Guidelines and Pharmacy Coverage Guidelines, and may change at any time without prior notice.

Benefit-Specific Exclusions:

- All benefit-specific exclusions listed under "Pharmacy Benefit," except for the exclusion for specialty self-injectable medications
- Medications obtained from a pharmacy not specifically contracted with BCBSAZ as a specialty pharmacy

HH. TRANSPLANTS - ORGAN - TISSUE - BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES

Precertification: Required prior to any organ, tissue or bone marrow transplant or stem cell procedure. You will not be penalized if your in-network provider fails to obtain precertification. If your out-of-network provider fails to obtain precertification, you will be responsible for a precertification charge.

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

If both a donor and a transplant recipient are covered by a BCBSAZ plan or a plan administered by BCBSAZ, the transplant recipient pays the cost-share related to the transplant.

BCBSAZ is contracted with certain facilities to provide covered transplants to BCBSAZ members. Not all such facilities are contracted to provide services related to a covered transplant, such as pre-transplant testing, certain types of chemotherapy and radiation therapy and other services covered under this plan. If you receive pre-transplant testing or other services associated with the transplant from a facility that is not contracted with BCBSAZ or a Host Blue to provide those services, you will pay your out-of-network cost-share, plus the balance bill.

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

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

Benefit Description: The following transplants are eligible for coverage if they meet the Medical Coverage Guidelines:

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

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

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

Benefit-Specific Exclusions:

- Expenses related to a noncovered transplant
- Expenses related to donation of an organ to a recipient who is not covered by BCBSAZ
- Transplants that do not meet the Medical Coverage Guidelines

II. TRANSPLANT TRAVEL AND LODGING

Precertification: Not required.

Your Cost-Share: You pay in-network deductible and coinsurance.

Benefit Maximum: Maximum of $10,000 per member, per transplant. Covered expenses incurred by a caregiver accumulate toward the member's $10,000 per transplant maximum.

Benefit-Specific Definition: "Caregiver" is the individual 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.

Benefit Description: Coverage is available for reimbursement of the travel and lodging expenses listed below, when all the following criteria are met:

- The expenses are incurred by a member receiving a covered transplant procedure or the member's Caregiver,
- BCBSAZ has precertified the transplant procedure;
- The distance from the member's, donor's or Caregiver's residence must be more than seventy-five (75) miles from the transplant facility;
- The member is receiving a covered solid organ, bone marrow or stem cell transplant;
- The member must receive the transplant from a provider contracted with BCBSAZ, a provider contracted with the local Blue Cross and/or Blue Shield plan where services are rendered or a Blue Distinction Centers for Transplants (BDCT) facility;
- The member must be receiving medically necessary pre- and post-operative treatments, including without limitation, treatment of complications related to the covered transplant or routine follow-up care for a covered transplant or a transplant that occurred while the member was covered by another insurance plan; **and**
- The expenses are for any of the following:
    - Meal expenses;
    - Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; bus; train or air fare; **and**
    - Room charges from hotels, motels and hostels or apartment rental.

Benefit-Specific Exclusions:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or Internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of the $10,000 per member, per transplant maximum
- Ambulance transportation (ground or air)
- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with noncovered transplant services or any follow-up care, including treatment of complications
- Expenses for travel or lodging related to evaluation, consultation or medical testing to determine if a member is a candidate for transplantation
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Travel and lodging expenses for transplants other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service
- Travel and lodging expenses for members, donors or Caregivers when the member, donor or Caregiver does not travel more than seventy-five (75) miles for an authorized transplant or transplant-related services
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement

To request reimbursement of eligible transplant travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to BCBSAZ. The address for claims submission and phone number for requesting claim forms are listed in the BCBSAZ Customer Service section at the front of this book.

JJ. URGENT CARE

Precertification: Not required.

Your Cost-Share: You pay in-network deductible and coinsurance for services from a provider who is contracted with BCBSAZ to render urgent care services. You pay applicable cost-share if you receive urgent care services from an in-network provider who is not specifically contracted for urgent care services. You pay out-of-network deductible and coinsurance if you receive services from an out-of-network urgent care provider. If you receive services from a noncontracted provider, you also pay the balance bill.

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

Benefit Description: Benefits are available for urgent care services rendered by a contracted, free-standing urgent care provider. These providers are listed in your provider directory and on the BCBSAZ website at www.azblue.comunder "Urgent Care Centers."

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

KK. VISION EXAMS (ROUTINE)

Precertification: Not required.

Your Cost-Share:

For Members Under Age 5: Applicable cost-share is waived for services from an in-network provider. For services from an out-of-network vision care provider, you pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

For Members Age 5 and Older: You pay in-network deductible and coinsurance for an exam by an in-network vision care provider. If you receive the exam from an out-of-network vision care provider, you pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

If a medical condition is identified during your routine vision exam, you will be responsible for additional cost-sharing.

Benefit Description: Benefits are available for routine vision exams.

Benefit-Specific Definition: 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.

Benefit-Specific Exclusions:

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

WHAT IS NOT COVERED

NOTWITHSTANDING ANY OTHER PROVISION IN THIS PLAN, NO BENEFITS WILL BE PAID FOR EXPENSES ASSOCIATED WITH THE FOLLOWING:

Abortions, except as stated in this plan

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

Acupuncture

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

Bariatric Surgeries excluded by the BCBSAZ Medical Coverage Guidelines

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

Biofeedback and hypnotherapy

Blood Administration for the purpose of general improvement in physical condition

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

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

Care required by state or federal 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. Inpatient and outpatient facility charges for services provided by residential treatment facilities are not covered except for certain very limited situations based upon BCBSAZ medical necessity criteria. All other inpatient and outpatient services provided by residential treatment facilities are not covered.

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

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

Complications of Noncovered Services – Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under this plan. Medical complications arising from an abortion are covered under this plan

Computer Speech Training, Therapy Programs and Devices

Consumable Medical Supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as stated in this plan

Cosmetic Services and any Related Complications – Surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy 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 this plan

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

Custodial Care

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

Dietary and Nutritional Supplements – All dietary, caloric and nutritional supplements, such as specialized formulas for infants, children or adults or other special foods or diets, even if prescribed, except as stated in this plan

Expenses for services that exceed benefit limitations

Experimental or Investigational Services

Fees- Associated with the collection or donation of blood or blood products

Fees – Fees other than for medically appropriate, in-person, direct member services, except as stated in this plan

Fees – Fees for concierge medicine services

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, except arch supports may be covered when medically necessary for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

Foot Care – Services for foot care, including trimming of nails or treatment of corns or calluses, except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

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

Genetic and Chromosomal Testing, Screening and Therapy – Genetic and chromosomal testing, screening and therapy for an individual who is asymptomatic, unaffected or not displaying signs or symptoms of a disorder for which the test, screening or therapy is performed

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

Growth Hormone – Growth hormone, except as specified in the Medical Coverage Guidelines. Growth hormone to treat Idiopathic Short Stature (ISS) is expressly excluded.

Hearing Services and Devices, except as stated in this plan

Inpatient or Outpatient Long Term Care

Lifestyle Education and Management Services

Lodging and Meals – Lodging and meals, except as stated in this plan

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

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

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

Massage Therapy – Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines

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

Medications – Medications which are:

- Not FDA approved
- Not required by the FDA to be obtained with a prescription, except as stated in this plan
- Not used in accordance with the Medical Coverage Guidelines or Pharmacy Coverage Guidelines
- Used to treat a condition not covered by BCBSAZ
- Off-label, unlabeled and orphan medications, except as stated in this plan

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

Membership Costs or Fees associated with health clubs and weight loss programs.

Neurofeedback

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

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

Over-the-Counter Items – Medications, devices, equipment and supplies that are lawfully obtainable without a prescription, except as stated in this plan

Payments for exclusions imposed by any certification requirement

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

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

Phase 3 Cardiac Rehabilitation

Private Duty Nursing

Refills or Replacements - Refills or replacements for medications covered under this benefit 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, employment, insurance or government licenses, and court-ordered, forensic, or custodial evaluations.

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

Respite Care, except as covered in the Hospice Services benefit

Reversal of Sterilization

Reversal of Transgender Surgery

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

Sensory Integration, LOVAAS Therapy and Music Therapy

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

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 Weight Loss and Gain, except as stated in this plan

Services from a Family Member – Services delivered by an eligible provider who is a member of your immediate family or a member of a Dependent's immediate family. "Immediate family" members are: parents, siblings, children, stepparents, stepchildren, spouses, domestic partners, grandparents, grandchildren and any of the preceding individuals related to the member by marriage. When a provider is also the covered person, services rendered by that provider for himself or herself are also excluded from coverage

Services from Ineligible Providers

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

Services Paid for By Other Organizations – Services customarily paid for by an employer, such as worksite or ergonomic evaluations; the government; a school; biotechnical, pharmaceutical or medical device industry sources; or other individuals and organizations

Services Prior to Member's Coverage Effective Date

Services Provided After the Member's Coverage Termination Date, except as stated in this plan

Services Related to or Associated with Noncovered Services

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

Sexual Dysfunction – Services for sexual dysfunction, regardless of the cause

Smoking Cessation – Smoking cessation programs

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, except as stated in this plan

Telemedicine Services, except as stated in this plan

Telephonic and Electronic Consultations – Telephonic and electronic consultations, except as stated in this plan

Therapy Services, except as stated in this plan

Therapy to Improve General Physical Condition including, but not limited to, inpatient and outpatient routine long term care

Training and Education – Training and education, except as stated in this plan

Transportation – Transport services and travel expenses, except as stated in this plan

Transgender Treatment, Surgery, Medications and Related Services

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; vision examinations for fitting of eyeglasses and contact lenses, except as stated in this plan

Vitamins – All vitamins, minerals and trace elements that are lawfully obtainable without a prescription, except as stated in this plan

Workers' Compensation – Illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election. BCBSAZ will only exclude claims for services to treat illnesses and injuries covered by Workers' Compensation when the claim(s) submitted to BCBSAZ are expressly identified as Workers' Compensation claim(s).

PLAN ADMINISTRATION

Changes to Your Information

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

Notify BCBSAZ Membership Services about changes to the following:

- Individuals being added to the benefit plan: Spouse, newborns, adopted children, children placed for adoption, stepchildren
- Eligibility of you or your Dependents for Medicare during the term of this contract
- Your mailing address or phone number
- Other medical coverage that you or your Dependents add or lose, including any changes in benefits
- Eligibility of you or your Dependents for Arizona Health Care Cost Containment System (AHCCCS) or other Medicaid coverage 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
- Eligibility of you or your Dependents for basic health plan (BHP) coverage during the term of this contract
- Eligibility of you or your Dependents for individual coverage purchased through a state or Federal Exchange.
- Individuals removed from the benefit plan due to divorce or death
- A disabled Dependent age 26 or older who is no longer disabled

Coordination of Benefits (COB)

If you are eligible for benefits under any other group health insurance, the combined benefit payments from all coverages will not exceed 100 percent of the billed charges. In addition, BCBSAZ's payment will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If your other group health insurance does not include a coordination of benefits provision, the other group coverage pays first. If your other group health insurance provides for coordination of benefits, the following rules will be used to determine which coverage will pay first:

- If the person is an inpatient on the day this benefit plan becomes effective and benefits are payable under the person's prior health care coverage for the inpatient stay, the prior health care coverage pays first.

- If the person who received care is covered as an active employee under one benefit plan and as a Dependent under another, the employee coverage pays first.

- If the person who receives care is covered as an active employee under one benefit plan and as an inactive employee under another, the coverage through active employment pays first.

- If the person who receives care is a Dependent child, then the plan benefits of the parent whose birthday occurred earlier in a calendar year shall cover the child first.

- If both parents have the same birthday, the benefits of the plan that covered a parent longer shall cover a Dependent child first.

- If one of the plans determines the order of benefits based upon the gender of a parent and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rule shall determine the order of benefits.

- If the Dependent child's parents are legally separated or divorced, the following applies:

    - If a court decree specifies the parent who is financially responsible for the child's healthcare expenses, the specified parent's coverage pays first.

    - If there is no applicable court decree, the custodial parent's coverage pays first. If the custodial parent has remarried, the stepparent's coverage pays second. The non-custodial parent's coverage pays last.

- If the parents have joint custody, the plan benefits of the parent whose birthday occurred earlier in a calendar year pays first.

When none of the above applies, the coverage you have had for the longest continuous period of time pays first (see *"Non-Duplication of Benefits"*).

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

Non-Duplication of Benefits

If services are covered under this benefit plan and one or more other group benefit plans that are issued or administered by BCBSAZ, the rules described above in *"Coordination of Benefits"* will be used to determine which coverage pays first. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If services are covered under this benefit plan and one or more BCBSAZ individual contracts, benefits will be paid first under the individual contract. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed 100 percent of the amount BCBSAZ would have paid if you had no other coverage. BCBSAZ does not coordinate benefits with non-group coverage provided by an insurance plan other than BCBSAZ.

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

Definitions Related to Plan Administration

- **"Dependents"** are the following individuals: (1) the Contractholder's spouse under a legally valid existing marriage; and (2) the Contractholder's children or the children of the Contractholder's spouse, including birth children, legally adopted children, stepchildren, children placed for adoption, children under legal guardianship substantiated by a court order and children who are entitled to coverage under a medical support order.
- **"Disabled Dependent Child"** is a child who has reached age 26 and who meets criteria for coverage under this plan described in "Eligibility Requirements," below.
- **"Employee/Retiree"** refers to the person eligible for this benefit plan because of his/her employment relationship or former employment relationship or affiliation to the Group. An employee is also the Contract holder under this plan.
- **"Group"** refers to the employer or other entity to which a Group Master Contract is issued by BCBSAZ.
- **"Group Master Contract"** refers to the agreement between the employer or other entity and BCBSAZ.
- **"Open Enrollment"** is an annual period during which the Contractholder and Dependents are eligible to enroll for coverage or change benefit plan options. Your Group's benefit plan administrator will notify the Contractholder of the Group's open enrollment period. Contractholders and/or any Dependents can change benefit plans only during an open enrollment period, except as set forth in this benefit book or as allowed under applicable law.

Eligibility Requirements

- **Children** – Children are eligible for Dependent coverage until their 26th birthday.
- **Contractholder** – A Contractholder becomes eligible to enroll for coverage after meeting the Group's eligibility requirements outlined in the Group Master Contract.
- **Disabled Dependent Child** – A child who has reached age 26 may continue coverage as a Dependent under this plan if the child is otherwise eligible for the plan and meets all of the following criteria:
  - Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;

- Is continuously incapable of self-sustaining employment because of mental or physical disability on the date the Dependent reaches age 26; **and**
- Is dependent on the Contractholder for maintenance and support, as determined by BCBSAZ criteria.

Medical reports, acceptable to BCBSAZ, must substantiate the incapacity and must be submitted by the Contractholder within thirty-one (31) days of the date such child reaches age 26. The child's eligibility to continue this coverage as a Dependent under this plan is subject to periodic review by BCBSAZ.

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

- **Retiree** – Please see your benefit plan administrator to determine eligibility requirements for a retiree and his/her eligible dependents.

Effective Date of Coverage

- **Contractholder** – A Contractholder's effective date of coverage will be either the date the Contractholder becomes eligible to enroll or the first billing date after the Contractholder becomes eligible to enroll as determined by the Group, as long as the Contractholder completes the application process within thirty-one (31) days of becoming eligible.

- **Dependent** – Dependent coverage is available only if an eligible Contractholder has enrolled for coverage. Eligible Dependents will have the same effective date as the Contractholder if they are included on the application at the time the Contractholder first enrolls. If the Contractholder and/or Dependents do not enroll when first eligible, the Contractholder and/or Dependents may only apply for coverage at the Group's annual open enrollment period, except as stated in *"Special Enrollment Provisions"* or if court-ordered. The effective date of coverage for an application made during an open enrollment period is the Group's anniversary date following that open enrollment period.

- **Spouse** – The effective date for a new spouse is the date of marriage, if the Contractholder completes an application within thirty-one (31) days of that date; otherwise, the spouse may not enroll until the next open enrollment period, unless he or she qualifies under *"Special Enrollment Provisions."*

- **Newborn/Adopted Child/Child Placed for Adoption** – A child is eligible for coverage under this benefit plan following birth or adoption, so long as: (1) the parent or guardian covered under this benefit plan remains eligible for coverage; and (2) the parent or guardian covered under this benefit plan submits the appropriate enrollment documentation to the group to enroll the child for coverage within thirty-one (31) days following the date of birth, adoption or placement for adoption. No claims will be paid until the child is enrolled in this benefit plan and BCBSAZ receives notification from the group that indicates the child has been enrolled in this benefit plan. If the parent or guardian covered under this benefit plan does not enroll the child within thirty-one (31) days following the date of birth, adoption or placement for adoption, the parent or guardian covered under this benefit plan must wait until the next open enrollment period to enroll the child.

  Contact Membership Services at the number listed in the front of this benefit book to receive a BCBSAZ adoption packet.

- **Other Children** – The effective date for a Dependent child who is not a newborn child, adopted child or a child placed for adoption (as described above) shall be the date the child becomes an eligible Dependent, as long as the Contractholder completes an application to add the child within thirty-one (31) days of that date. If an application is not completed within thirty-one (31) days, the child may not enroll until the next open enrollment period, unless the child qualifies under *"Special Enrollment Provisions."*

Loss of Eligibility

Contractholder eligibility ends on the following days:

- The end of the month in which the Contract holder was entitled to receive compensation from the group, regardless of the date such compensation is actually paid.

- The end of the month in which an approved leave of absence expires, if the Contract holder fails to return to active employment.

- The date of death.
- The end of the month in which the Group and/or Contractholder fails to pay any amounts due and any grace period available under Arizona law is exhausted.

Dependent eligibility ends on the following days:

- For a dependent spouse and any children of that spouse who are not the birth or adopted children of the Contract holder, the end of the month during which the divorce decree becomes final.
- The end of the month in which the child turns age 26, if the child is not a disabled dependent child.
- The end of the month in which the disability or dependency ceases for a disabled dependent child over age 26.
- The end of the month in which a child covered by a medical support order is no longer eligible under the court order or administrative order.
- The end of the month in which the Contract holder's death occurs or as might otherwise be provided in the Group Master Contract.
- The surviving dependent spouse, and any eligible dependent children of any employee killed in the line of duty or in the course and scope of City Employment are covered until the end of the month in which the spouse remarries or attains Medicare eligibility; or to the end of the month in which the eligible dependent child turns age 26.

Some Groups have up to thirty-one (31) days to notify BCBSAZ that a Contractholder or Dependent has become ineligible. Until BCBSAZ receives notice and processes the termination of eligibility, BCBSAZ may quote benefits, give precertification or pay claims that ultimately will be recouped from members or providers, if it is later determined the member was ineligible on the date services were received. Such benefit quotations or precertifications become null and void, regardless of whether the Group has notified the Contractholder that eligibility terminated.

Retiree eligibility:

Please see your benefit plan administrator for information regarding loss of retiree's eligibility and termination dates of coverage and the dates for a retiree's dependents.

Special Enrollment Periods

A special enrollment period is available for the following qualifying events, as applicable to the individual seeking coverage when such individual requests coverage under this benefit plan by completing an application within thirty-one (31) days of the loss of other coverage:

- A person loses minimum essential coverage, as that term is defined in applicable law
- A person gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption
- The death of the covered employee
- A person has coverage through his or her spouse and the spouse dies
- A person has coverage through his or her spouse and a divorce or legal separation occurs
- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of the covered employee's employment
- The divorce or legal separation of the covered employee from the covered employee's spouse
- The covered employee becomes entitled to Medicare
- A dependent child ceases to be a dependent child under the generally applicable requirement of the plan
- A proceeding in a case under title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time
- Exhaustion of a person's COBRA coverage;
- Termination of the employer's contribution toward coverage
- Termination of the covered employee's eligibility for coverage
- The covered employee's employer terminates coverage
- The covered employee is employed by an employer that offers multiple health benefit plans and the covered employee elects a different plan during open enrollment
- A person loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP)

- A person received notice that he or she is eligible for a Medicaid or CHIP premium assistance subsidy
- A person exhausts a lifetime maximum on all benefits under the other policy or plan (qualifying event is denial of claim due to operation of a lifetime maximum;
- A person no longer lives, resides or works in the other plan's service area and no other benefit plan is available to that person
- Any other special enrollment rights available under applicable state or federal law

Termination of Coverage

Reasons for Termination

The Contractholder and/or any Dependents' coverage under this benefit plan may terminate for the following reasons, including but not limited to:

- The Contractholder and/or any Dependent(s) die
- The Contractholder and/or Dependent(s) request termination of coverage
- The Contractholder and/or Dependents obtain other coverage that qualifies as minimum essential coverage
- The Contractholder and/or Dependents are newly eligible for Medicaid, CHIP or the Basic Health Plan (BHP
- Nonpayment of amounts due by the Group and/or Contractholder, after expiration of any applicable grace period available under Arizona law
- Coverage for the Contractholder and/or Dependents is rescinded

Termination Date of Coverage

BCBSAZ will notify the Group and/or the Contractholder of any termination dates of coverage for the Contractholder and/or any Dependents. The Contractholder and/or Dependents' coverage ends no later than the date the Group Master Contract terminates. If the Contractholder's coverage terminates, coverage for all Dependents also terminates on same day.

Benefits After Termination

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

Continuation of Coverage

Under federal law it is the Group's responsibility, as plan administrator, to inform employees and Dependents of the availability, terms and conditions of continuation of coverage available under COBRA.

COBRA requires most employers who have twenty or more employees and sponsor a group health plan to offer employees and their covered Dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Continuation of coverage is available when an employee is absent from employment by reason of service in the uniformed services, as defined by applicable federal law. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Disability Extension of Benefits

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

- **Group Discontinuation:** If you are totally disabled on the date that the Group discontinues coverage through BCBSAZ, medical expense benefits will continue, **for the disabling condition only, for a period not to exceed twelve (12) months from the date of termination.** To ensure an orderly extension of benefits and timely processing of your claims, it is important to provide BCBSAZ with written notice of the

disabling condition no later than thirty-one (31) days after such termination. You do not waive your right to extended benefits if you do not notify BCBSAZ; however, BCBSAZ cannot pay claims until notice is received.

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

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

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

  If you are eligible for an extension of benefits because of an individual termination as described above and you elect continuation coverage under COBRA, the extension of benefits shall run concurrently with your continuation coverage under COBRA, until the 12-month extension of benefits period is exhausted. Because these provisions run concurrently, please contact your employer before making any changes to or terminating your COBRA continuation coverage.

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

Leave of Absence

If a Contract holder takes a leave of absence, the group may continue coverage for the Contract holder and covered dependents for up to the length of the approved absence, subject to payment of applicable premiums.

BCBSAZ will also continue coverage for members during any leave of absence the group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 and any amendments or successor provisions. If the Contract holder returns to active employment by the end of the leave of absence period, coverage under this benefit plan will continue for the Contract holder and covered dependents, so long as the group maintains coverage with BCBSAZ. If not, the Contract holder will cease to be eligible and coverage for the Contract holder and dependent(s) will terminate as described in *"Termination of Coverage."*

Medical Support Orders

Coverage is available to a child of the Contractholder in accordance with any court order or administrative order issued by a court of competent jurisdiction, that requires the Contractholder to provide health benefits coverage for such child.

The order must clearly specify the name of the Contractholder, the name and birth date of each child covered by the order and the time period to which the order applies.

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

Benefit-Specific Eligibility

Under the following limited circumstances, a nonmember may be eligible to receive benefits under this plan:

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

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

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