Chandler · Arizona
Where Values Make The Difference

PURCHASING ITEM
FOR
COUNCIL AGENDA

1. Agenda Item Number: RCDI. PGS 27

2. Council Meeting Date: September 24, 2015

TO: **MAYOR & COUNCIL**

THROUGH: **CITY MANAGER**

3. Date Prepared: August 31, 2015

4. Requesting Department: Human Resources

5. SUBJECT: Agreement with Blue Cross Blue Shield of Arizona for Medical and Pharmacy Benefits

6. RECOMMENDATION: Staff recommends City Council approve Agreement No. HR5-948-3502, with Blue Cross Blue Shield of Arizona (BCBS) for group medical benefits, group pharmacy benefits, and stop loss insurance in an amount not to exceed $900,000 for one year. The term of this agreement is January 1, 2016 through December 31, 2016, with the option of up to seven one-year extensions.

7. BACKGROUND/DISCUSSION: The City's medical benefit is reviewed throughout the year by staff and in collaboration and input from the city-wide Healthcare Task Force with assistance from a benefits consulting firm. Staff recommends the City continue to contract with BCBS 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. There are no plan design changes for the Red and Blue plans. There is one plan change that is mandated by the Affordable Care Act in 2016 that impacts the White Plan only. The mandate requires an imbedded individual out-of-pocket maximum that will now allow an individual to meet a $3,000 out-of-pocket maximum for in-network services instead of the current maximum of $5,000. In order to maintain parity among all of the medical plans, the family out-of-pocket maximum for the White Plan will be changed from $5,000 to $6,000. Out-of-network out-of-pocket maximums will change from $7,500 to $8,000 for an individual and from $15,000 to $16,000 for a family.

8. EVALUATION: On February 5, 2015, staff issued a Request for Proposal for group medical and pharmacy benefits. Notification was sent to all registered vendors. Four proposals were received from the following offerors:

United Healthcare
Aetna
Blue Cross Blue Shield
Cigna

The Evaluation Committee reviewed the proposals and recommends the award to BCBS who submitted the most advantageous offer to the City in accordance with the evaluation criteria. The term of this agreement is January 1, 2016, through December 31, 2016, with the option of up to seven one-year extensions.

The 2016 premiums represent a 4.5% increase above 2015 largely as a result of national increases in medical services and pharmacy. The Health Care Trust Board recommended the 2016 rates by a majority vote.

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	$765.74	$612.58	$153.16	$76.58	$643.54	$514.84	$128.70	$64.35	$514.84	$514.84	$0.00	$0.00
Employee + spouse	$1,278.70	$1,022.96	$255.74	$127.87	$1,074.66	$859.72	$214.94	$107.47	$859.74	$859.74	$0.00	$0.00
Employee + child(ren)	$1,133.18	$906.54	$226.64	$113.32	$952.34	$761.88	$190.46	$95.23	$761.90	$761.90	$0.00	$0.00
Employee + family	$1,860.58	$1,488.46	$372.12	$186.06	$1,563.70	$1,250.96	$312.74	$156.37	$1,250.98	$1,250.98	$0.00	$0.00

9. FINANCIAL IMPLICATIONS:

Cost: $900,000
Savings: N/A
Long Term Costs: N/A

Acct. No.:	Fund:	Program Name:	Amount:
741.1290.5219.0.0.0 (active)	Medical Self Ins. Fund	Employee Benefits	$848,000
741.1290.5219.2SIR. (retiree)	Medical Self Ins. Fund	Employee Benefits	51,000
741.1290.5219.2COB (Cobra)	Medical Self Ins. Fund	Employee Benefits	1,000
		Total:	$900,000

10. PROPOSED MOTION: Move City Council approve Agreement No. HR5-948-3502, with Blue Cross Blue Shield of Arizona (BCBS) for group medical benefits, group pharmacy benefits, and stop loss insurance in an amount not to exceed $900,000 for one year. The term of this agreement is January 1, 2016 through December 31, 2016, with the option of up to seven one-year extensions.

ATTACHMENTS: Administrative Services Agreement, Stop Loss Agreement

APPROVALS

11. Requesting Department Lynna Soller RLR Lynna Soller, Benefit Program Manager	**13. Department Head** Debra Stapleton Debra Stapleton, Human Resources Director
12. Purchasing Manager Christina Pryor	**14. Acting City Manager** Marsha Reed Marsha Reed

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13. Department Head
Debra Stapleton, Human Resources Director

12. Purchasing Manager
Christina Pryor

14. Acting City Manager
Marsha Reed

Administrative Service Agreement ("Agreement")

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

THIS AGREEMENT is made and entered into this ____ day of _____, 2015, by and between the City of Chandler, a Municipal Corporation of the State of Arizona, hereinafter referred to as "City", and Blue Cross Blue Shield of Arizona, Inc., hereinafter referred to as "BCBSAZ".

Effective Date:	1/1/2016-12/31/2016	Date:	8/27/2015
Group / Bid ID:	28399	Bid/Renewal:	Bid
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:	Self Funded Medical and Pharmacy	Underwriter:	Anita Ortiz
Broker Paid:	Segal Company/Amy Girado	UW Code:	JO
Commission:	0.0%		
Commission (% of Billed Rate):	0.0%		
Total Enrollment:	1,582		

Definitions

1. **OOP Max - out-of-pocket maximum**
2. **OV -office visit**
3. **Spec - specialist**
4. **UC - urgent care**
5. **ded & coins - deductible & coinsurance**
6. **Admin - administration**
7. **SSL - specific stop loss**
8. **ASL - aggregate stop loss**
9. **PEPM - per employee per month**
10. **Fixed Expenses - the amount BCBSAZ bills the City of Chandler each month for administration, specific stop loss, aggregate stop loss and broker commissions.**

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%	$3,000/$6,000	@ded & coins	@ded & coins	@ded & coins	@ded & coins	$10/$20/$40, 2x MOD
OON:	$4,500/$9,000	70%	$8,000/$16,000					

SOLD Administration Rates

Red Medical Option	Enrollment	Admin
Employee	213	$40.16
Employee + Spouse	172	$40.16
Employee + Child(ren)	119	$40.16
Employee + Family	283	$40.16
Total	787	

HCR Suite: N = Non-Grandfathered

Blue Medical Option	Enrollment	Admin
Employee	31	$40.16
Employee + Spouse	29	$40.16
Employee + Child(ren)	19	$40.16
Employee + Family	17	$40.16
Total	96	

HCR Suite: N = Non-Grandfathered

White Medical Option	Enrollment	Admin
Employee	212	$40.16
Employee + Spouse	71	$40.16
Employee + Child(ren)	87	$40.16
Employee + Family	329	$40.16
Total	699	

HCR Suite: N = Non-Grandfathered

Sold HealthEquity Account Pricing PEPM (not included above) Health Savings Account	Plan	Billed by BCBSAZ	HealthEquity	Total
	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 ("Agreement") and forward those fees to HealthEquity, along with the required personal health information. BCBSAZ is collecting the HealthEquity administration fees as 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) = -$12.00.

Is Mayo Provider included in network?	No	Wellness $s Sold:	Yes
			See Assumption for details
Rate Guarantee Sold:	Yes	Performance Guarantees:	Yes
-Rate Guarantee Period:	Multi Year through 2020		
-Rate Guarantee Details:	Administration Rate Guarantee	Network Discount Guarantees:	Yes
HealthEquity Integration:	Yes		

All information from the exhibit Assumptions #IASC-2016-28399-1, Attachment A To Administrative Service Agreement, 100+ Employer Application (Exhibit 1), Performance Guarantees (Exhibit 2), and Disclosure of "Eligible Indirect Compensation" (Exhibit 3) 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.

BCBSAZ reserves the right to adjust these premium rates retroactive to the first day of any billing month in which enrollment varies by more than ten percent (+/-15%) from that listed above.

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. If any information on this Form is inaccurate, please provide the correct information on this Form.

Intending to be legally bound, the Parties have executed this Agreement as of its Effective Date.

BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC.,
an Arizona nonprofit corporation

By: _____
(signature)

Jeff Stelnik
(printed)

Title: SVP, Strategy, Sales + Marketing

FOR THE CITY OF CHANDLER

_____

Attest: _____

APPROVED AS TO FORM:

_____
City Attorney

APPROVED AS TO FORM
BCBSAZ Legal Division
By _____ Attorney
Date 9/11/15

Assumptions #IASC-2016-28399-1 Exhibit To Administrative Service Agreement

* BCBSAZ may adjust rates if the following requirements are not met:

  Where the employer contributes 100% of the employee cost, BCBSAZ requires 100% participation of all eligible employees, excluding those with other qualifying medical coverage.
  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 1/1/2016 thru 12/31/2020. 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
1/1/2016 - 12/31/2016 Gross Administration Rate	$ 52.16
1/1/2017 - 12/31/2017 Gross Administration Rate	$ 53.72
1/1/2018 - 12/31/2018 Gross Administration Rate	$ 55.33
1/1/2019 - 12/31/2019 Gross Administration Rate	$ 58.10
1/1/2020 - 12/31/2020 Gross Administration Rate	$ 61.01

  Guarantee is contingent upon BCBSAZ being selected as the sole stop loss carrier (Specific and Aggregate) for policy periods: 1/2016 - 12/2016, 1/2017 - 12/2017, 1/2018 - 12/2018, 1/2019 - 12/2019 and 1/2020 - 12/2020 .

* 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. 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. Cost for services provided by the BSA, 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 BSA. The BCBSAZ allowance (the difference between the PMPM rate BCBSAZ charges the Employer and the capitated fee BCBSAZ pays the BSA) in effect as of the Employer's contract effective date may change over the course of the Employer's contract year if BCBSAZ negotiates a different rate with the provider during the Employer's contract year. The PMPM rate BCBSAZ charges the employer is subject to change by BCBSAZ upon 60 days prior written notice. The PMPM rate(s) the Employer pays BCBSAZ and the PMPM capitated fee(s) BCBSAZ pays BSA are only applicable to Arizona enrollment.

  The PMPM rate(s) the Employer pays BCBSAZ is/are:
  1. Red Medical Option $2.13 PMPM
  2. Blue Medical Option $2.13 PMPM

  The PMPM capitated fee(s) BCBSAZ pays the BSA is/are:
  1. Red Medical Option $1.94 PMPM
  2. Blue Medical Option $1.94 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 2013, BCBSAZ calculates that the Rx rebates amount to approximately $5.88 Per Employee Per Month (PEPM) for Calendar Year 2013. 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 Agreement/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 $11.20 PEPM.

* 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 Pass Through model effective 1/1/2016.

  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 requested allotments amount under a self funding arrangement.

Policy Period	Amount	Fund
1/1/2016-12/31/2016	$ 80,000	Misc Trust & Wellness Expenses
1/1/2016-12/31/2016	$ 100,000	On-site Wellness Consultant as requested
Total	$ 180,000	

To monitor these allotments an available funds worksheet will 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.

D. Upon termination of the group contract, any portion of the Allotment Funds not already used will be retained by BCBSAZ.

* Performance Guarantees stated on Exhibit 2 are effective for the 1/1/2016 -12/31/2016 Policy Period.

* The Network Savings Guarantee stated in Exhibit 2 is offered for policy period 1/1/2016 - 12/31/2016.

* BCBSAZ will pay run out claims (i.e., claims incurred but not paid during the term of the contract) as follows:
  - Month 1 through month 24 following the effective date of termination with stop loss.

* **VALUE BASED SERVICES**

1. LOCAL

BCBSAZ pays some of its contracted medical providers an amount to manage the medical care of members diagnosed with certain medical conditions if the provider demonstrates to BCBSAZ it has satisfied BCBSAZ's criteria for effectively managing the care ("Value Based Services").

With respect to a BCBSAZ group members residing and receiving Value Based Services in Arizona under a BCBSAZ value based program, BCBSAZ will estimate at the beginning of the contract year the amount BCBSAZ projects it will pay BCBSAZ's contracted providers for members who receive Value Based Services throughout the upcoming year in the form of a PMPM or PEPM charge ("PMPM Charge"). BCBSAZ will charge BCBSAZ's ASC Groups via the Group's Claims Invoice this PMPM Charge beginning January 1, 2016.

On an aggregate basis for the entire Value Based Program, the amounts used to calculate PMPM charge are fixed amounts estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by BCBSAZ until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

On an aggregate basis for the entire Value Based Program, , at the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, BCBSAZ will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

NOTE: If an ASC Group terminates its BCBSAZ contract, that Group will neither receive a refund nor a charge to reflect any variance between what BCBSAZ charged the Group in Value Based Charges and what BCBSAZ paid the providers for Value Based Services.

2. NATIONAL

Value Based Services will also apply to your members who reside in other states/geographical locations served by other Blue Cross Blue Shield Plans. A full description of these arrangements will be described in your contract.

Exhibit 1 to Administrative Service Agreement

EMPLOYER APPLICATION

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

REQUESTED EFFECTIVE DATE (MM/DD/YYYY)
1/1/2016

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	LEGAL ENTITY
City of Chandler	☐ CORP ☐ LLC ☑ MUNICIPALITY
DBA: City of Chandler, Arizona	☐ NON PROFIT ☐ PARTNERSHIP ☑ POLITICAL SUBDIVISION ☐ TRUSTS ☐ UNIONS

GROUP HEALTH PLAN NAME (IF DIFFERENT THAN LEGAL COMPANY NAME): City of Chandler

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

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

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

GROUP EXECUTIVE	TITLE
Debra Stapleton	Director of Human Resources

E-MAIL	PHONE NUMBER	FAX
debra.stapleton@chandleraz.gov	480-782-2351	480-782-2366

CHIEF FINANCIAL OFFICER	TITLE
Dawn Lang	Management Services Director

E-MAIL	PHONE NUMBER	FAX
dawn.lang@chandleraz.gov	480-782-2255	

CHIEF EXECUTIVE OFFICER	TITLE
Marsha Reed	Acting City Manager

E-MAIL	PHONE NUMBER	FAX
marsha.reed@chandleraz.gov	480-782-2210	480-782-2209

GROUP BENEFIT ADMINISTRATOR ☐ BILLING CONTACT	TITLE
Lynna Soller	Benefits Program Manager

E-MAIL	PHONE NUMBER	FAX
lynna.soller@chandleraz.gov	480-782-2359	

OTHER CONTACT PERSON ☐ BILLING CONTACT ATTACHED SHEET FOR ADDITIONAL CONTACTS	TITLE
Carol Osterhaus	Benefits Analyst

E-MAIL	PHONE NUMBER	FAX
carol.osterhaus@chandleraz.gov	480-782-2371	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

See Resolution #4529 attached herein as Exhibit 1A

SECTION III – BROKER/CONSULTANT ☑ BROKER ☐ CONSULTANT

LAST NAME	FIRST NAME	MI
Amy	Girardo	

AGENCY NAME	SUITE NO.
Segal Consulting	501

STREET ADDRESS	CITY, STATE	ZIP CODE PLUS FOUR
1230 W. Washington	Tempe, AZ	85281-1248

PHONE NUMBER	FAX NUMBER
602-381-4065	602-532-7654
E-MAIL	**BCBSAZ BROKER NUMBER**
agirardo@segalco.com	

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	PRINT NAME
X	

TITLE	DATE

STREET ADDRESS	CITY, STATE	ZIP CODE PLUS FOUR

BCBSAZ AUTHORIZED SIGNATURE	PRINT NAME
X	

TITLE	DATE

Exhibit 1 to Administrative Service Agreement – Employer Application Continued

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

Secondary Groups Benefits Administrator
Rae Lynn Nielsen, Benefits & Labor Relations Administrator
Office: 480-782-2353
raelynn.nielsen@chandleraz.gov

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

Exhibit 1A to Employer Application

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 Mayor and City Council of the City of Chandler, Arizona, this 28th 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 28th day of July 2011, and that a quorum was present thereat.

CITY CLERK

APPROVED AS TO FORM:

CITY ATTORNEY

Exhibit 2 to Administrative Service Agreement - 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	Customer/Member overall satisfaction - the satisfaction level conveyed by CITY members.	95% or greater in year one; 98% or greater in subsequent years	See Deviations		
Implementation					
2	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	$20,000

Exhibit 2 to Administrative Service Agreement - Performance Guarantees Continued

	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
3	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 provided to and agreed upon by the City.	Measured group specific We will work with the City to develop a mutually agreed upon implementation plan.	N/A	$20,000
Client Services and Account Management					
4	Monthly Eligibility Reconciliation	60 business days or less	Measured group specific	Quarterly	$20,000
5	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 Percentage of claims processed incorrectly vs. correctly, based on BCBSAZ standard auditing procedures.[1]	Quarterly	$20,000

BCBSAZ Notes:

- Total of all risk measures cannot exceed $100,000.
- The above stated performance guarantees will be effective for the contract period 1/1/2016-12/31/2016.
- The Performance Guarantee payout does not include stop loss premiums, claims reimbursement amounts, vendor interface fees, capitated claim payments, etc.
- 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 would be payable annually on the 15th of the month following the 90-day period. BCBSAZ will not be required to pay a penalty for Performance Guarantees if the group is in default of its contract with BCBSAZ and/or has not paid all claims and premiums by the date due.

[1] If BCBSAZ fails to perform in accordance with these Guarantee(s) for two (2) consecutive reporting periods after the Guarantee(s) are effective, BCBSAZ will refund or credit the group up to the amount at risk per measure during the time period which BCBSAZ did not meet the performance guarantee(s).

Exhibit 2 to Administrative Service Agreement - Performance Guarantees Continued

The City will require specific performance guarantees. All guarantees shall be set and measured annually, and must have the ability to measure performance separately based on its experiences with the chosen PBM. Measurement of performance guarantees may be based on internal self-reporting, subject to independent audit.

Performance guarantees offered below are for the first contract year. For each subsequent year, BCBSAZ will verify the performance guarantees and amounts at-risk as part of the renewal process. Generally, we can offer initial guarantees for the entire multi-year duration of a client's contract. However, our current contract with our PBM, Catamaran, ends 12/31/17 and certain guarantees are passed directly through this contract. Should any modifications be required, BCBSAZ will work with the City to offer mutually-agreeable standards.

BCBSAZ is submitting a bundled quote including medical and pharmacy administration. As such, many of our performance guarantees are based on overall performance (including medical and pharmacy).

Measurement of performance guarantees is based on internal self-reporting. BCBSAZ does not offer independent audit of reporting results at this time. BCBSAZ wishes to note that, while we are unable to offer independent auditing for performance guarantees, we offer clients robust audit rights in other areas, as detailed within the Audit Rights section of the sample contract.

1. The City is looking for flat dollar ($) performance guarantee amounts. Indicate the amount you are willing to place at risk for each item listed in the table below. In addition, you may provide other guarantees designed to differentiate your program.

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
Implementation				
Clean Implementation	No systems errors, ID card delays, and the City online access to all tools prior to effective date	Not proposed separately. BCBSAZ agrees as part of overall implementation, provided clean pharmacy benefits and eligibility are received by the BCBSAZ	Please see Medical performance guarantees. BCBSAZ is not placing a separate amount at-risk for PBM.	n/a

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		Pharmacy department at least 45 days prior to the effective date. BCBSAZ will discuss and mutually agree upon tools for online access.		
Implementation Timeline	Implementation team will be assigned and introduced to the City at least 3 months in advance of effective date	Not proposed separately. BCBSAZ agrees as part of overall implementation. After award, Client Implementation Managers Scott Salisbury and Trisha Honaker will meet with the City to develop a mutually agreed upon implementation plan.	Please see Medical performance guarantees. BCBSAZ is not placing a separate amount at-risk for PBM.	n/a
Implementation Team	Implementation team members will not change and will be responsible for the accurate installation of all administrative, clinical and financial parameters for the City's program	Not proposed separately. Client Implementation Managers Scott Salisbury and Trisha Posser will oversee	Please see Medical performance guarantees. BCBSAZ is not placing a separate	n/a

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		implementation.	amount at-risk for PBM.	
Implementation Satisfaction Scorecard	Assigned Account Executive will work with the City prior to the start of implementation to agree on terms of a satisfaction scorecard to be issued to the City after effective date for completion	Not proposed separately.	Please see Medical performance guarantees. BCBSAZ is not placing a separate amount at-risk for PBM.	n/a
Payment Accuracy & System Performance				
Protected Health Information	PBM guarantees no incidents in violation of HIPAA Security Rules which results in a transmission of electronic PHI for the City's covered members	Not proposed. We have standards and monitoring in place to comply with government rules and regulations.	n/a	n/a
Plan Administration Accuracy	Implementation of all plan design changes will be 100% accurate	Not proposed.	n/a	n/a
Pricing Change Accuracy	Implementation of all pricing changes will be 100% accurate	Not proposed.	n/a	n/a
Financial accuracy (electronic and paper claims)	Percentage of claim payments made without error relative to the total dollars paid will be at least 99%	Not proposed. Pricing guaranteed are offered instead, as documented in PBM	n/a	n/a

Exhibit 2 to Administrative Service Agreement - Performance Guarantees Continued

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		RFP response.		
Mail Service Non-Financial Accuracy	The mail service pharmacy shall guarantee dispensing accuracy of at least 99.995% (correct participant name, correct participant address, correct drug, correct dosage form, and correct strength)	**Book of Business** **Modification offered:** At least 99.95% prescription dispensing accuracy.	**$500 per quarter**	**Measured quarterly** **Paid annually**
System Downtime	At least 99.5% access to its systems by all the retail pharmacies in PBM's network 24 hours a day, 7 days a week, 365 days a year	**Book of Business** **Modification offered:** Average of at least 98% availability (excluding scheduled downtimes).	**$500 per quarter**	**Measured quarterly** **Paid annually**
Invoicing Errors	All invoicing errors will be credits back to the City by next billing cycle or PBM will pay interest	Not proposed.	n/a	n/a
Claims Eligibility Data	Eligibility loads not to exceed 24-hours after receipt	**Book of Business**	**$500 per quarter**	**Measured quarterly** **Paid annually**
Eligibility Data Error Reporting	Eligibility file error reporting on all eligibility file updates will be provided to the City within 2 business days	**City-specific**	**$2,000 per year**	**Measured annually** **Paid annually**
Eligibility Error Rate Audits	Error rate identified through quarterly audits shall not exceed, on an average basis, 2%	Not proposed.	n/a	n/a
Retail Pharmacy Audit	PBM will perform an on-site audit of 3% or more of their retail pharmacies which dispense	**City-specific**	**$500 per year**	**Measured**

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
	greater than 500 claims a year	Results will be provided within 90 days of the close of the calendar year.		**annually** **Paid annually**
Retail Pharmacy Turnover	Less than 5% of retail pharmacies will leave the retail network	Not proposed.	n/a	n/a
Claims Detail File	All claims detail files sent to external vendors will be provided within 8 days of request or scheduled delivery date	Not applicable. Our pharmacy benefit management program is only offered when medical administration is selected.	n/a	n/a
Account Management				
City Approval of Member Communications	100% of all member communications will be approved by the City – exceptions for drug recalls and urgent patient safety communications	Not proposed.	n/a	n/a
Delivery of Standard Reports	Within 30 days of end of reporting quarter	**City-specific** Our clients can obtain pharmacy reporting through BlueInsight℠. BlueInsight, our online reporting tool, is available 24 hours a day, seven days a week. It is updated on	**$2,000 per year**	**Measured annually** **Paid annually**

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		the 20th of each month.		
Accuracy of Standard Reports	All standard reports provided will be 100% accurate	**City-specific** Our clients can obtain pharmacy reporting through BlueInsight℠. BlueInsight is an integrated reporting tool, with information aggregated directly from our claims and eligibility system.	**$2,000 per year**	**Measured annually** **Paid annually**
Pharmacy Audit Resolution	48 hours after receipt of findings	Not proposed.	n/a	n/a
PBM Account Team's Performance	The City may assess a penalty after the first Contract Year and each successive Contract Year, the City's benefits staff do not rate PBM account team's performance for such Contract Year an average of 3 or better on a scale of 1 to 5 (5 being the best based on a range of performance criteria agreed to between the City and PBM at the beginning of such Contract Year)	**City-specific** Overall score of 3 (satisfied) or better on the annual BCBSAZ medical Account Management Score Card (annual Group Benefit Administrator survey). Categories include: effective support for open enrollment events, timely client notification of issues	**$5,000 per year**	**Measured annually** **Paid annually**

Exhibit 2 to Administrative Service Agreement - Performance Guarantees Continued

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		impacting members, response to client issues and questions in timely, comprehensive manner, effective coordination to resolve open issues, accessibility, and delivery of agreed-upon reports on time. BCBSAZ Account Management Score Card (annual) – see attached.		
Account Management Turnover	Account team members will remain constant for at least the first 18 months of the contract period, unless a change in account management staff is requested by the City	Not proposed. BCBSAZ will make every effort to comply and will advise the City of any unforeseen circumstances relating to Account Management team.	n/a	n/a
Member Services				
Mail Turnaround – Prescriptions not requiring intervention	95% of prescriptions dispensed within average of 2 business days and 100% within average of 3 business days	**Book of Business** **Modification offered:** Average of 90% of	**$500 per quarter**	**Measured quarterly** **Paid annually**

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		prescriptions not subject to intervention will be dispensed within two (2) business days and prescription subject to intervention within two business days after resolution of intervention.		
Mail Turnaround – Prescriptions requiring intervention	95% of prescriptions dispensed within average of 4 business days and 100% within average of 5 business days	Not proposed separately; see guarantee above.	n/a	n/a
Paper Claims Turnaround	95% of prescriptions reimbursed within average of 10 business days and 100% within average of 14 business days	**Book of Business** **Modification offered:** Average of 95% within an average of ten (10) business days after receipt by Catamaran.	**$500 per quarter**	**Measured quarterly** **Paid annually**
ID Cards Mailing	98% of all ID cards are sent within 5 business days of receipt of eligibility. 100% mailed within 10 business days.	**City-specific** 99% of ID Cards issued within 10 business days after receipt of finalized benefits and account structure, authorized signature documents and	**$5,000 per year**	**Measured annually** **Paid annually**

Exhibit 2 to Administrative Service Agreement - Performance Guarantees Continued

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		complete and accurate information in a format agreed upon between the City and BCBSAZ.		
Mailing Member Materials	All applicable member materials (for example, mail order forms) will be mailed at least 10 days prior to the effective date and will be 100% accurate (provided that eligibility file was received at least 30 days prior to the effective date).	Not proposed.	n/a	n/a
Phone Average Speed of Answer	100% of calls to the City-specific toll free line shall be answered within 20 seconds (excluding IVR)	**Book of Business** **Modification offered:** Average of 30 seconds or less.	**$500 per quarter**	**Measured quarterly** **Paid annually**
Phone Abandonment Rate	100% of calls to the City-specific toll free line shall be answered with an abandonment rate of 3% of less	**Book of Business** **Modification offered:** Equal to or less than 3% after 30 seconds.	**$500 per quarter**	**Measured quarterly** **Paid annually**
Written Inquiry Answer Time	95% of inquiries responded to in 5 business days – 100% in 20 business days	Not proposed.	n/a	n/a
Member Satisfaction Survey	The PBM agrees to conduct a Member Satisfaction Survey for each contract year and that the Satisfaction Rate will be 90% or greater. A penalty may be assessed against the PBM for failure to meet this standard. "Member Satisfaction Rate" means (i) the number of Eligible Persons responding to PBM annual	Not proposed separately. BCBSAZ's pharmacy benefits administration (PBM) quote is	Please see Medical performance guarantees. BCBSAZ is not placing a	n/a

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
	standard Patient Satisfaction Survey as being satisfied with the overall performance under the Integrated Program divided by (ii) the number of Eligible Persons responding to such annual Patient Satisfaction Survey; the City must provide timely approvals and responses, and a minimum of 20% of surveys must be returned for the Performance standard to be applicable.	contingent upon selection of BCBSAZ medical coverage. This performance guarantee is addressed within the medical performance guarantees.	separate amount at-risk for PBM.	
Issue Resolution: Verbal Inquiries	PBM will resolve 99% of all telephone issues at the first point of contact (the number of telephone inquiries completely resolved at the time of initial contact divided by the total number of calls)	**Book of Business** **Modification offered:** First call resolution: 93% or greater of calls related to pharmacy matters will be resolved on first call.	**$500 per quarter**	**Measured quarterly** **Paid annually**
Issue Resolution: Written Inquiries	PBM will resolve 98% of all written inquiries within 10 business days of receipt of inquiry	Not proposed.	n/a	n/a
Issue Resolution: the City Staff Involvement / Escalation	When the City contacts you with an elevated claim issue via phone, email or through their Consultant, you will respond within 24 hours and provide progress reports every 48 hours until the issue is resolved.	Not proposed separately. Responsiveness measure will be included in annual medical Account Management Scorecard, as proposed in the "PBM Account	n/a	n/a

Exhibit 2 to Administrative Service Agreement - Performance Guarantees Continued

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		Team's Performance" guarantee, above.		

BCBSAZ Notes:

- Total of all risk measures cannot exceed $100,000.
- The above stated performance guarantees will be effective for the contract period 1/1/2016-12/31/2016.
- The Performance Guarantee payout does not include stop loss premiums, claims reimbursement amounts, vendor interface fees, capitated claim payments, etc.
- 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 would be payable annually on the 15th of the month following the 90-day period. BCBSAZ will not be required to pay a penalty for Performance Guarantees if the group is in default of its contract with BCBSAZ and/or has not paid all claims and premiums by the date due.

[1] If BCBSAZ fails to perform in accordance with these Guarantee(s) for two (2) consecutive reporting periods after the Guarantee(s) are effective, BCBSAZ will refund or credit the group up to the amount at risk per measure during the time period which BCBSAZ did not meet the performance guarantee(s).

Exhibit 2 to Administrative Service Agreement - Performance Guarantees Continued

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Group Name: City of Chandler
Group Number: 28399

NETWORK SAVINGS GUARANTEE

*Guaranteed Period: 1/1/2016 - 12/31/2016

I. In-Network Medical only

Total Savings %*	Administrative Charge at Risk PEPM	Administrative Charge at Risk Annual
59.0% or more	$0.00	$ -
57.0% - 58.9%	$1.00	$ 18,900
55.0% - 56.9%	$2.00	$ 37,800
53.0% - 54.9%	$3.00	$ 56,700
less than 52.0%	$4.00	$ 75,600

Network Savings Guarantee:

***Savings % will be based on incurred claims 1/01/16-12/31/16 (paid through 3/31/2017)**

1. BCBSAZ has agreed to put a portion of the administrative fees at risk based on actual network savings (**Eligible Billed Charges minus Eligible Allowed Charges**) realized by group.

2. Enroll Assumption (Employees): **1,575**

3. This discount applies only to the following policy period: **01/01/2016-12/31/2016**
   At the end of said contract period the savings percentage will be calculated to determine if any money will be returned to group.
   If money is due, the final amount will be calculated using actual enrollment during the applicable policy period.

4. The incurred claims used for the contract period will include In-Network Medical only claims. The discount does not apply to out-of-network Medical claims nor to pharmacy claims.

5. The proposed Network Savings Guarantee does NOT include Mayo as an in-network provider.

6. The proposed Network Savings Guarantee is subject to re-rate retroactive to the first day of any billing month in which the enrollment varies by more than +/- 10% from the enrollment as of: **February-15** .

7. Notwithstanding any other provisions in this rate proposal, if the government imposes a new tax or fee on insurers the rates set forth in this rate proposal may be adjusted to include, even retroactively, such taxes and fees. BCBSAZ reserves the right to change its rate if a change in administration is required due to legislative or regulatory change.

8. This agreement is null and void if group terminates prior to the end of the guaranteed policy period.

Exhibit 3 to Administrative Service Agreement - Eligible Indirect Compensation

For informational Purposes Only - NO Action Required

Re: 2015 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 2015.

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 2014 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 2015:

   Standard BlueCard Arrangement
   4.79% of savings (max = $2,000 per claim)

   Reduced BlueCard PPL Arrangement
   2.67% 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 or more contracts.

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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 2014 and 2015:

Non-standard negotiated fees can range from either $5.48 to $18.22 per claim, or $10.00 to $16.75 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:

Exhibit 3 to Administrative Service Agreement - Eligible Indirect Compensation Continued

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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; excluding translation and currency conversion)	$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, issue check)	$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

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Exhibit 3 to Administrative Service Agreement - Eligible Indirect Compensation Continued

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The following Service Providers received EIC from BCBSAZ during 2015:

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 $5.74 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.
If you have any questions, please contact your BCBSAZ Account Manager.

Sincerely,

Shawn A. Fried
Supervisor, Large Group Underwriting

cc: Report File

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ATTACHMENT A TO ADMINISTRATIVE SERVICE AGREEMENT

ARTICLE 1. DEFINITIONS

For purposes of this Agreement, the following terms have the following meanings unless otherwise expressly provided herein:

1.1 **Allowed Amount** means the amount payable by or through BCBSAZ for a Covered Service, including any contracted discounts and amounts payable by a Participant under the terms of the Plan and the Benefit Plan Booklet.

1.2 **Application** means the 100+ Employer Application.

1.3 **Association** means the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans permitting BCBSAZ to use the Blue Cross and Blue Shield service marks in the State of Arizona.

1.4 **Covered Services** means health care services and supplies rendered or delivered to a Participant for which benefits are available under the Plan.

1.5 **Eligible Dependent** means a dependent eligible for benefits under the Plan as described in the 100+ Employer Application and Benefit Plan Booklet.

1.6 **Grandfathered Plan** means coverage provided by a group health plan in which an individual was enrolled on March 23, 2010 and which has not been modified or changed in a manner which would cause it to lose its grandfathered status as provided by PPACA.

1.7 **Network Provider** means a hospital, health care facility, person or other provider of medical services which has a written agreement with BCBSAZ, a vendor of BCBSAZ, or another Blue Cross Blue Shield plan in accordance with Exhibit 3.

1.8 **Non-Grandfathered Plan** means either coverage provided by a group health plan in which an individual was not enrolled on March 23, 2010 or a group health plan which has been modified or changed in a manner which caused it to lose its grandfathered status as provided by PPACA.

1.9 **Out-of-Network Services** means Covered Services received by a Participant from any Provider other than a Network Provider.

1.10 **Participant** means any employee of The City and any Eligible Dependent that is covered by the Plan.

1.11 **PPACA** means the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and the Health Coverage and Education Reconciliation Act (Pub. L. No. 111-152), as amended, and any regulations issued thereunder.

1.12 **Provider** means any hospital, health care facility, laboratory, person or entity duly licensed to render Covered Services to a Participant or any other provider of medical services, products, or supplies which are Covered Services subject to any definitions or provisions of the Plan regarding providers or medical professionals whose services are covered under the Plan.

1.13 **Waiting Periods** mean with respect to a group health plan and an individual who is a potential participant or beneficiary in the group health plan, the period that must pass before the individual is eligible to be covered for benefits under the terms of the Plan.

ARTICLE 2. ADMINISTRATIVE SERVICES PROVIDED BY BCBSAZ

2.1 **Licenses**. BCBSAZ shall maintain in current status all Federal, State and local licenses and permits required for the operation of the business conducted by BCBSAZ as applicable to this Agreement.

2.2 **Contract Administrator.** BCBSAZ shall act under the authority and approval of the Human Resources Director or designee (Contract Administrator), to provide the services required by this Agreement.

2.3 **Key Staff.** This Agreement has been awarded to BCBSAZ based partially on the key personnel proposed to perform the services required herein. BCBSAZ shall not change nor substitute any of these key staff for work on this Agreement without prior written approval by the City.

2.4 **Subcontractors.** During the performance of the Agreement, BCBSAZ may engage such additional Subcontractor as may be required for the timely completion of this Agreement. In the event of subcontracting, the sole responsibility for fulfillment of all terms and conditions of this Agreement rests with BCBSAZ.

2.5 **Subcontracts.** BCBSAZ may not subcontract all or substantially all of the scope of work under this Agreement, without the express written permission of the City. A subcontract does not include any contract between BCBSAZ and any health care provider or any contract between BCBSAZ and any third party administrator reimbursement entity or any specially contracted health care provider arrangement. An example of a third party administrator reimbursement entity is a vendor that provides mental health services to BCBSAZ's customers. In addition, the term "Subcontract" shall not include any normal service arrangements with information systems providers such as Microsoft, EDS and the drug claims processor.

2.6 **Booklets, Identification Cards and Certificates**. The Benefit Plan Booklets for the Red Plan, the Blue Plan, and the White Plan are attached hereto as Exhibit 1 to Attachment A and incorporated herein by this reference. The parties acknowledge that these Exhibit 1 Benefit Plan Booklets are in near final form but may be changed after execution but before the Effective Date. If so, the new Benefit Plan Booklets will be, upon the acknowledgement of both parties' legal counsel that the changes are insubstantial, and are accepted as substitutes in this Administrative Service Agreement. BCBSAZ shall provide Benefit Plan Booklets and identification cards to employees unless the City directs otherwise. BCBSAZ shall complete and issue certifications of Creditable Coverage, as required by federal or state law, for the coverage administered by BCBSAZ.

2.7 **Claims Services**. BCBSAZ shall receive claims and process payment of benefits in accordance with the Plan for all claims incurred during the Term and determine benefits payable under the Plan pursuant to the terms and conditions of the Benefit Plan Booklet. BCBSAZ provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. BCBSAZ will provide notice to Participants regarding the reason(s) for denial of benefits (when such are denied) and provide to Participants an explanation of benefits resulting from claim transactions. BCBSAZ shall use reasonable efforts to pay ninety percent (90%) of non-investigated claims (no precertification or additional information needed) that are locally processed (received and paid by BCBSAZ) within fourteen (14) calendar days of receipt by BCBSAZ, and pay ninety-nine percent (99%) of non-investigated claims that are locally processed within thirty (30) calendar days of the date of receipt by BCBSAZ.

2.8 **Access to Provider Network**. BCBSAZ shall provide Participants access to a network or networks of Providers. BCBSAZ reserves the right to change Network Providers at any time without notice to The City, Plan or Participants. Network Providers will accept the BCBSAZ Allowed Amount as the only payment for Covered Services required from and on behalf of Participants except that they may collect the difference between their billed charge and the BCBSAZ Allowed Amount when there is compensation for Covered Services from other sources (e.g., other insurers, government payors, or personal injury recovery), so long as permitted by law.

2.9 **Appeals and Grievances**. BCBSAZ shall provide the appeals and grievance services described in the Health Coverage Appeals Information Packet.

2.10 **Coordination of Benefits**. BCBSAZ will cooperate with Plan to coordinate benefits in accordance with the Benefit Plan Booklet and applicable state and federal law if services to which Participants are entitled under the Plan and this Agreement are also covered under any other group health coverage, Medicare, or other governmental health care benefit programs (except those provided under Medicaid and/or AHCCCS).

2.11 **Form 5500**. Upon the City's request, BCBSAZ will furnish information related to BCBSAZ's administration of the Plan and reasonably necessary for the City to complete the Form 5500 and other similar Plan reports required by a state or federal authority from the City as the Plan Administrator.

2.12 **HIPAA Privacy Notice**. Unless directed otherwise, BCBSAZ will distribute a HIPAA Notice of Privacy Practices which addresses BCBSAZ's handling of Participant Protected Health Information.

2.13 **Services By BCBSAZ:** A short summary of the services BCBSAZ will provide to the City are as stated in Article 2 of this Agreement. A more detailed description of the services BCBSAZ agreed to provide is attached hereto as Exhibit 2 to Attachment A and incorporated herein by this reference.

ARTICLE 3. CITY'S DUTIES AND ACKNOWLEDGEMENTS

3.1 **Furnish Plan Information**. The City shall provide timely and accurate information as may be required by BCBSAZ to perform its duties under this Agreement including, but not limited to:

a. Eligibility information (including any eligibility changes within 31 days of the date of such change and COBRA eligibility, if applicable);
b. Prior written notice of any change to its contribution rates;
c. Any Participant consent or authorization required for BCBSAZ to perform its duties under this Agreement; and
d. Thirty (30) days prior written notice of any change in the City's physical location, mailing address, state of incorporation, or state in which The City is headquartered.

BCBSAZ depends upon the City for the delivery of current and accurate information which is in City's possession or control and the City agrees to exercise reasonable care and due diligence to keep BCBSAZ promptly informed of any changes when they occur. The City acknowledges and agrees that BCBSAZ may rely on the information provided by the City or its designee, and the City agrees to indemnify, defend and hold BCBSAZ harmless from any liability resulting from inaccurate or untimely information provided to BCBSAZ by the City or its designee. Additionally, the City is responsible for claims errors arising from erroneous eligibility data or inaccurate or untimely data submitted by the City or by a third party retained by the City. If timely notice regarding an eligibility

change is not received, a Participant's coverage termination will be the 1st day of the month following BCBSAZ's receipt of written notice.

3.2 **Notices to Participants**. The City shall (a) notify Participants of any conversion privilege set forth in the Benefit Plan Booklet(s); (b) notify all Participants when this Agreement terminates that their coverage has terminated, provided however, that coverage will terminate even if such notice is not given by the City; and (c) distribute all notices from BCBSAZ to Participants and comply with federal and state disclosure and notice laws.

3.3 **City Acknowledgments**. The City acknowledges and agrees that a Benefit Plan Booklet is not a Summary Plan Description and this Agreement is not a plan document for purposes of ERISA. In the event of any conflict between the Summary Plan Description and the Benefit Plan Booklet, the terms of the Benefit Plan Booklet shall control BCBSAZ's performance under this Agreement. The City acknowledges that an "employee welfare benefit plan" as defined in ERISA must be established and maintained through a separate plan document.

3.4 **Medicare**. The City will forward to BCBSAZ the information identified and described below to permit BCBSAZ to fulfill its Medicare secondary payer reporting obligations to the Centers for Medicare & Medicaid Services or its delegate:

a. No later than thirty (30) days after: (i) the date the Participant's coverage first becomes effective, (ii) the date a new Participant is hired and (iii) the date the City is notified of a new Eligible Dependent, provide BCBSAZ with the following information for each Participant and Eligible Dependent: (a) Social Security Number, (b) Date of Birth, (c) Medicare identification number (HICN) if applicable, and (d) Medicare effective date, if applicable.
b. No later than thirty (30) days after a Participant's effective date of coverage, provide BCBSAZ with a list of all Participants who are enrolled in Medicare or who are Medicare eligible;
c. No later than three (3) business days after learning that a Participant who was not enrolled in Medicare or who was not Medicare eligible has now enrolled in Medicare or become eligible for Medicare, The City shall notify BCBSAZ in writing of the Participant's enrollment or eligibility.
d. No later than three (3) business days after learning that a Participant who was enrolled in Medicare has now terminated Medicare, The City shall provide BCBSAZ written notice of the Participant's Medicare termination.
e. The City shall forward any notification received with regard to Medicare secondary payer reporting or collections thereunder no later than five (5) days after receipt.
f. The City shall indemnify and hold harmless BCBSAZ for any and all penalties assessed against BCBSAZ for failure to timely provide regulators with the Medicare, Medicare related and other information stated in this section to the extent that such failure was caused by The City's failure to timely provide BCBSAZ with the written notice required by this section.

3.5 **Medicaid**. The City acknowledges that state Medicaid agencies, including AHCCCS (collectively referred to as "Medicaid Agencies") are considered payers of last resort for the claims of Participants who are also Medicaid beneficiaries ("Medicaid Beneficiaries"). The City 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 Medicaid Beneficiaries, not to exceed the lesser of the Participant's benefits under this plan or the Medicaid Agencies' payment on behalf of the Participant. The Plan agrees that BCBSAZ shall, on the Plan's behalf and as legally required, reimburse Medicaid Agencies or their designees for the health claims of

Participants who were also Medicaid Beneficiaries on the date of service. The Plan agrees to promptly reimburse BCBSAZ for such claims.

3.6 **Enrollment**. The City will provide for and administer any special enrollment periods as required by applicable law, including the provision of any notification to employees of any restrictions. The City will provide an annual open enrollment period of at least thirty-one (31) days. The City shall provide all eligible employees with information regarding the open enrollment period, including but not limited to the date the open enrollment begins and ends.

3.7 **Providers.** The City agrees that (i) BCBSAZ is not liable for any act or omission of any Provider, nor is BCBSAZ responsible for a Provider's failure or refusal to render Covered Services to a Participant, (ii) the use (or lack of use) of a descriptive term such as "Network" or "non-Network" in describing any Provider is not a statement as to the professional ability of the Provider, and (iii) the choice of Provider is exclusively that of the Participant. It is understood and agreed that neither BCBSAZ nor the Plan is engaged in the practice of medicine. Providers are solely responsible for all decisions regarding medical care and treatment of Participants, and the traditional relationship between physician and patient shall in no way be affected by or interfered with by any of the terms of the Plan of this Agreement or any agreement between BCBSAZ and such Providers. Accordingly, the Plan and this Agreement are in no way intended to affect the responsibility of Providers to provide appropriate services to Participants.

3.8 **Claims Determinations.** The City acknowledges and agrees that BCBSAZ is neither the plan administrator nor a named fiduciary of the Plan. The City acknowledges and agrees that the fact that a Provider has prescribed, ordered, recommended, or approved a service or supply does not make it a Covered Service or make the charge eligible for benefits under the Plan and this Agreement, even though such service or supply is not specifically listed as an exclusion under the Plan or this Agreement.

3.9 **HDHP and HSA** The City shall offer Participants the option of 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.

3.10 **HSA Integration Option.** 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.

3.11 **Mental Health Parity.** If the Plan is not subject to ERISA and does not comply with the Mental Health Parity and Addiction Equity Act of 2008, the City represents and warrants that it has satisfied all the requirements to opt out from such Act including but not limited

to notifying all employees of the opt out prior to the beginning of the plan year and is identified on the CMS website as having successfully opted out.

3.12 **Qualified Medical Child Support Orders.** The City is responsible for determining whether an order received by the City (or BCBSAZ) is a qualified medical child support order under ERISA and/or Arizona law (and related regulations and amendments or successor provisions) and whether the children named in such order are eligible for coverage under the Plan and this Agreement. The City shall not request that BCBSAZ terminate the coverage of a minor child whose coverage is mandated by a court or administrative order unless the City has written proof that the court or administrative order is no longer in effect or that the child is enrolled in comparable health insurance coverage and that coverage will take effect not later than the effective date of the termination of coverage as required by A.R.S. Section 25-534. The City acknowledges and agrees that BCBSAZ will assume that any request from the City to terminate the coverage of a minor child whose coverage is mandated by a court or administrative order will mean that the City has obtained such written proof.

3.13 **Provider Agreements.** The City will comply with the participation agreements between BCBSAZ and Providers. If the terms and conditions of such participation agreements require the amendment or modification of this Agreement, BCBSAZ shall provide written notice of such amendment or modification to the City. If the Plan conflicts with the terms of the participation agreements between BCBSAZ and Providers, the terms and conditions of the participation agreements shall control.

3.14 **Participant Cost Sharing.** Participants are responsible for payment of all applicable cost sharing as well as expenses incurred for services that are not Covered Services, including services in excess of specified benefit maximums. Network Providers will seek payment for these amounts directly from Participants.

ARTICLE 4. PLAN CHANGES BY THE CITY

4.1 **Plan Design.** The City is responsible for design of the Plan, including any modification or termination of the Plan. From time to time during the term of this Agreement, The City may change the Plan's details of operation, specific benefits, or other terms and conditions provided that no such change shall be covered by this Agreement unless there is a prior written acceptance by BCBSAZ. The City acknowledges that changes to a Grandfathered Plan may result in the plan losing its grandfathered status.

4.2 **Plan Changes.** The City agrees to provide BCBSAZ with a written description of changes to the Plan at least thirty (30) days prior to the proposed effective date of the changes. Any changes to BCBSAZ's processing system or payment policies and procedures required by a change to the Plan and agreed to be BCBSAZ shall be made at an additional charge to the Plan to be negotiated in good faith and mutually agreed upon by the Parties. In addition to other available remedies, BCBSAZ may terminate this Agreement as a result of any material modification of the Plan upon which BCBSAZ has not agreed, by providing ten (10) days' prior written notice of termination.

ARTICLE 5: PAYMENT DISCLOSURES

5.1 **Preferred Drug List.** With guidance from its Pharmacy and Therapeutics Committee, BCBSAZ develops and adopts for its entire book of insured and administered business and not on behalf of any specific individual or group benefit plan, a preferred drug list (PDL). A copy of the current list is available on the BCBSAZ website. BCBSAZ may add and delete drugs from the preferred drug list, or move drugs from one level on the list, to another, at any time. The City hereby adopts the BCBSAZ preferred drug list, as it may be amended from time to time, as the City's Preferred Drug List and shall notify

BCBSAZ if The City wishes to withdraw such approval. The City acknowledges that withdrawal of approval will affect The City's participation in the BCBSAZ pharmaceutical product rebate program, and any administrative fee credit taken in lieu of rebates.

5.2 **Recovery of Payment.** If BCBSAZ pays a Provider, Participant, or ineligible person and such payment is thirty-five ($35.00) dollars or more in excess of the amount actually owed, BCBSAZ shall make a single written demand upon such person for the return of the overpayment or improper payment. BCBSAZ shall have no further obligation with respect to any such overpayment or improper payment to a Participant or payment to any ineligible person, and in no event shall BCBSAZ be liable for such payments. The City agrees that BCBSAZ shall have no obligation to attempt to collect any overpayments of less than thirty-five ($35.00) dollars. The above obligation does not apply to the extent the erroneous payment was the result of incorrect eligibility information from the City.

5.3 **Payment for Inpatient Services**. The BCBSAZ Allowed Amount for inpatient services is referred to as the "Diagnosis Related Grouping" or "DRG." A DRG is a category of diagnoses or procedures used to reimburse hospitals specific dollar amounts depending on the category of reason for admission (diagnosis) or treatment (procedure). Some institutional providers are paid on a per diem (per day) basis.

5.4 **IRS W9 Form.** In order to receive payment BCBSAZ shall have a current I.R.S. W9 Form on file with the City, unless not required by law.

5.5 **Taxes.** BCBSAZ shall be solely legally responsible for any and all tax obligations, which may result out of BCBSAZ's performance of this Agreement. The City shall have no legal obligation to pay any amounts for taxes, of any type, incurred by BCBSAZ. The City agrees that BCBSAZ may bill the City for applicable privilege license taxes which are paid for by BCBSAZ and that the City will reimburse BCBSAZ for privilege license taxes actually paid by BCBSAZ. If BCBSAZ obtains any refund of privilege license taxes paid, the City will be entitled to a refund of such amounts.

5.6 BCBSAZ shall be solely responsible for any and all tax obligations, which may result out of BCBSAZ's performance of this Agreement. The City shall have no obligation to pay any amounts for taxes, of any type, incurred by BCBSAZ.

ARTICLE 6. THE CITY'S FINANCIAL RESPONSIBILITY

6.1 **Claims Payments**. The City shall provide funds sufficient to satisfy payments made for all Covered Services under the Plan during the Term of this Agreement, provided, however, that if The City has purchased a Maximum Aggregate and Specific Liability Agreement from BCBSAZ, the City is liable for all benefits the Participants incur which do not exceed the Maximum Liabilities set forth in that Agreement. After the close of each contract month, BCBSAZ shall forward an invoice for the total amount paid for Covered Services during that month by BCBSAZ for and on behalf of the City. The Plan or the City shall pay the entire invoice amount within fifteen (15) days of the invoice date in United States funds from a United States bank and branch.

6.2 **Other Fees and Charges**

a. **Administrative Fees**. For the services provided by BCBSAZ under this Agreement, the City agrees to pay or cause the Plan to pay BCBSAZ the administrative fees as set forth in this Agreement (the "Administrative Fees"). BCBSAZ will invoice the City for Administrative Fees on a monthly basis, and such Administrative Fees will be due and payable on the first (1st) day of each calendar month or as otherwise stated in the BCBSAZ invoice.

b. **BlueCard Fees**. The City will pay BCBSAZ's fees associated with the BlueCard Program ("BlueCard Fees"). The BlueCard Fees include fees paid to other Blue Plans which are an "Access Fee" (generally 10% of claims savings not to exceed $2,000 per Claim) and an administrative expense "Allowed Amount" ("AEA") (generally $5.00 per physician claim and $11.00 per hospital claim). The Access Fee and AEA are passed through as a Claims expense. The BlueCard Fees also include other fees, paid by BCBSAZ to the Association for the BlueCard Program, including a "Central Financial Agency Fee" (charged by Claim), an "ITS Transaction Fee" (charged by Claim), 800 toll-free number fees, and Provider directory fees that are not directly passed through as a Claims expense but affect BCBSAZ's administrative expenses. BlueCard Fees may be changed from time to time in accordance with the Association's processes for changing such fees.

c. **Other Fees**. The City will pay any taxes, licenses and fees levied, if any, by all local, state or federal authorities in connection with BCBSAZ's performance of its duties under this Agreement, excluding BCBSAZ's income taxes and BCBSAZ's own employee benefits taxes. BCBSAZ reserves the right to recover from the City any taxes, licenses and fees that may be assessed against BCBSAZ as a result of BCBSAZ's performance of its duties under this Agreement, whether such deficiencies are assessed during the term of this Agreement or following its termination. Additionally, if any state or federal law results in increased costs or fees to BCBSAZ, BCBSAZ may, at any time, including on a retroactive basis if the fee or charge has been retroactively imposed on BCBSAZ by federal or state authorities, increase the fees due from the City under this Agreement.

BCBSAZ will apply a grace period of thirty-one (31) days to the payment of Administrative Fees and Taxes during which time those may be paid without BCBSAZ taking further action. The grace period will not apply to any Claims payments due under the Agreement. During the grace period, the Agreement shall remain in force, and the Plan shall remain liable for any fees and charges that are or become due. If the Plan fails to pay any Administrative Fees or Taxes before the end of the applicable grace period, this Agreement may be terminated at the option of BCBSAZ, effective on the date on which such fees first became due. The Plan will remain liable for all Covered Services rendered to Participants during the grace period, and the Plan agrees to hold BCBSAZ harmless from all fees, charges, and costs therefore and for Covered Services rendered to Participants after the expiration of the grace period.

d. **Failure to Pay**. The City agrees that any amounts not paid when due (or in the case of Administrative Fees and Taxes, not paid by the end of the Grace Period) shall accrue interest at the rate of one percent (1%) per month compounded daily until paid in full. BCBSAZ may offset any amounts BCBSAZ would otherwise owe the Plan under this Agreement or under any other agreement against any amounts the Plan fails to timely pay BCBSAZ under this Agreement. The City agrees that BCBSAZ may offset any amounts BCBSAZ would otherwise owe to the City or to any affiliate of the City, including a subsidiary of the City, under this Agreement or under any other agreement, against any amounts the City fails to timely pay BCBSAZ under this Agreement. Additionally, BCBSAZ may require the City to deposit funds in an amount determined by BCBSAZ which will be held in a non-interest bearing account.

ARTICLE 7. BLUECARD ADMINISTRATION

7.1 **Out-of-Area Services.** BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "**Inter-Plan Programs**."

Whenever Participants access healthcare services outside the geographic area BCBSAZ serves, the Claim(s) for those services may be processed through one of these Inter-Plan Programs and presented to BCBSAZ for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. Typically, Participants, when accessing care outside the geographic area BCBSAZ serves, obtain care from healthcare providers that have a contractual agreement (*i.e.*, are "participating providers") with the local Host Blue in that other geographic area. In some instances, Participants may obtain care from non-contracted healthcare providers (*i.e.*, "non-participating providers"). BCBSAZ payment practices in both instances are described in Exhibit 3. The Inter-Plan Programs available to Participants under this Agreement are described generally in Exhibit 3.

ARTICLE 8. RECORDS

8.1 **Records.** BCBSAZ will retain electronic or paper copies of its claims for Participant's for a minimum of seven (7) years after such records' creation or receipt by BCBSAZ. The obligation to retain records as stated in this Section shall not apply to any records that BCBSAZ returns to the City or the Plan, nor with respect to any records for which the City or Plan has duplicate copies. The City acknowledges and agrees that at the end of seven (7) years' retention of records as stated herein, BCBSAZ may destroy any such records without any obligation to provide prior notice of such destruction to the City or Plan.

8.2 **Property of City.** Any materials, including reports, computer programs and other deliverables, created under this Agreement are the sole property of the City. BCBSAZ is not entitled to a patent or copyright on those materials and may not transfer the patent or copyright to anyone else. BCBSAZ shall not use or release these materials without the prior written consent of the City.

8.4 **New/Current Products.** All equipment, materials, parts and other components incorporated in the work or services performed pursuant to this Agreement shall be new, or the latest model and of the most suitable grade for the purpose intended. All work shall be performed in a skilled and workmanlike manner.

ARTICLE 9. TERM OF AGREEMENT

9.1 **Use of this Agreement:** This Agreement is for the sole convenience of the City. The City reserves the right upon 60 days written notice to obtain like services from another source to secure significant cost savings or when timely completion cannot be met by BCBSAZ.

9.2 The term of the Agreement is one year, commencing on January 1, 2016 and terminating on December 31, 2016 unless sooner terminated in accordance with the provisions herein. The City reserves the right, at its sole discretion, to extend the Agreement for up to seven additional terms of one year each at rates mutually agreed upon in accordance with Article 9.4.

9.3 **Renewal**. Prior to the end of the term or any renewal term, if BCBSAZ wishes to renew, BCBSAZ will forward to the City at least two hundred ten (210) days prior to the term expiration date an offer to renew this Agreement (Administrative Services Agreement Amendment). If BCBSAZ has not received the signed Administrative Services Agreement Amendment on or before the last day of the then-current term or renewal term, this Agreement will terminate as of the last day of the then-current term or renewal term.

9.4 **Price Adjustment (Annual).** All prices offered herein shall be firm against any increase for one (1) year from the effective date of the Contract. Prior to commencement of subsequent renewal terms, City will entertain a fully documented request for price adjustment. The requested increase shall be based upon a cost increase to BCBSAZ that was clearly unpredictable at the time the Contract was executed directly correlated to the price of the product concerned. If the parties are unable to agree on price, the contract shall terminate as of the last day of the then-current term or renewal term.

9.5 **Acceptance by City.** City reserves the right to accept or reject the request for a price increase. If the parties are unable to agree on price, the contract shall terminate as of the last day of the then-current term or renewal term. If City approves the price increase, the price shall remain firm for the renewal term for which it was requested. If a price increase is agreed upon a written Contract Amendment must be approved and executed by the Parties.

ARTICLE 10. TERMINATION OF AGREEMENT

10.1 **BCBSAZ's Right to Term**. This Agreement may be terminated as provided below:

a. **BCBSAZ's Termination Right Without Cause**: After this Agreement has been in effect for twelve (12) months, either Party may terminate this Agreement at any time, without cause, as of the last day of any calendar month by giving sixty (60) days' prior written notice to the other Party.

b. **BCBSAZ's Termination Right For Cause**: BCBSAZ may terminate this Agreement effective immediately in the event of a material breach of the Agreement by the City but only if the breach is not cured within thirty (30) days after written notice of the breach is given to the City.

c. Notwithstanding Paragraph 2(b) above, BCBSAZ may terminate this Agreement upon the occurrence of any of the following:

(i) Upon five (5) days' prior written notice to the City if the City fails to provide funds necessary to satisfy its liability for payments for Covered Services;

(ii) The City's insolvency, appointment of a receiver or a trustee for the City, assignment for the benefit of creditors by the City, or the commencement of any proceedings under bankruptcy or insolvency laws by or against the City that continues for sixty (60) days, or the attachment, levy or other seizure by legal process of any substantial part of the assets of the City, and such attachment, levy, or seizure is not quashed, stayed, or released within sixty (60) days of its occurrence;

(iii) Fraud or misrepresentation by the City;

(iv) Changes to the Plan which are not accepted by BCBSAZ

10.2 **The City's Right to Terminate:** This Agreement may also be terminated as provided below:

a. **City's Termination Right for Cause:** The City may terminate this Agreement for Cause upon the occurrence of any one or more of the following events:

1) If BCBSAZ fails to perform pursuant to the terms of this Agreement

2) If BCBSAZ is adjudged a bankrupt or insolvent;

3) If BCBSAZ makes a general assignment for the benefit of creditors;

4) If a trustee or receiver is appointed for BCBSAZ or for any of BCBSAZ's property;

5) If BCBSAZ files a petition to take advantage of any debtor's act, or to reorganize under the bankruptcy or similar laws;

6) If BCBSAZ disregards applicable and lawful laws, ordinances, rules, regulations or orders of any public body having jurisdiction;

Where Agreement has been so terminated by the City, the termination shall not affect any rights of the City against BCBSAZ then existing or which may thereafter accrue.

10.3 **Termination for Convenience:** The City reserves the right to terminate this Agreement or any part thereof for its sole convenience with sixty (60) written notice. In the event of such termination, BCBSAZ shall immediately stop all work hereunder, and shall immediately cause any of its suppliers and subcontractor s to cease such work. As compensation in full for services performed to the date of such termination, BCBSAZ shall receive a fee for the percentage of services actually performed. This fee shall be in the amount to be mutually agreed upon by BCBSAZ and the City, based on the agreed Scope of Work. If there is no mutual agreement, the Management Services Director or designee shall determine the percentage of work performed under each task detailed in the Scope of Work and BCBSAZ's compensation shall be based upon such determination and BCBSAZ's fee schedule included herein.

10.4 **Cancellation for Conflict of Interest.** Pursuant to A.R.S. § 38-511, the City may cancel this Agreement after Agreement execution without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the Agreement on behalf of the City is or becomes at any time while this Agreement or an extension of this Agreement is in effect, an employee of or a consultant to any other party to this Agreement. The cancellation shall be effective when BCBSAZ receives written notice of the cancellation unless the notice specifies a later time.

10.5 **Gratuities.** The City may, by written notice, terminate this Agreement, in whole or in part, if the City determines that employment or a Gratuity was offered or made by BCBSAZ or a representative of BCBSAZ to any officer or employee of the City for the purpose of influencing the outcome of the procurement or securing this Agreement, an amendment to this Agreement, or favorable treatment concerning this Agreement, including the making of any determination or decision about contract performance. The City, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the Gratuity offered by BCBSAZ.

10.6 **Suspension or Debarment.** The City may, by written notice to BCBSAZ, immediately terminate this Agreement if the City determines that BCBSAZ has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity, including but not limited to, being disapproved as a subcontractor of any public procurement unit or other governmental body. Submittal of an offer or execution of a contract shall attest that BCBSAZ is not currently suspended or debarred. If BCBSAZ becomes suspended or debarred, BCBSAZ shall immediately notify the City.

10.7 **Continuation of Performance Through Termination.** BCBSAZ shall continue to perform, in accordance with the requirements of the Agreement, up to the date of termination, as directed in the termination notice.

10.8 **No Waiver.** Either party's failure to insist on strict performance of any term or condition of the Agreement shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the nonconforming performance knows of the nature of the performance and fails to object to it.

10.9 **Availability of Funds for the next Fiscal Year.** Funds may not presently be available under this Agreement beyond the current fiscal year. No legal liability on the part of the City for services may arise under this Agreement beyond the current fiscal year until funds are made available for performance of this Agreement. The City may reduce services or terminate this Agreement without further recourse, obligation, or penalty in the event that insufficient funds are appropriated. The City Manager shall have the sole and unfettered discretion in determining the availability of funds.

10.10 **Automatic Termination:** This Agreement shall terminate automatically upon the occurrence of any of the following: (i) Termination of the Plan in its entirety; (ii) The enactment of any law or the adoption of any regulation that makes it illegal to continue this Agreement or for BCBSAZ to perform any of the services required under this Agreement.

10.11 **Effect of Termination**. Upon termination, the parties shall have only those continuing duties of performance, as provided herein; provided however, that (a) upon completion of its performance under this Agreement, BCBSAZ shall cause the orderly transfer of records, if any, from BCBSAZ to the City or its designee in a time frame mutually agreed upon, but not to exceed six (6) months from the date of termination, and (b) for a period of twenty-four (24) months following the termination of this Agreement (the "Run-Out Period"), BCBSAZ shall continue to process and pay claims incurred prior to the termination of this Agreement in accordance with this Agreement, provided the City funds such claims and pays the fees and charges required by this Agreement. Notwithstanding the foregoing, BCBSAZ is not obligated to continue to process claims during the Run-Out Period if this Agreement is terminated for cause. All the City's obligations under this Agreement shall remain in effect through the end of the Run-Out Period. The City agrees to reimburse BCBSAZ for any and all amounts BCBSAZ is required to pay pursuant to this Agreement, including but not limited to any those resulting from a grievance or appeals or a determination by CMS that Medicare was not primary, regardless of whether BCBSAZ is administering claims for the City at the time CMS makes such determination.

ARTICLE 11. CITY'S CONTRACTUAL REMEDIES:

11.1 **Right to Assurance.** If the City in good faith has reason to believe that BCBSAZ does not intend to, or is unable to perform or continue performing under this Agreement, the Contract Administrator may demand in writing that BCBSAZ give a written assurance of intent to perform. Failure by BCBSAZ to provide written assurance within the number of Days specified in the demand may, at the City's option, be the basis for terminating the Agreement in addition to any other rights and remedies provided by law or this Agreement.

11.2 **Stop Work Order.** The City may, at any time, by written order to BCBSAZ, require BCBSAZ to stop all or any part, of the work called for by this Agreement for period(s) of days indicated by the City after the order is delivered to BCBSAZ. The order shall be specifically identified as a stop work order issued under this clause. Upon receipt of the order, BCBSAZ shall immediately comply with its terms and take all reasonable steps to

minimize the incurrence of costs allocable to the work covered by the order during the period of work stoppage.

11.3 If a stop work order issued under this clause is canceled or the period of the order or any extension expires, BCBSAZ shall resume work. The Contract Administrator shall make an equitable adjustment in the delivery schedule or Agreement price, or both, and the Agreement shall be amended in writing accordingly.

11.4 **Non-exclusive Remedies.** The rights and the remedies of the City under this Agreement are not exclusive.

11.5 **Nonconforming Tender.** Services and materials supplied under this Agreement shall fully comply with contract requirements and specifications. Services or materials that do not fully comply constitute a breach of contract.

11.6 **Right of Offset.** The Parties shall be entitled to offset against any sums due each other, any expenses or costs incurred by the other, or damages assessed by the other concerning the other's non- conforming performance or failure to perform the Agreement, including expenses to complete the work and other costs and damages incurred by the Party.

ARTICLE 12. DISPUTE RESOLUTION:

12.1. **Arizona Law.** This Agreement shall be governed and interpreted according to the laws of the State of Arizona.

12.2. **Jurisdiction and Venue.** The parties agree that this Agreement is made in and shall be performed in Maricopa County. Any lawsuits between the Parties arising out of this Agreement shall be brought and concluded in the courts of Maricopa County in the State of Arizona, which shall have exclusive jurisdiction over such lawsuits.

12.3 **Fees and Costs.** Except as otherwise agreed by the parties, the prevailing party in any adjudicated dispute relating to this Agreement is entitled to an award of reasonable attorney's fees, expert witness fees and costs including, as applicable, arbitrator fees.

ARTICLE 13. INDEMNIFICATION:

13.1 **Indemnification By BCBSAZ** - BCBSAZ shall indemnify, defend, save and hold harmless the City and its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of BCBSAZ or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such BCBSAZ to conform to any federal, state or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the "Indemnitee" shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the "Indemnitee", be indemnified by BCBSAZ from and against any and all claims. It is agreed that BCBSAZ will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this Agreement, BCBSAZ agrees to waive all rights of subrogation against the City, its officers, officials, agents and employees for losses arising from the work performed by BCBSAZ for the City.

13.2 **Indemnification By the City** - The City shall indemnify, hold harmless, and defend BCBSAZ, its directors, officers, employees or agents from and against any and all actions, causes of action, suits, claims, judgments, settlements, liabilities, damages, penalties, losses and/or expenses, and costs, including, without limitation, attorneys' fees, punitive and exemplary damages, resulting from or arising solely out of or in connection with negligent or willful acts or omissions of the City, its directors, officers, employees or agents including but not limited to breach of this Agreement. This indemnification obligation shall survive the termination or expiration of this Agreement.

ARTICLE 14. LIMITATIONOF LIABILITY AND INDEMNIFICATIONS

14.1 **Scope of Responsibility.** With respect to the Plan, the parties agree that BCBSAZ is not the Plan administrator or a Plan fiduciary under ERISA (including PPACA) or COBRA (or comparable provisions of other state or federal law). The City acknowledges and agrees that it is the plan administrator and named fiduciary and is responsible for any liability arising out of the requirements of COBRA, ERISA, the PHSA and the Internal Revenue Code, including PPACA, (or comparable provisions of other state or federal law). Both Parties acknowledge and agree that the City is responsible for compliance with all applicable laws and regulations. BCBSAZ does not assume any responsibility for the general policy direction of the Plan, the adequacy of its funding, or any act or omission or any breach of duty by the City. BCBSAZ is not in any way to be deemed an insurer, underwriter, or guarantor with respect to any benefits payable under the Plan, nor is BCBSAZ a fiduciary under the Plan. BCBSAZ does not assume any risk, including but not limited to, insurance and/or financial or credit risk, unless and only to the extent BCBSAZ and the City have executed a Maximum Aggregate and Specific Liability Agreement.

14.2 **Liability for Misrepresentation or Fraud.** The City shall be liable for providing misleading, false, or inaccurate statements and for failing to provide adequate, accurate and timely information or notice to BCBSAZ under this Agreement. BCBSAZ reserves the right to take whatever action it deems necessary and appropriate to return BCBSAZ to the position it would have been in but for those misrepresentations, misstatements, or omissions by the City. Such actions shall include, but not be limited to, the right to immediately terminate or rescind this Agreement.

14.3 **Limitation of Liability.** BCBSAZ shall not be liable for any loss or expense to the City resulting from the performance of BCBSAZ under this Agreement, when BCBSAZ has adhered to the framework of the policies, interpretations, rules, practices, and procedures made or established by the City or has otherwise performed under this Agreement, except for losses resulting directly from and to the extent of the gross negligence, fraud, or willful misconduct of BCBSAZ, its directors, officers, employees, or agents.

14.3 **Lawsuits by BCBSAZ.** BCBSAZ may, on occasion, investigate opportunities to initiate or join class action or other lawsuits premised on suspected conduct that results in higher payments by third party payors, for example insurance companies, 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 file a lawsuit or participate in a pending matter. BCBSAZ may also bring lawsuits against vendors or other entities to recover various economic damages. If BCBSAZ participates as a plaintiff and recovers damages, those funds (unless determined to be plan assets under ERISA) are retained by BCBSAZ to reduce overall administrative costs. The lawsuits are brought on behalf of BCBSAZ and funds are not distributed to the Plan or Participants. This paragraph is not intended to limit or waive any claims BCBSAZ may have against any person or entity.

ARTICLE 15. INSURANCE:

15.1. **General**.

a. At the same time as execution of this Agreement, BCBSAZ shall furnish the City of Chandler a certificate of insurance on a standard insurance industry ACORD form. The ACORD form must be issued by an insurance company authorized to transact business in the State of Arizona possessing a current A.M. Best, Inc. rating of A-7, or better and legally authorized to do business in the State of Arizona with policies and forms satisfactory to City. Provided, however, the A.M. Best rating requirement shall not be deemed to apply to required Workers' Compensation coverage.

b. BCBSAZ shall procure and maintain, until all of their obligations have been discharged, including any warranty periods under this Agreement are satisfied, the insurances set forth below.

c. The insurance requirements set forth below are minimum requirements for this Agreement and in no way limit the indemnity covenants contained in this Agreement.

d. The City in no way warrants that the minimum insurance limits contained in this Agreement are sufficient to protect BCBSAZ from liabilities that might arise out of the performance of the Contract services under this Agreement by BCBSAZ, its agents, representatives, employees, subcontractors, and BCBSAZ is free to purchase any additional insurance as may be determined necessary.

e. Failure to demand evidence of full compliance with the insurance requirements in this Agreement or failure to identify any insurance deficiency will not relieve BCBSAZ from, nor will it be considered a waiver of its obligation to maintain the required insurance at all times during the performance of this Agreement.

15.2. **Minimum Scope And Limits Of Insurance**. BCBSAZ shall provide coverage with limits of liability not less than those stated below.

a. *Commercial General Liability-Occurrence Form*. BCBSAZ must maintain "occurrence" form Commercial General Liability insurance with a limit of not less than $2,000,000 for each occurrence, $4,000,000 aggregate. Said insurance must also include coverage for products and completed operations, independent contractors, personal injury and advertising injury. If any Excess insurance is utilized to fulfill the requirements of this paragraph, the Excess insurance must be "follow form" equal or broader in coverage scope than underlying insurance.

b. *Automobile Liability-Any Auto or Owned, Hired and Non-Owned Vehicles*

Vehicle Liability: BCBSAZ must maintain Business/Automobile Liability insurance with a limit of $1,000,000 each accident on BCBSAZ owned, hired, and non-owned vehicles assigned to or used in the performance of BCBSAZ's work or services under this Agreement. If any Excess or Umbrella insurance is utilized to fulfill the requirements of this paragraph, the Excess or Umbrella insurance must be "follow form" equal or broader in coverage scope than underlying insurance.

c. *Workers Compensation and Employers Liability Insurance*: BCBSAZ must maintain Workers Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of BCBSAZ employees engaged in

the performance of work or services under this Agreement and must also maintain Employers' Liability insurance of not less than $1,000,000 for each accident and $1,000,000 disease for each employee.

15.3 **Additional Policy Provisions Required**.

a. *Self-Insured Retentions Or Deductibles*. Any self-insured retentions and deductibles must be declared and approved by the City. If not approved, the City may require that the insurer reduce or eliminate any deductible or self-insured retentions with respect to the City, its officers, officials, agents, employees, and volunteers.

b. *The City as Additional Insured*. The policies are to contain, or be endorsed to contain, the following provisions:

1. The Commercial General Liability and Automobile Liability policies are to contain, or be endorsed to contain, the following provisions: The City, its officers, officials, agents, and employees are additional insureds with respect to liability arising out of activities performed by, or on behalf of, BCBSAZ including the City's general supervision of BCBSAZ; Products and Completed operations of BCBSAZ; and automobiles owned, leased, hired, or borrowed by BCBSAZ.

2. BCBSAZ's insurance must contain broad form contractual liability coverage and must not exclude liability arising out of explosion, collapse, or underground property damage hazards ("XCU") coverage.

3. The City, its officers, officials, agents, and employees must be additional insureds to the full limits of liability purchased by BCBSAZ even if those limits of liability are in excess of those required by this Agreement.

4. BCBSAZ's insurance coverage must be primary insurance with respect to the City, its officers, officials, agents, and employees. Any insurance or self-insurance maintained by the City, its officers, officials, agents, and employees shall be in excess of the coverage provided by BCBSAZ and must not contribute to it.

5. BCBSAZ's insurance must apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

6. Coverage provided by BCBSAZ must not be limited to the liability assumed under the indemnification provisions of this Agreement.

7. The policies must contain a severability of interest clause and waiver of subrogation against the City, its officers, officials, agents, and employees, for losses arising from Work performed by BCBSAZ for the City.

8. BCBSAZ, its successors and or assigns, are required to maintain Commercial General Liability insurance as specified in this Agreement for a minimum period of 3 years following completion and acceptance of the Work. BCBSAZ must submit a Certificate of Insurance evidencing Commercial General Liability insurance during this 3 year period containing all the Agreement's insurance requirements, including naming the City of Chandler, its agents, representatives, officers, directors, officials and employees as Additional Insured as required.

9. If a Certificate of Insurance is submitted as verification of coverage, the City will reasonably rely upon the Certificate of Insurance as evidence of coverage but this acceptance and reliance will not waive or alter in any way the insurance requirements or obligations of this Agreement. If any of the required policies expire during the life of this Agreement, BCBSAZ must forward renewal or replacement Certificates to the City within 10 days after the renewal date containing all the necessary insurance provisions.

10. By signing this Agreement, BCBSAZ certifies it is fully aware of Insurance Requirements contained in the Agreement and assures the City of Chandler that it is able to produce the Insurance coverage required.

11. Should BCBSAZ become unable to produce the Insurance coverage specified within ten working days, BCBSAZ is fully aware and understands that it may not be considered for further projects by the City of Chandler.

ARTICLE 16. CONFLICT OF INTEREST:

16.1 **No Kickback.** BCBSAZ warrants that no person has been employed or retained to solicit or secure this Agreement upon an agreement or understanding for a commission, percentage, brokerage or contingent fee; and that no member of the City Council or any employee of the City has any interest, financially or otherwise, in the firm unless this interest has been declared pursuant to the provisions of A.R.S. Section 38-501. Any such interests were disclosed in BCBSAZ's proposal to the City.

16.2 **Kickback Termination.** The City may cancel any contract or agreement, without penalty or obligation, if any person significantly involved in initiating, negotiating, securing, drafting or creating the Agreement on behalf of the City is, at any time while the Agreement or any extension of the Agreement is in effect, an employee of any other party to the Agreement in any capacity or a BCBSAZ to any other party to the Agreement with respect to the subject matter of the Agreement. The cancellation shall be effective when written notice from the City is received by all other parties, unless the notice specifies a later time (A.R.S. §38-511).

16.3 **No Conflict:** BCBSAZ stipulates that its officers and employees do not now have a conflict of interest and it further agrees for itself, its officers and its employees that it will not contract for or accept employment for the performance of any work or services with any individual business, corporation or government unit that would create a conflict of interest in the performance of its obligations pursuant to this project.

ARTICLE 17. HIPAA BUSINESS ASSOCIATE PROVISION

17.1 **Definitions**

In General. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR § 160.103 and § 164.501. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

17.2 **Specific Definitions**

a. "Applicable Law" shall mean any of the following items, including any amendments to any such item as such may become effective:

- the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");
- the federal regulations regarding privacy and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Privacy Rule");
- the federal regulations regarding electronic data interchange and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 162 (the "Transaction Rule");
- the federal regulations regarding security and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Security Rule"); and
- the American Recovery and Reinvestment Act of 2009 ("ARRA"), §§ 13400-24.

b. "Business Associate shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean Blue Cross Blue Shield of Arizona.

c. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean the City of Chandler.

d. "Effective Date" means the effective date of this Agreement, except as otherwise specified in this Agreement.

e. "ePHI" means electronic protected health information within the meaning of 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

f. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and 164.

17.3 **RIGHTS AND OBLIGATIONS OF COVERED ENTITY**

a. Privacy Practices and Restrictions

Upon request, Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520. If Covered Entity subsequently revises the notice, Covered Entity shall provide a copy of the revised notice to Business Associate.

Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

b. **Permissible Requests by Covered Entity**

Covered Entity shall not request Business Associate to use or disclose PHI in

any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

If Covered Entity requests PHI from Business Associate, Covered Entity will limit its request to the minimum necessary PHI required to fulfill the purpose of Covered Entity's use or further disclosure of such PHI.

17.4 **OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE**

a. **Business Associate agrees to:** In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same or substantially similar restrictions, conditions, and requirements that apply to the business associate with respect to such information.

b. **Access to Books and Records by Covered Entity.** Business Associate shall make its internal practices, books, and records relating to the use, disclosure, and security of PHI available to Covered Entity, after receiving reasonable advance notice from Covered Entity in a time and manner designated by Covered Entity, for purposes of allowing Covered Entity to confirm Business Associate's compliance with HIPAA.

c. **Access to Books and Records by Secretary.** Business Associate shall make its internal practices, books, and records available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with HIPAA.

d. **Mitigation.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of (a) a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement, or (b) a Security Incident.

e. **Compliance with Privacy Rule.**

(i) Business Associate shall not use or disclose PHI other than as permitted or required by this Agreement or as required by law.
(ii) Business Associate shall use appropriate safeguards, and comply with Subpart C of *45*
(iii) *CFR Part 164* with respect to electronic protected health information, to prevent use or disclosure of the PHI other than as provided for by this Agreement.
(iv) Business Associate shall report to Covered Entity any use or disclosure of PHI, not provided for by this Agreement, of which it becomes aware, including breaches of unsecured PHI as required at *45 CFR 164.410,* and any security incident of which it becomes aware.

f. **Compliance with Transaction Rule.** To the extent that Business Associate, on behalf of Covered Entity or Plan Sponsor, conducts transactions that are subject to the Transaction Rule, Business Associate shall comply with the Transaction Rule. Business Associate agrees that it shall not require Plan Sponsor (or the members of its workforce) to communicate with Business Associate using the specifications set forth in the Transaction Rule.

g. **Compliance with Security Rule.**

Business Associate shall implement administrative, physical, and technical

safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI.

Business Associate shall report to Covered Entity any Security Incident of which Business Associate becomes aware.

h. **Compliance with ARRA.**

If Business Associate discovers that there has been a HIPAA Breach, Business Associate shall notify Covered Entity without unreasonable delay and in no event more than 10 business days of the discovery. Such notice shall include identification of each Individual whose PHI Business Associate reasonably believes to have been accessed, acquired, or disclosed during such HIPAA Breach. As soon as possible thereafter, and to the extent known, Business Associate shall also provide Covered Entity with a description of (i) what happened, including the date of the HIPAA Breach and the date of the discovery, (ii) the types of unsecured PHI involved in the HIPAA Breach, (iii) any steps individuals should take to protect themselves from potential harm from the HIPAA Breach, and (iv) what Business Associate is doing to investigate the HIPAA Breach, to mitigate harm to individuals, and to protect against any further HIPAA Breaches. For purposes of this paragraph, a HIPAA Breach shall be treated as discovered as of the first day on which the HIPAA Breach is known or should reasonably have been known to Business Associate (including any person, other than the one committing the HIPAA Breach, that is an employee, officer, or other agent of the Business Associate).

Business Associate shall not receive remuneration, either directly or indirectly, in exchange for PHI, except as may be permitted by ARRA § 13405(d).

Business Associate shall not make any fundraising communication on behalf of Covered Entity or to Covered Entity's "participants and beneficiaries," "patients," etc.

Pursuant to the Privacy Rule, made applicable to Business Associate by ARRA, Business Associate shall adopt, implement, and follow privacy policies and procedures in the same manner and to the same extent as if it were a Covered Entity.

Pursuant to the Security Rule, made applicable to Business Associate by ARRA, Business Associate shall adopt, implement, and follow security policies and procedures in the same manner and to the same extent as if it were a Covered Entity.

17.5 **Obligations Relating to Individual Rights**.

a. **Restrictions on Disclosures.** Upon request by an Individual, Covered Entity shall determine whether an Individual is entitled to a restriction on disclosure of the PHI pursuant to 45 CFR § 164.522. If Covered Entity determines that an Individual is entitled to such a restriction, Covered Entity will communicate the decision to Business Associate. Business Associate will restrict its disclosures of the Individual's PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request for restrictions, Business Associate shall forward such request to Covered Entity within 5 business days.

b. **Access to PHI.** Upon request by an Individual, Covered Entity shall determine whether an Individual is entitled to access his or her PHI pursuant to 45 CFR §

164.524. If Covered Entity determines that an Individual is entitled to such access, and that such PHI is under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide access to the PHI in the same manner as would be required for Covered Entity. Business Associate shall make available protected health information in a designated record set to the individual or the individual's designee as necessary to satisfy covered entity's obligations under 45 CFR 164.524. If Business Associate receives an Individual's request to access his or her PHI, Business Associate shall forward such request to Covered Entity within 5 business days.

c. **Amendment of PHI.** Upon request by an Individual, Covered Entity shall determine whether any Individual is entitled to amend his or her PHI pursuant to 45 CFR § 164.526. If Covered Entity determines that an Individual is entitled to such an amendment, and that such PHI is both in a designated record set and under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide an opportunity to amend the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request to amend his or her PHI, Business Associate shall forward such request to Covered Entity within 5 business days.

d. **Accounting of non-EHR Disclosures.** Upon request by an Individual, Covered Entity shall determine whether any Individual is entitled to an accounting pursuant to 45 CFR § 164.528. If Covered Entity determines that an Individual is entitled to an accounting, Covered Entity will communicate the decision to Business Associate. Business Associate will provide information to Covered Entity that will enable Covered Entity to meet its accounting obligations under 45 CFR 164.528. If Business Associate receives an Individual's request for an accounting, Business Associate shall forward such request to Covered Entity within 5 business days.

e. To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, business associate shall comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s).

17.6 **Permitted Uses and Disclosures by Business Associate**

Except as otherwise limited in this Agreement or by Applicable Law, Business Associate may: Except for the specific uses and disclosures set forth in this Section Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity.

Use or disclose PHI to perform functions, activities, or services for or on behalf of Covered Entity, as specified in the Services Agreement between the parties and in this Agreement, provided that such use or disclosure is consistent with Covered Entity's Notice of Privacy Practices, and provided that such use or disclosure would not violate HIPAA or the Privacy Rule if done by Covered Entity;

Use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate;

Disclose PHI for the proper management and administration of Business Associate, provided that (i) Business Associate obtains reasonable assurances from the person to

whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached or (ii) the disclosures are Required By Law; and

Use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

17.7 **Termination**

a. **Termination for Cause.** Upon Covered Entity's knowledge of a material breach of this Agreement by Business Associate, Covered Entity and Plan Sponsor shall have the following rights:

If the breach is curable, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation. Alternatively, or if Business Associate fails to cure the breach or end the violation, Covered Entity and/or Plan Sponsor may upon sixty (60) days prior written notice terminate this Agreement and the Services Agreement.

If the breach is not curable, Covered Entity and/or Plan Sponsor may upon ten (10) days prior written notice terminate this Agreement and the Services Agreement, provided however the City should continue to pay run out claims for twenty (24) months after the effective date of termination. If termination is not feasible, Covered Entity shall report the problem to the Secretary.

b. **Effect of Termination**

Except as provided in the following paragraph, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI within its possession or control, and all PHI that is in the possession or control of Business Associate's subcontractors or agents. Business Associate shall retain no copies of the PHI.

If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

17.8 **Miscellaneous**

a. **Electronic Health Record.** Business Associate shall not maintain any "electronic health record" or "personal health record," as those terms are defined in ARRA, for or on behalf of Covered Entity.

b. **Regulatory References.** A reference in this Agreement to a section in any Applicable Law means the section in effect or as amended, and for which compliance is required.

c. **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other Applicable Law. All

amendments to this Agreement, except those occurring by operation of law, shall be in writing and signed by both parties.

d. **Survival.** The respective rights and obligations of Business Associate under Section 17.4 of this Agreement shall survive the term and termination of this Agreement.

e. **Interpretation.** Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with Applicable Law.

f. **No Third Party Beneficiaries.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer upon any person, other than Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

g. **Effect on Agreement.** Except as specifically required to implement the purposes of this Agreement, or to the extent inconsistent with this Agreement, all other terms of the underlying Services Agreement shall remain in force and effect.

h. **Counterparts.** This Agreement may be executed in counterparts, each of which may be deemed an original.

ARTICLE 18. GENERAL TERMS:

18.1 **Cooperative Use of Agreement.** In addition to the City of Chandler and with approval of BCBSAZ, this Agreement may be extended for use by other municipalities, school districts and government agencies of the State. A current listing of eligible entities may be found at www.maricopa.gov/materials and then click on 'Contracts', 'S.A.V.E.' listing and 'ICPA'. Any such usage by other entities must be in accordance with the ordinance, charter and/or procurement rules and regulations of the respective political entity.
If required to provide services on a school district property at least five (5) times during a month, BCBSAZ shall submit a full set of fingerprints to the school of each person or employee who may provide such service. The District shall conduct a fingerprint check in accordance with A.R.S. 41-1750 and Public Law 92-544 of all BCBSAZs, subcontractors or vendors and their employees for which fingerprints are submitted to the District. Additionally, BCBSAZ shall comply with the governing body fingerprinting policies of each individual school district/public entity. BCBSAZ, sub-contractors, vendors and their employees shall not provide services on school district properties until authorized by the District.

Orders placed by other agencies and payment thereof will be the sole responsibility of that agency. The City shall not be responsible for any disputes arising out of transactions made by other agencies who utilize this Agreement.

18.2. **Emergency Purchases:** The City reserves the rights to purchase from other sources those items, which are required on an emergency basis and cannot be supplied immediately by BCBSAZ.

18.3 **Non-Exclusive Agreement:** This Agreement is for the sole convenience of the City of Chandler. The City reserves the right, after the first year of this Agreement, to obtain like goods or services.

18.4 **Exclusive Possession:** All services, information, computer program elements, reports and other deliverables created under this Agreement are the sole property of the City of

Chandler and shall not be used or released by BCBSAZ or any other person except with prior written permission by the City.

18.5 **Non-Discrimination**. BCBSAZ shall comply with all applicable City, State and Federal laws, rules and regulations, including the Americans with Disabilities Act.

18.6 **Compliance with Applicable Laws**. BCBSAZ shall comply with all applicable Federal, state and local laws, and with all applicable licenses and permit requirements.

a. BCBSAZ hereby warrants to the City that BCBSAZ and each of its subcontractors ("subcontractors") will comply with all Federal Immigration laws and regulations that relate to the immigration status of their employees and the requirement to use E-Verify, hereinafter "Contractor Immigration Warranty".

b. A breach of the Contractor Immigration Warranty shall constitute a material breach of this Agreement that is subject to penalties up to and including termination of the Agreement.

c. The City retains the legal right to inspect the papers of any contractor or subcontractor employee who works on this Agreement to ensure that the contractor or subcontractor is complying with the Contractor Immigration Warranty. BCBSAZ agrees to assist the City in the conduct of any such inspections.

d. The City may, at its sole discretion, conduct random verifications of the employment records of the contractor and any subcontractors to ensure compliance with Contractors Immigration Warranty. BCBSAZ agrees to assist the City in performing any such random verification.

18.7 **Ownership**. All deliverables and/or other products of the Agreement (including but not limited to all software documentation, reports, records, summaries and other matter and materials prepared or developed by BCBSAZ in performance of the Agreement) shall be the sole, absolute and exclusive property of the City, free from any claim or retention of right on the part of BCBSAZ, its agents, sub-contractors, officers or employees.

18.8 **Entire Agreement.** This Agreement, including all Exhibits attached hereto, constitutes the entire understanding of the parties and supersedes all previous representations, written or oral, with respect to the services specified herein. This Agreement may not be modified or amended except by a written document, signed by authorized representatives or each party.

18.9 **Assignment and Subcontracting.** Neither Party may assign or transfer any right, benefit, obligation, or duty under the terms of this Agreement without the advance written consent of the other, provided, however, that BCBSAZ may transfer and assign this Agreement to a subsidiary or parent or an entity or person acquiring control of BCBSAZ or its assets or acquiring a division of BCBSAZ providing administration services under this Agreement. BCBSAZ may contract with other entities for the performance of any services to be performed by BCBSAZ hereunder.

18.10 **Amendments.** The Agreement may be modified only through a written Amendment executed by authorized persons for both parties, however, BCBSAZ may alter, amend, or modify this Agreement, the Benefit Plan Booklet(s), and its performance under this Agreement as BCBSAZ in its sole discretion determines may be necessitated by applicable state or federal law or by the terms and conditions of various participation agreements between BCBSAZ and Providers. Changes to the Agreement, including the addition of work or materials, the revision of payment terms, or the substitution of work

or materials, directed by a person who is not specifically authorized by the City in writing or made unilaterally by BCBSAZ are violations of the Agreement. Except as stated in this Section, any such changes, including unauthorized written Amendments shall be void and without effect, and BCBSAZ shall not be entitled to any claim under this Agreement based on such changes.

18.11 **Independent Contractors.** BCBSAZ is an independent contractor with respect to the services being performed under this Agreement and shall not for any purpose be deemed an employee of the Plan or The City , nor shall BCBSAZ and the Plan or the City be deemed partners, joint venturers, or governed by any legal relationship other than that of independent contractor.

18.12 **No Parole Evidence.** This Agreement is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any terms used in this document and no other understanding either oral or in writing shall be binding.

18.13 **Authority:** Each party hereby warrants and represents that it has full power and authority to enter into and perform this Agreement, and that the person signing on behalf of each has been properly authorized and empowered to enter this Agreement.

18.14 **Attorneys' Fees.** If any legal action is brought to enforce or interpret any of the terms, conditions or obligations of this Agreement, the prevailing Party shall be entitled to recover all court costs and reasonable attorneys' fees from the non-prevailing Party.

18.15 **Relationship to the Association.** The Plan, on behalf of itself and its participants, hereby expressly acknowledges its understanding this Agreement constitutes a contract solely between the Plan 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 Blue Shield Service Mark[s] in Arizona, and that BCBSAZ is not contracting as the agent of the Association. The Plan, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSAZ and that no person, entity, or organization other than BCBSAZ shall be held accountable or liable to the Plan for any of BCBSAZ's obligations to the Plan created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSAZ other than those obligations created under other provisions of this agreement.

18.16 **Non-Assignability of Right of Payment.** Payment for Covered Services shall be made directly to the Provider of such Covered Services if that Provider has a participation agreement with BCBSAZ or direct payment to that Provider is required under agreements between BCBSAZ and the Association and/or other independent licensees of the Association. If a Provider is not in either of these categories, the payment of Covered Services shall be made directly to the Participant, except as may otherwise be required by applicable state or federal law. Rights to payment available under this Agreement are not assignable.

18.17 **Non-Disclosure of Proprietary Information.** The City and Plan acknowledge that each has received, and shall continue to receive, information which is proprietary or confidential to BCBSAZ ("Proprietary Information"). The term Proprietary Information shall mean: (a) any information provided by BCBSAZ to the City and Plan which a reasonable person would regard as confidential including, without limitation, information pertaining to providers, rates, pricing, proposed products, strategies and financial information; (c) information acquired by BCBSAZ under terms limiting or protecting the disclosure thereof; and (d) any information marked confidential. The City and Plan

acknowledge that the Proprietary Information is confidential and proprietary to BCBSAZ and each agrees that it shall not disclose the Proprietary Information to any third party without the prior written consent of BCBSAZ. Additionally, the City and Plan shall not utilize the Proprietary Information for any purpose other than as set forth in this Agreement. Additionally, the City and Plan acknowledge and agree that the reimbursement arrangements and discounts BCBSAZ has negotiated with its providers ("Pricing Information") is confidential trade secret information belonging to BCBSAZ and the City and Plan shall not be entitled to such information. If the City or Plan inadvertently receives Pricing Information, the City and Plan will promptly notify BCBSAZ and destroy the information. The terms and conditions of this paragraph shall survive the termination or expiration of this Agreement.

18.18 **Notices:** All notices or demands required to be given pursuant to the terms of this Agreement shall be given to the other party in writing, delivered by hand, overnight delivery, registered or certified mail, at the addresses set forth below, or to such other address as the parties may substitute by written notice given in the manner prescribed in this paragraph.

In the case of the CITY		In the case of BCBSAZ	
Contract Administrator:	Debra Stapleton	Firm Name:	BCBSAZ
Contact:	Director Human Resources	Contact:	Vice President - Sales
Mailing Address:	M.S. 703, P.O. Box 4008	Address:	8220 N. 23rd Avenue
Physical Address:	175 S. Arizona Ave., Second Floor	City, State, Zip	Phoenix, Az 85021
City, State, Zip	Chandler, AZ 85225	Phone:	(602) 864-4570
Phone:	480-782-2351	FAX:	
FAX:	480-782-2366		

Notices shall be deemed received on date delivered, if delivered by hand, and on the delivery date indicated on receipt if delivered by certified or registered mail. Notice to the City's designated Broker/Consultant shall constitute notice to the Plan.

18.19 **Parties to the Agreement.** This Agreement is between BCBSAZ and the Plan and does not create any rights or legal relationships between BCBSAZ and any Participants.

18.20 **Severability.** If any provision of this Agreement is held to be illegal, invalid, or unenforceable under current or future laws or regulations effective during the term of this Agreement, (a) the illegal, invalid, or unenforceable provision shall be severed from this Agreement, (b) this Agreement shall be construed and enforced as if such illegal, invalid, or unenforceable provision had never comprised a part of this Agreement, and (c) the remaining provisions shall remain in full force and effect and shall not be affected by such illegal, invalid or unenforceable provision or by its severance.

18.21 **Successors and Assigns.** The provisions of this Agreement shall be binding upon and inure to the benefit of the Parties, their permissible successors, and their permissible assigns.

18.22 **Use of Trade Name.** The City agrees not to use the corporate name or any trade name, trademark, or service mark of BCBSAZ, or of any pharmaceutical manufacturers or vendor firms contracted with BCBSAZ, in any advertising, publications, press releases, brochures, or other public communications without the prior written consent of BCBSAZ, the pharmaceutical manufacturer, or vendor, as applicable.

18.23 **Waiver.** There shall be no waiver of any term, provision, or condition of this Agreement

unless in writing and signed by both Parties.

18.24 **Massachusetts.** The City acknowledges and agrees that: (a) the City is aware Massachusetts enacted health reform legislation which requires, among other things, Massachusetts residents to have health insurance that qualifies as "creditable coverage" under Massachusetts law and which imposes significant penalties on Massachusetts residents and their employers who fail to comply with Massachusetts creditable coverage related laws and regulations; (b) BCBSAZ does not perform any of the duties required of employers with Massachusetts resident employees, including but not limited to: (i) making electronic filing(s) with Massachusetts regulators; (ii) sending the Massachusetts Form 1099 HC to Massachusetts residents; (iii) assessing whether BCBSAZ plans satisfy, in whole or in part, Massachusetts credible coverage requirements; (iv) making any representation that any BCBSAZ coverage qualifies as "creditable coverage" under Massachusetts law.

18.25 **Survival**. In addition to those provisions identified in the Agreement, the following additional provisions contained in these Terms and Conditions shall survive expiration or termination of the Agreement: Articles 3, 6, 8.3, 10.11, 14, 17 and 18.17.

18.26 **Force Majeure:** Neither party shall be responsible for delays or failures in performance resulting from acts beyond their control. Such acts shall include, but not be limited to, acts of God, riots, acts of war, epidemics, governmental regulations imposed after the fact, fire, communication line failures, power failures, or earthquakes.

18.27 **Agreement**. Each party further acknowledges that it has read this Agreement, understands it, and agrees to be bound by it.

THE CITY'S BENEFIT PLAN BOOKLETS WHICH ARE EXHIBIT 1 ARE THE PAGE(S) IMMEDIATELY FOLLOWING THIS PAGE

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.

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact 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) 864-4456	(602) 864-4823	(602) 864-4884
		(800) 232-2345, ext. 4456	(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)

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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
Behavioral Services Administrator (BSA)	(800) 224-2125
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 providing services in Arizona 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	

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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

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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 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.

"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 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.**

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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, access fee, coinsurance, pharmacy deductible, and precertification charges.

"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.**

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“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.

“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.

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“Summary of Benefits and Coverage” (SBC) means a federally required document in a specified template with information on applicable copays, access fees, 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.

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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.

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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.

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.

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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.

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Network Status

In-Network Providers (Contracted)

In-network providers are the following: (1) Except as noted in this benefit book, health care providers licensed in the United States who have a PPO contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ PPO members); and (2) Except as noted in this benefit book, out-of-state health care providers licensed in the United States who have a PPO contract with a Blue Cross and/or Blue Shield plan other than BCBSAZ.

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

- Independent Clinical Laboratory & Specialty Pharmacy: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the referring provider is located.

- Durable Medical Equipment/Medical Supplies: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the member resides.

- Air Ambulance: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state of the member pickup location.

In-network providers will file your claims with BCBSAZ or the applicable out-of-state Blue Cross and/or Blue Shield plan. 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.**

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); (3) Providers who are contracted with the BlueCard Worldwide program; and (4) Providers who do not have a PPO contract with the Blue Cross and/or Blue Shield plan to which the applicable claim is filed.

- **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, 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

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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, coinsurance, and access fees (except for emergency services), plus the balance bill.

Eligible Provider Status and Payment – Summary Table Subject to all terms and conditions noted in this section.				
Provider Contract Status	**Network Status and Applicable Cost-Share**	**Provider Required to File Claim on Member's Behalf**	**Accept 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.

***Except as noted in this benefit book**

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

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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 Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BCBSAZ serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside BCBSAZ's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; **or**
- The negotiated price that the Host Blue makes available to 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 also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSAZ has used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, BCBSAZ may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price made available to BCBSAZ by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than any related patient cost sharing under this contract.

Special Cases: Value-Based Programs

BlueCard® Program

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

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Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If BCBSAZ has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on your behalf, BCBSAZ will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

Nonparticipating Providers Outside BCBSAZ's Service Area

1. **Liability Calculation**

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

2. **Exceptions**

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

BlueCard Worldwide® Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the 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, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

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

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

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- **Submitting a BlueCard Worldwide Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should 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.

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.

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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. If it is required, your provider must obtain it on your behalf before rendering services.

BCBSAZ may change the services that require precertification at any time without providing notice. Go to www.azblue.com for a current 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, as follows:

- 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.

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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.

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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.

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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

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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.

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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.com or 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, duplicate procedures, application of Correct Coding Initiative (CCI) guidelines, member's age and sex edits, services inappropriately billed with office visit (evaluation and management) codes, modifier validation, pre and post-operative service validation, multiple surgical procedure pricing guidelines and other types of claim edits as determined by BCBSAZ. 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.

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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.

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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

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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

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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.

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MEMBER COST-SHARING & OTHER PAYMENTS

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.

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 plus 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.

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 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.

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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 access fees and 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. 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

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

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

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:

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

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- 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: Not required.

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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. 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. Intensive ourtpatient services, ECT and partial hospitalization services are not available through the BSA.

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 (See the "Neuropsychological and Cognitive Testing" section)
- 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

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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 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-Specific 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 or eyeglasses 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-Specific 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

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- 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, 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 - 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.

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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

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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: 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.

H.1 Durable Medical Equipment (DME)

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

- Be designed for appropriate 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:

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- 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:

- Cochlear implants
- 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, 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

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I. EDUCATION AND TRAINING

Precertification: Not required.

Your Cost-Share: See descriptions under subheadings.

I.1 Diabetes and Asthma Education and Training

Your Cost-Share: Waived.

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

- An in-network provider delivers the education and training;
- Education and training are provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Training is conducted in person; **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.

I.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
- Eating Disorders
- Heart Failure
- High Cholesterol
- Hypertension
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

I.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.

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Emergency Room: You pay one emergency room 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 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 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.

"Formula" is amino-acid based formula.

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.

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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 "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.

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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. The cost-share amount will depend on the provider's network status. 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.

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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 facility services are received from in-network hospitals.

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

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- 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 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 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 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: 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.

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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 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

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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

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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: 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 facility services are received from in-network hospitals.

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.

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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: 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. The list of medications that require precertification is subject to change at any time without prior notice. 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.

Other than as noted in this section, no exceptions will be made concerning the cost-share you will pay, regardless of the medical reasons requiring use of a particular medication, even when there is no equivalent medication on a lower Level or if you are unable to take a medication on the lower Level for any reason.

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:

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- 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.

"Specialty Self-Injectable Medications" are medications that treat chronic or complex conditions. BCBSAZ and/or the PBM determine which medications are Specialty Self-Injectable Medications.

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

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 most prescription medications from retail pharmacies or the in-network mail order pharmacy. Compounded medications must be obtained from retail pharmacies that have been credentialed by BCBSAZ (or BCBSAZ's vendor) to dispense compound medications. Please contact BCBSAZ Customer Service at the number listed in your benefit plan materials for a list of pharmacies credentialed to dispense compound medications.

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

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

If a medication is not processing at the pharmacy, you or your physician/provider may request an exception by calling the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception. Reasons for requesting an exception include but are not limited to the following: quantity, age, gender, dosage and/or frequency of refill limitations, requests for a Formulary Exception and requests for waiver of cost-share for brand name medications or devices taken or used for a preventive purpose.

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If you are currently obtaining a Specialty Self-Injectable Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book. BCBSAZ will decide whether you are eligible to receive the Specialty Self-Injectable medication from a retail pharmacy instead of a Specialty Pharmacy.

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, the medication is excluded from coverage under this Pharmacy Benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

Benefit-Specific Exclusions:

- Abortifacient 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

N. 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.

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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 PT, OT, and ST services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration and home independence
- All services in excess of the sixty (60) visit limit
- Any care 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
- 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
- Work re-entry therapy, services or programs

Z. 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.

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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 (including follow-up care) of FDA-approved contraceptive devices in female members
- FDA-approved implanted contraceptive devices for female members
- Abortifacient medications for the abortions covered under this plan, including oral medications as described in the BCBSAZ Medical Coverage Guidelines.

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.

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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 abortifacient 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, 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 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.

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Your Cost-Share:

In-Network:

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 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.

For certain covered preventive medications and items obtained from an in-network pharmacy, your cost-share is waived for the generic version of the medication or item and you pay applicable cost-share for the brand-name version of the medication or item. You may request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy. See the **"Benefit-Description"** section below for information about the exception process.

Please note: Your cost-share is waived 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.

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 procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.

Benefit-Specific 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. **If a preventive service has been denied due to a gender edit and you are undergoing or have undergone transgender treatment, please contact BCBSAZ Customer Service at the number listed in the front of this benefit book for assistance.**

Benefits are available for the following services:

- 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

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- 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, HPV and syphilis screening
- prostate specific antigen (PSA) testing
- TB testing

- Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
- Aspirin for asymptomatic pregnant women who are at increased risk of preeclampsia and who have no prior adverse effects with or contraindications to low-dose aspirin (after 12 weeks of gestation)
- 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 and interventions for tobacco cessation and augmented pregnancy counseling and interventions 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 counseling for all sexually active adolescents and for adults at risk of sexually transmitted infections
- Intensive behavioral dietary counseling interventions for overweight or obese adults with hyperlipidemia who have other cardiovascular disease (CVD) risk factors such as hypertension, dyslipidemia, impaired fasting glucose, or metabolic syndrome to promote a healthful diet and physical activity for CVD prevention
- 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 medication 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 durable medical equipment (DME) providers. See the “Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics” benefit section.

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- 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, HPV and other cervical cancer screening tests
- 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 and referrals for individuals who screen positive
- Screening, counseling and behavioral intervention for obesity, including children age 6 and older
- Screening for chlamydia for sexually active women ages 24 and younger and all women who are at increased risk of infection
- Screening for gonorrhea for sexually active women ages 24 and younger and all women who are at increased risk of infection
- Screening for high blood pressure in adults age 18 and older
- Screening and testing for Pompe disease (glycogen storage disease)
- 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 and behavioral counseling interventions for alcohol and drug use/misuse 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 diabetes
- 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 in persons at high risk for infection, including asymptomatic, non-pregnant adolescents and adults who have not been vaccinated and other persons at high risk for HBV infection (including persons at high risk who were vaccinated before being screened for HBV infection)
- 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 obesity
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Screening sigmoidoscopy or colonoscopy, including related anesthesia services and prescription prep kits
- Screening, genetic counseling and BRCA testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer
- Screening, genetic counseling and BRCA testing for women with a history of non-BRCA cancer
- 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.

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In order to request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy, you or your physician/provider can call the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception.

Benefit-Specific Exclusions:

- Abortifacient 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 applicable deductible and coinsurance.

Benefit-Specific Maximum: You have a combined in- and out-of-network maximum of Two Hundred Forty (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.

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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 a Level A, B, C or D copay. Copays do not apply to deductibles. For Cancer Treatment Medications that are also classified as Specialty Self-Injectable Medications, you pay the Level 1 retail/mail order pharmacy copay. BCBSAZ determines which Cancer Treatment Medications are classified as Specialty Self-Injectable Medications. Copays do not apply to deductibles or out-of-pocket coinsurance maximums.

If you are currently obtaining a Specialty Self-Injectable Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book. BCBSAZ and/or the PBM will decide whether you are eligible to receive the Specialty Self-Injectable Medication from a retail pharmacy instead of a Specialty Pharmacy.

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. 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.

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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

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- 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-Specific 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, the donor 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 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 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

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- 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 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.com under "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 received from an in-network provider. You pay out-of-network deductible and coinsurance for services received from an out-of-network provider. 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 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)

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- 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

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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.

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

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

Inpatient or Outpatient Long Term Care

Laboratory Services Provided Without an Order from an Eligible Provider

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, except as stated in this plan

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

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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

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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

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

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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).

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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.

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- 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;

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- 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 Periods"* 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 Periods."*

- **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 Periods."*

Loss of Eligibility

Contractholder eligibility ends on the following days:

- The end of the month in which the Contractholder was entitled to receive compensation from the group, regardless of the date such compensation is actually paid and for which BCBSAZ has received payment from the Group.

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- The end of the month in which an approved leave of absence expires, if the Contractholder fails to return to active employment.

- The date on which the Contractholder's death occurs.

- 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 Contractholder, 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 child.

- The end of the month in which the disability or dependency ceases for a disabled 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 date the Contractholder's death occurs.

- 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

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- 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; **and**

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 sixty (60) days of the loss of other coverage:

- 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; **and**
- 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
- 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.

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- **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 amounts due.

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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.

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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.

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact 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) 864-4456	(602) 864-4823	(602) 864-4884
		(800) 232-2345, ext. 4456	(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)

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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
Behavioral Services Administrator (BSA)	(800) 224-2125
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 providing services in Arizona 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	

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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

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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 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.

"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 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.**

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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, access fee, coinsurance, pharmacy deductible, and precertification charges.

"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.**

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“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.

“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.

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“Summary of Benefits and Coverage” (SBC) means a federally required document in a specified template with information on applicable copays, access fees, 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.

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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.

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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.

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.

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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.

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Network Status

In-Network Providers (Contracted)

In-network providers are the following: (1) Except as noted in this benefit book, health care providers licensed in the United States who have a PPO contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ PPO members); and (2) Except as noted in this benefit book, out-of-state health care providers licensed in the United States who have a PPO contract with a Blue Cross and/or Blue Shield plan other than BCBSAZ.

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

- Independent Clinical Laboratory & Specialty Pharmacy: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the referring provider is located.

- Durable Medical Equipment/Medical Supplies: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the member resides.

- Air Ambulance: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state of the member pickup location.

In-network providers will file your claims with BCBSAZ or the applicable out-of-state Blue Cross and/or Blue Shield plan. 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.**

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); (3) Providers who are contracted with the BlueCard Worldwide program; and (4) Providers who do not have a PPO contract with the Blue Cross and/or Blue Shield plan to which the applicable claim is filed.

- **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, 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

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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, coinsurance, and access fees (except for emergency services), plus the balance bill.

Eligible Provider Status and Payment – Summary Table Subject to all terms and conditions noted in this section.				
Provider Contract Status	**Network Status and Applicable Cost-Share**	**Provider Required to File Claim on Member's Behalf**	**Accept 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.

***Except as noted in this benefit book**

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

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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 Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BCBSAZ serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside BCBSAZ's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; **or**
- The negotiated price that the Host Blue makes available to 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 also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSAZ has used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, BCBSAZ may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price made available to BCBSAZ by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than any related patient cost sharing under this contract.

Special Cases: Value-Based Programs

BlueCard® Program

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

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Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If BCBSAZ has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on your behalf, BCBSAZ will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

Nonparticipating Providers Outside BCBSAZ's Service Area

1. **Liability Calculation**

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

2. **Exceptions**

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

BlueCard Worldwide® Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the 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, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

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

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

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- **Submitting a BlueCard Worldwide Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should 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.

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.

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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. If it is required, your provider must obtain it on your behalf before rendering services.

BCBSAZ may change the services that require precertification at any time without providing notice. Go to www.azblue.com for a current 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, as follows:

- 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.

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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.

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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.

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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

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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.

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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.com or 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, duplicate procedures, application of Correct Coding Initiative (CCI) guidelines, member's age and sex edits, services inappropriately billed with office visit (evaluation and management) codes, modifier validation, pre and post-operative service validation, multiple surgical procedure pricing guidelines and other types of claim edits as determined by BCBSAZ. BCBSAZ periodically updates its computer system claim edits.

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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.

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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

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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.

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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.

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- **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.

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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.

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MEMBER COST-SHARING & OTHER PAYMENTS

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.

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 plus 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.

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 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.

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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 access fees and 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. 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

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

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

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:

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

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- 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: Not required.

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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, home, or walk-in clinic 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. 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. Intensive ourtpatient services, ECT and partial hospitalization services are not available through the BSA.

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, home, or walk-in clinic 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, member's home, or a walk-in clinic.

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. 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

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- Neurofeedback
- Neuropsychological and cognitive testing (See the "Neuropsychological and Cognitive Testing" section)
- 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 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, 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-Specific 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 or eyeglasses 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 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-Specific 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.

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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, 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 - 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.

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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

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- 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: 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.

H.1 Durable Medical Equipment (DME)

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

- Be designed for appropriate 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

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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:

- Cochlear implants
- 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, 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

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- 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.

I.1 Diabetes and Asthma Education and Training

Your Cost-Share: Waived.

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

- An in-network provider delivers the education and training;
- Education and training are provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Training is conducted in person; **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.

I.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
- Eating Disorders
- Heart Failure
- High Cholesterol
- Hypertension
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

I.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.**

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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 emergency room 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 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 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.

"Formula" is amino-acid based formula.

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.

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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 "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, 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 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

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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. The cost-share amount will depend on the provider's network status. 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.

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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 facility services are received from in-network hospitals.

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.

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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 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 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 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.

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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:

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 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.

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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).

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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, 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.

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

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 in-network 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: 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. The list of medications that require precertification is subject to change at any time without prior notice. 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.

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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.

Other than as noted in this section, no exceptions will be made concerning the cost-share you will pay, regardless of the medical reasons requiring use of a particular medication, even when there is no equivalent medication on a lower Level or if you are unable to take a medication on the lower Level for any reason.

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.

"Specialty Self-Injectable Medications" are medications that treat chronic or complex conditions. BCBSAZ and/or the PBM determine which medications are Specialty Self-Injectable Medications.

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

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.

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You may obtain most prescription medications from retail pharmacies or the in-network mail order pharmacy. Compounded medications must be obtained from retail pharmacies that have been credentialed by BCBSAZ (or BCBSAZ's vendor) to dispense compound medications. Please contact BCBSAZ Customer Service at the number listed in your benefit plan materials for a list of pharmacies credentialed to dispense compound medications.

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

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

If a medication is not processing at the pharmacy, you or your physician/provider may request an exception by calling the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception. Reasons for requesting an exception include but are not limited to the following: quantity, age, gender, dosage and/or frequency of refill limitations, requests for a Formulary Exception and requests for waiver of cost-share for brand name medications or devices taken or used for a preventive purpose.

If you are currently obtaining a Specialty Self-Injectable Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book. BCBSAZ will decide whether you are eligible to receive the Specialty Self-Injectable medication from a retail pharmacy instead of a Specialty Pharmacy.

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, the medication is excluded from coverage under this Pharmacy Benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

Benefit-Specific Exclusions:

- Abortifacient 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.

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- 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

N. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), AND SPEECH THERAPY (ST) SERVICES

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 PT, OT, and ST services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration and home independence
- All services in excess of the sixty (60) visit limit
- Any care 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
- 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
- Work re-entry therapy, services or programs

Z. 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:

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- 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 (including follow-up care) of FDA-approved contraceptive devices in female members
- FDA-approved implanted contraceptive devices for female members
- Abortifacient medications for the abortions covered under this plan, including oral medications as described in the BCBSAZ Medical Coverage Guidelines.

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.

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- 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, 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 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, 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 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.**

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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 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:

In-Network:

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 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.

For certain covered preventive medications and items obtained from an in-network pharmacy, your cost-share is waived for the generic version of the medication or item and you pay applicable cost-share for the brand-name version of the medication or item. You may request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy. See the **"Benefit-Description"** section below for information about the exception process.

Please note: Your cost-share is waived 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.

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.

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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-Specific 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. **If a preventive service has been denied due to a gender edit and you are undergoing or have undergone transgender treatment, please contact BCBSAZ Customer Service at the number listed in the front of this benefit book for assistance.**

Benefits are available for the following services:

- 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, HPV and syphilis screening
    - prostate specific antigen (PSA) testing
    - TB testing
- Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
- Aspirin for asymptomatic pregnant women who are at increased risk of preeclampsia and who have no prior adverse effects with or contraindications to low-dose aspirin (after 12 weeks of gestation)
- 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 and interventions for tobacco cessation and augmented pregnancy counseling and interventions for members who use tobacco
- Counseling on contraceptive methods for all women with reproductive capacity

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- 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 counseling for all sexually active adolescents and for adults at risk of sexually transmitted infections
- Intensive behavioral dietary counseling interventions for overweight or obese adults with hyperlipidemia who have other cardiovascular disease (CVD) risk factors such as hypertension, dyslipidemia, impaired fasting glucose, or metabolic syndrome to promote a healthful diet and physical activity for CVD prevention
- 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 medication 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 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, HPV and other cervical cancer screening tests
- 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 and referrals for individuals who screen positive
- Screening, counseling and behavioral intervention for obesity, including children age 6 and older
- Screening for chlamydia for sexually active women ages 24 and younger and all women who are at increased risk of infection
- Screening for gonorrhea for sexually active women ages 24 and younger and all women who are at increased risk of infection
- Screening for high blood pressure in adults age 18 and older
- Screening and testing for Pompe disease (glycogen storage disease)
- 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 and behavioral counseling interventions for alcohol and drug use/misuse 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 diabetes
- 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.

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- Screening for Hepatitis B (HBV) virus infection in persons at high risk for infection, including asymptomatic, non-pregnant adolescents and adults who have not been vaccinated and other persons at high risk for HBV infection (including persons at high risk who were vaccinated before being screened for HBV infection)
- 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 obesity
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Screening sigmoidoscopy or colonoscopy, including related anesthesia services and prescription prep kits
- Screening, genetic counseling and BRCA testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer
- Screening, genetic counseling and BRCA testing for women with a history of non-BRCA cancer
- 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.

In order to request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy, you or your physician/provider can call the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception.

Benefit-Specific Exclusions:

- Abortifacient 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.

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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 applicable deductible and coinsurance.

Benefit-Specific Maximum: You have a combined in- and out-of-network maximum of Two Hundred Forty (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 a Level A, B, C or D copay. Copays do not apply to deductibles. For Cancer Treatment Medications that are also classified as Specialty Self-Injectable Medications, you pay the Level 1 retail/mail order pharmacy copay. BCBSAZ determines which Cancer Treatment Medications are classified as Specialty Self-Injectable Medications. Copays do not apply to deductibles or out-of-pocket coinsurance maximums.

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If you are currently obtaining a Specialty Self-Injectable Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book. BCBSAZ and/or the PBM will decide whether you are eligible to receive the Specialty Self-Injectable Medication from a retail pharmacy instead of a Specialty Pharmacy.

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. 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, 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.

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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: Not applicable.

Benefit-Specific 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, the donor or the member's Caregiver;
- BCBSAZ has precertified the transplant procedure;

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- 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 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 which are not emergencies.

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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.com under "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 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 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

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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.

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

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

Inpatient or Outpatient Long Term Care

Laboratory Services Provided Without an Order from an Eligible Provider

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, except as stated in this plan

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

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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

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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

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

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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).

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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.

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- 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 Periods"* 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 Periods."*

- **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 Periods."*

Loss of Eligibility

Contractholder eligibility ends on the following days:

- The end of the month in which the Contractholder was entitled to receive compensation from the group, regardless of the date such compensation is actually paid and for which BCBSAZ has received payment from the Group.

- The end of the month in which an approved leave of absence expires, if the Contractholder fails to return to active employment.

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- The date on which the Contractholder's death occurs.

- 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 Contractholder, 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 child.

- The end of the month in which the disability or dependency ceases for a disabled 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 date the Contractholder's death occurs.

- 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 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)

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- 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; **and**

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 sixty (60) days of the loss of other coverage:

- 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; **and**
- 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
- 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

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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 amounts due.

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).

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- 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.

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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.

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact 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) 864-4456	(602) 864-4823	(602) 864-4884
		(800) 232-2345, ext. 4456	(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)

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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 providing services in Arizona 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	

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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

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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.

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“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, and precertification charges.

“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.

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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.

"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.

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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.

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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

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- 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.

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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.

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Network Status

In-Network Providers (Contracted)

In-network providers are the following: (1) Except as noted in this benefit book, health care providers licensed in the United States who have a PPO contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ PPO members); and (2) Except as noted in this benefit book, out-of-state health care providers licensed in the United States who have a PPO contract with a Blue Cross and/or Blue Shield plan other than BCBSAZ.

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

- Independent Clinical Laboratory & Specialty Pharmacy: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the referring provider is located.

- Durable Medical Equipment/Medical Supplies: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the member resides.

- Air Ambulance: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state of the member pickup location.

In-network providers will file your claims with BCBSAZ or the applicable out-of-state Blue Cross and/or Blue Shield plan. 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.**

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); (3) Providers who are contracted with the BlueCard Worldwide program; and (4) Providers who do not have a PPO contract with the Blue Cross and/or Blue Shield plan to which the applicable claim is filed.

- **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

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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.

Except as noted in this benefit book

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

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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 Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BCBSAZ serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside BCBSAZ's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; **or**
- The negotiated price that the Host Blue makes available to 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 also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSAZ has used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, BCBSAZ may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price made available to BCBSAZ by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than any related patient cost sharing under this contract.

Special Cases: Value-Based Programs

BlueCard® Program

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

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Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If BCBSAZ has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on your behalf, BCBSAZ will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

Nonparticipating Providers Outside BCBSAZ's Service Area

1. **Liability Calculation**

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

2. **Exceptions**

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

BlueCard Worldwide® Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the 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, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

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

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

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- **Submitting a BlueCard Worldwide Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should 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.

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.

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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. If it is required, your provider must obtain it on your behalf before rendering services.

BCBSAZ may change the services that require precertification at any time without providing notice. Go to www.azblue.com for a current 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, as follows:

- 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.

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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.

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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.

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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

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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.

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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.com or 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, duplicate procedures, application of Correct Coding Initiative (CCI) guidelines, member's age and sex edits, services inappropriately billed with office visit (evaluation and management) codes, modifier validation, pre and post-operative service validation, multiple surgical procedure pricing guidelines and other types of claim edits as determined by BCBSAZ. 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.

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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.

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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.

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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.

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- **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.

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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.

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MEMBER COST-SHARING & OTHER PAYMENTS

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.

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 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.

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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

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

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

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. 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:

- Diagnostic testing
- Intensive care units and other special care units
- Medications, biologicals and solutions
- Treatment and recovery rooms and equipment for covered services

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- 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. 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:

- 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: 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.

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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 (See the "Neuropsychological and Cognitive Testing" section)
- 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.

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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-Specific 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 or eyeglasses 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-Specific 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.

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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.

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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:

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- 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 applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status and the place you receive services. 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 appropriate 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.

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H.3 Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

- Cochlear implants
- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- 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, 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.

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**

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- 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
- Eating Disorders
- 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 your in-network cost-share for emergency services, even for services from out-of-network providers.

Emergency Room: You pay in-network deductible and coinsurance for services received in the emergency room. 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.

Admission to the Hospital from the Emergency Room: 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 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.

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"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 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.

"Formula" is amino-acid based formula.

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 "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.

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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

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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 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.

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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 facility services are received from in-network hospitals.

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 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 must be for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time.

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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 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: 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. 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.

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.

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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. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

For 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 facility services are received from in-network hospitals.

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: 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. The list of medications that require precertification is subject to change at any time without prior notice. 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 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.

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Other than as noted in this section, no exceptions will be made concerning the cost-share you will pay, regardless of the medical reasons requiring use of a particular medication, even when there is no equivalent medication on a lower Level or if you are unable to take a medication on the lower Level for any reason.

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.

"Specialty Self-Injectable Medications" are medications that treat chronic or complex conditions. BCBSAZ and/or the PBM determine which medications are Specialty Self-Injectable Medications.

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

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 most prescription medications from retail pharmacies or the in-network mail order pharmacy. Compounded medications must be obtained from retail pharmacies that have been credentialed by BCBSAZ (or BCBSAZ's vendor) to dispense compound medications. Please contact BCBSAZ Customer Service at the number listed in your benefit plan materials for a list of pharmacies credentialed to dispense compound medications.

Certain vaccines are covered when obtained from in-network retail pharmacies and administered by a certified, licensed pharmacist. The following medical devices are covered under this benefit: diabetic test strips, lancets, diabetic syringes/needles for insulin and spacer devices for asthma medications. **Covered medications are subject to limitations, including but not limited to, quantity, age, gender, dosage, and frequency of refills. BCBSAZ and/or the PBM determine which medications are subject to limitations. Medication limitations are subject to change at any time without prior notice.**

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If a medication is not processing at the pharmacy, you or your physician/provider may request an exception by calling the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception. Reasons for requesting an exception include but are not limited to the following:

quantity, age, gender, dosage and/or frequency of refill limitations, requests for a Formulary Exception and requests for waiver of cost-share for brand name medications or devices taken or used for a preventive purpose.

If you are currently obtaining a Specialty Self-Injectable Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book. BCBSAZ will decide whether you are eligible to receive the Specialty Self-Injectable Medication from a retail pharmacy instead of a Specialty Pharmacy.

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, the medication is excluded from coverage under this Pharmacy Benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

Benefit-Specific Exclusions:

- Abortifacient 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

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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-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 PT, OT, and ST services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration and home independence
- All services in excess of the sixty (60) visit limit
- Any care 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
- 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
- Work re-entry therapy, services or programs

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

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- 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
- Abortifacient medications for the abortions covered under this plan, including oral medications as described in the BCBSAZ Medical Coverage Guidelines.

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.

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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 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:

In-Network:

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 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.

For certain covered preventive medications and items obtained from an in-network pharmacy, your cost-share is waived for the generic version of the medication or item and you pay applicable cost-share for the brand-name version of the medication or item. You may request an exception for waiver

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of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy. See the **"Benefit-Description"** section below for information about the exception process.

Please note: Your cost-share is waived 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.

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 procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.

Benefit-Specific 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. **If a preventive service has been denied due to a gender edit and you are undergoing or have undergone transgender treatment, please contact BCBSAZ Customer Service at the number listed in the front of this benefit book for assistance.**

Benefits are available for the following services:

- 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, HPV and syphilis screening
    - prostate specific antigen (PSA) testing
    - TB testing

- Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
- Aspirin for asymptomatic pregnant women who are at increased risk of preeclampsia and who have no prior adverse effects with or contraindications to low-dose aspirin (after 12 weeks of gestation)

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- 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 and interventions for tobacco cessation and augmented pregnancy counseling and interventions 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 counseling for all sexually active adolescents and for adults at risk of sexually transmitted infections
- Intensive behavioral dietary counseling interventions for overweight or obese adults with hyperlipidemia who have other cardiovascular disease (CVD) risk factors such as hypertension, dyslipidemia, impaired fasting glucose, or metabolic syndrome to promote a healthful diet and physical activity for CVD prevention
- 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 medication 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 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, HPV and other cervical cancer screening tests
- 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 and referrals for individuals who screen positive
- Screening, counseling and behavioral intervention for obesity, including children age 6 and older
- Screening for chlamydia for sexually active women ages 24 and younger and all women who are at increased risk of infection
- Screening for gonorrhea for sexually active women ages 24 and younger and all women who are at increased risk of infection

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- Screening for high blood pressure in adults age 18 and older
- Screening and testing for Pompe disease (glycogen storage disease)
- 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 and behavioral counseling interventions for alcohol and drug use/misuse 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 diabetes
- 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 in persons at high risk for infection, including asymptomatic, non-pregnant adolescents and adults who have not been vaccinated and other persons at high risk for HBV infection (including persons at high risk who were vaccinated before being screened for HBV infection)
- 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 obesity
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Screening sigmoidoscopy or colonoscopy, including related anesthesia services and prescription prep kits
- Screening, genetic counseling and BRCA testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer
- Screening, genetic counseling and BRCA testing for women with a history of non-BRCA cancer
- 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.

In order to request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy, you or your physician/provider can call the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception.

Benefit-Specific Exclusions:

- Abortifacient 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.

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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 applicable deductible and coinsurance.

Benefit-Specific Maximum: You have a combined in- and out-of-network maximum of Two Hundred Forty (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

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- 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:

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- 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-Specific 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, the donor 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 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;

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- 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, 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 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.com under “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.

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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

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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.

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

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

Inpatient or Outpatient Long Term Care

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Laboratory Services Provided Without an Order from an Eligible Provider

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

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

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

Massage Therapy – 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

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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

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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

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).

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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.

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- 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;

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- 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 Periods"* 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 Periods."*

- **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 Periods."*

Loss of Eligibility

Contractholder eligibility ends on the following days:

- The end of the month in which the Contractholder was entitled to receive compensation from the group, regardless of the date such compensation is actually paid and for which BCBSAZ has received payment from the Group.

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- The end of the month in which an approved leave of absence expires, if the Contractholder fails to return to active employment.

- The date on which the Contractholder's death occurs.

- 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 Contractholder, 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 child.

- The end of the month in which the disability or dependency ceases for a disabled 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 date the Contractholder's death occurs.

- 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 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; **and**

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 sixty (60) days of the loss of other coverage:

- 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; **and**
- 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
- 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.

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- **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 amounts due.

Benefit-Specific Eligibility

Under the following limited circumstances, a nonmember may be eligible to receive benefits under this plan:

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- 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.

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Exhibit 2 to Attachment A to Administrative Service Agreement – Services Provided by BCBSAZ

1. BCBSAZ Written Final Offer and Clarifications
2. BCBSAZ Response to Scope of Work
3. BCBSAZ Response to Minimum Requirements
4. BCBSAZ Response to Medical Questionnaire
5. BCBSAZ Response to Pharmacy Benefit Management Minimum Contractual Requirements
6. BCBSAZ Response to Pharmacy Benefit Management Questionnaire
7. BCBSAZ Exceptions to RFP

Exhibit 2 to Attachment A to Administrative Service Agreement - Services Provided by BCBSAZ
BCBSAZ Written Final Offer and Clarifications

Medical Questionnaire

1. **Attached please find updated claims. Please provide your best fee quotation, including any multi-year rate/fee guarantees or component guarantees. The preference is for a multi-year rate/fee guarantee. For your convenience to submit your best offer, see the separate attachment for the fee forms in Excel format. Please return the completed Excel workbook with your proposal.**

   Please refer to the attached Excel workbook for our best fee quotation.

2. **Please confirm the $25,000 annual wellness allowance can be paid to the City of Chandler so that the City may pay program support providers directly. This process would be consistent with past practice. In addition, please confirm that this allowance amount will be paid to the City in the first year and all subsequent extension years.**

   Yes, BCBSAZ confirms.

3. **Onsite Wellness Consultant:**

   a. **What happens to the $100,000 for the City to hire an Onsite Wellness Consultant should the City not use the full $100,000?**

      The unused funds can be used toward other wellness services, and any balance would roll over to future years.

   b. **Would any unused portion of the $100,000 roll over to a future year?**

      Yes.

   c. **Will the $100,000 be paid directly to the City so that the City may use it to pay the salary and benefits of the City employee in the role of Onsite Wellness Consultant?**

      Yes.

   d. **Please confirm that the proposed $100,000 is an annual amount and will be paid to the City in subsequent extension terms.**

      Yes, BCBSAZ confirms.

4. **Please confirm the City's understanding of the overall wellness program offer, as follows:**

   $25,000 annual wellness allowance + $100,000 annual onsite consultant allowance = $125,000 total annual wellness program allowance.

   Yes, the City's understanding is correct.

5. **Please identify the amount of any capitation fees Blue Cross retains to maintain the network/capitation arrangement.**

The rates for both capitated services—Biodyne and Chiropractic—are provided on the following page. Please see the Rate Assumption page in **Attachment 2** for details.

Biodyne

The PMPM rates the City pays BCBSAZ are:

1. Red Medical Option $2.13 PMPM
2. Blue Medical Option $2.13 PMPM

The PMPM capitated fees BCBSAZ pays the BSA are:

1. Red Medical Option $1.94 PMPM
2. Blue Medical Option $1.94 PMPM

Chiropractic

The PMPM rates for chiropractic services applicable to the City 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 fees BCBSAZ pays the chiropractic provider are:

1. Red Medical Option $2.62 PMPM
2. Blue Medical Option $2.62 PMPM
3. White Medical Option $2.62 PMPM

6. **The City is interested in a more comprehensive biometric screening program to begin in Plan Year 2017 or after that includes full venipuncture. Please indicate whether Blue Cross is able to offer these services as part of its proposal.**

   Yes, we are able to provide a fasting venipuncture biometric screening offering our standard tests at no additional cost. We will be happy to further discuss the City's objectives with this request.

Pharmacy Questionnaire

1. **Please provide your best minimum PASS THROUGH financial guarantees for three (3) years of the contract term effective *01/01/16*.**

   All pricing and notes remain the same as original response, with the exception of AWP Discount Mail Supply, Non-MAC generics, year 1. This was erroneously reported as 15.30% in our original proposal, and has been modified in the following chart, in red font, to accurately reflect 25.00%.

Retail Network	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31–90 days	AWP Discount Mail Supply 1–90 days
Projected PEPM credit in lieu of earned rebates	Year 1 **$12.00 PEPM** Year 2 **The PEPM pharmacy rebate credit (offset) to the administration rate is based on the City's actual amount of pharmacy rebates for the most current 12 months (available reporting). This will be reviewed**		

Retail Network	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31–90 days	AWP Discount Mail Supply 1–90 days
	and determined as part of the Year 2 renewal. Year 3 **BCBSAZ agrees to a two-year pricing guarantee but is unable to agree to a three-year guarantee because our current contract with our PBM, Catamaran, ends 12/31/17.**		
Brand Drugs			
Discount from AWP for all Brand Products[1] (retail ingredient cost must be pass through price guarantee)	**up to 83 days** Year 1: **15.30%** Year 2: **15.30%** Year 3: **n/a**	**84-90 days*** Year 1: **22.00%** Year 2: **22.00%** Year 3: **n/a**	**>84 days** Year 1: **25.00%** Year 2: **25.00%** Year 3: **n/a**
Dispensing Fee Per Rx	**up to 83 days** Year 1: **$1.40** Year 2: **$1.40** Year 3: **n/a**	**84-90 days*** Year 1: **$0.00** Year 2: **$0.00** Year 3: **n/a**	**>84 days** Year 1: **$0.00** Year 2: **$0.00** Year 3: **n/a**
Generic Drugs			
Discount from AWP for <u>all</u> Generics regardless of exclusivity (retail ingredient cost must be pass through and include single source generics, composite discount)[2]	**up to 83 days** **MAC generics**:** Year 1: **78.75%** Year 2: **79.00%** Year 3: **n/a** **Non-MAC generics:** Year 1: **15.30%** Year 2: **15.30%** Year 3: **n/a**	**84-90 days*** **MAC generics**:** Year 1: **78.75%** Year 2: **79.00%** Year 3: **n/a** **Non-MAC generics:** Year 1: **15.30%** Year 2: **15.30%** Year 3: **n/a**	**>84 days** **MAC generics**:** Year 1: **82.25%** Year 2: **82.50%** Year 3: **n/a** **Non-MAC generics:** Year 1: **25.00%** Year 2: **25.00%** Year 3: **n/a**
Dispensing Fee Per Rx	**up to 83 days** Year 1: **$1.40** Year 2: **$1.40** Year 3: **n/a**	**84-90 days*** Year 1: **$0.00** Year 2: **$0.00** Year 3: **n/a**	**>84 days** Year 1: **$0.00** Year 2: **$0.00** Year 3: **n/a**

BCBSAZ Notes:

*BCBSAZ has shown discounts for our broadest network, as requested. For Retail-90, these discounts apply at any in-network pharmacy. BCBSAZ also offers a Walgreens-only Retail-90 option with improved discounts and would be pleased to present pricing, discounts and additional information should the City desire.

[1] All pricing must be based on actual NDC11 dispensed (Post September 26, 2009 AWP rollback prices). Brand Discount Guarantees include both single-source and multi-source brand products.

[2] Includes all single-source and multi-source generic products regardless of exclusivity period and/or number of manufacturers.

**MAC discount from AWP is offered as an effective overall Generic discount (Ingredient Cost) and includes all MAC and non-MAC drugs, including single source generic products.

Regarding year 3 pricing guarantees: BCBSAZ agrees to a two-year pricing guarantee, but is unable to agree to a three-year guarantee because our current contract with our PBM, Catamaran, ends 12/31/17.

Regarding the pricing guarantee: the City agrees that BCBSAZ may unilaterally change the guarantees in the event of one or more of the following:

- Any government imposed change in federal, state or local law that significantly impacts BCBSAZ's agreement with BCBSAZ's PBM, Catamaran
- A change in the scope of services to be performed by Catamaran under BCBSAZ's agreement with Catamaran
- A change of more than 20% in the total number of memberships subject to BCBSAZ's agreement with Catamaran
- Changes made to the industry AWP benchmark

These discounts and the dispensing fees will be measured annually on a calendar year basis and on BCBSAZ's entire, applicable book of business. Compounds, specialty claims, direct member reimbursements, COB claims, OTC claims (except OTC diabetic supplies) and claims with ancillary charges (e.g., flu shots and vaccines) will be excluded from the calculation.

All AWP discounts are based on Post-Rollback Average Wholesale Price.

Specialty drug specific discounts are available in **Attachment 4** and only apply when the drug is dispensed by BCBSAZ exclusive Specialty Pharmacy provider, BriovaRx.

2. Please confirm that 90 days following each plan year you will provide an accounting to the City of actual rebates paid to Blue Cross Blue Shield during the plan year and compare it to the medical administration credit and pay the difference of any amounts over the administrative credits to the City.

BCBSAZ is unable to provide an administrative fee offset with a full final reconciliation based on actual earned rebates. To provide flexibility to our large group clients, BCBSAZ offers two rebate options to our large groups, as follows:

1. **PEPM credit (City's current model):** BCBSAZ will provide a per employee per month (PEPM) administrative fee credit in lieu of BCBSAZ remitting any rebates attributable to drug utilization by the City's participants. The PEPM pharmacy rebate credit (offset) to the administration rate is based on the City's actual amount of pharmacy rebates for the most current 12 months (available reporting).

   As part of our proposal, by using the most recent 12 months' drug utilization, BCBSAZ has calculated this administrative fee offset to be $12.00 PEPM. For each subsequent renewal, BCBSAZ will review the prior 12 months' drug utilization to estimate a PEPM offset amount for the following year. Most clients elect to receive a PEPM credit in lieu of earned rebates as it allows for a real-time reduction in fees.

2. **Remittance of actual rebates earned:** BCBSAZ will pass 100% of the City's earned rebates (rebates attributable to drug utilization by the City's participants) to the City. BCBSAZ does not charge a rebate administrative fee or participate in rebate sharing of any kind. Actual rebates earned will be remitted to the City the following September after close of the calendar year; this allows for any adjustments to be accounted for and fully reconciled before rebates are remitted.

3. **Specialty Discounts - Provide best overall percent discounts off of Medispan AWP-based, NDC level pricing. Confirm this guarantee be reconciled annually and is a stand-alone guarantee.**

   Specialty drug specific discounts are available in **Attachment 4** and only apply when the drug is dispensed by BCBSAZ exclusive Specialty Pharmacy provider, BriovaRx.

Minimum Contractual Requirements

Please confirm the minimum contractual requirements listed below. Any deviations from the minimum contractual requirements may be cause for disqualification.

1. **The City requests that billing be processed on the 20th of each month. Please indicate whether Blue Cross can accommodate this request.**

   BCBSAZ is offering bundled medical and pharmacy administration. BCBSAZ does not charge a separate pharmacy administrative fee for clients who have BCBSAZ medical administration services. BCBSAZ is proposing billing and invoicing remain the same as the process the City currently has with us, which is as follows:

   Administrative Fees

   BCBSAZ generates billings 15 days prior to the start of the month with payments generally due by the first of the month; however, we offer a 31-day grace period to pay administrative fees, counting the day the invoice is issued. For example, January administrative fee invoices are issued mid-December and have a due date of January 1 with a final due date of January 31.

   If the bill is not paid by the final due date, all benefits may be suspended at 12:01 a.m. the following day.

   Enrollment processing occurs daily. If enrollment additions or terminations are processed after billing statements are issued, these will be reconciled on the next billing statement.

   Claims

   BCBSAZ pays claims from its bank account throughout the month on behalf of the group. The group is invoiced generally within 10 to 15 days after the close of the month. Payment is due from the group within 15 days of the invoice date, counting the day the invoice was issued. For example, if an invoice for January claims is issued on February 14, it will have a final due date of February 28. Our unique banking arrangement eliminates the need for our clients to have a separate bank account to pay claims and affords our clients a 45- to 60-day claim 'float.' Our clients find that this saves administrative time, reduces banking fees and provides assurance that payments are made based upon actual claims incurred. As such, there is no additional grace period beyond the due date for claims invoice payments.

2. **The City or its designee will have the right to audit, with an auditor of its choice, with full cooperation of the selected PBM, the claims, services and pricing to verify compliance with all program requirements and contractual guarantees. Please confirm.**

   BCBSAZ agrees, with the assumption that the City will select a third-party auditor.

   Notwithstanding any other agreement to the contrary, in the event the City has a right to audit the enrollment and/or claims, any audit for any plan year must commence and finalize within twelve (12) months of the last day of the plan year being audited. Pharmacy network

agreements are not available to audit on a group level basis; however, BCBSAZ does audit an appropriate sample of payments on a BCBSAZ book of business level and can share these results with the City.

Audit is subject to the audit requirements noted in **Attachment 5**. Additionally, a 200 pharmacy claim limit applies to the following:

1. Approved and denied utilization management reviews
2. Clinical program outcomes
3. Appeals

3. The City or its designee will have the right to conduct an audit at any time during the year, at any time during the first term and subsequent extension terms, and the selected PBM will provide all documentation necessary to perform the audit. This provision shall survive the termination of the agreement between the parties for a period of 3 years. Please confirm.

BCBSAZ affirms the City's right to audit and agrees to provide reasonable assistance and information to the City's auditors without charge.

However, audits must commence and finalize within 12 months of the last day of the plan year being audited. Additionally, audit activity is subject to our audit requirements as noted in **Attachment 5**.

A limit of 200 pharmacy claim limit applies to the following:

1. Approved and denied utilization management reviews
2. Clinical program outcomes
3. Appeals

NCPDP fields are confidential and proprietary and may not be released. Appropriate access to MAC rates may not be available depending upon the City's final pricing arrangement selection. Wholesaler agreements are not applicable.

Additionally, pharmacy network agreements are not available to audit on a group level basis; however BCBSAZ does audit an appropriate sample of payments on a BCBSAZ book of business level and can share these results with the City.

4. All costs incurred by the PBM to comply with the audit (e.g. data, access, evaluation) shall be the responsibility of the PBM. Please confirm.

Audit activity is subject to our audit requirements as noted in **Attachment 5**. BCBSAZ agrees to provide reasonable assistance and information to the City's auditors without charge. The City shall bear the cost of the audit provided that; however, if the City reveals a breach of this agreement, BCBSAZ will bear the cost of the audit.

5. Any shortfall between the actual result and the guarantee will be paid, dollar-for-dollar, to the City within 60 days of the end of the measurement period. Please confirm.

No. Discounts and dispensing fees will be measured annually on a calendar year basis and on BCBSAZ's entire, applicable book of business. Payments for any shortfalls will be made within 120 days after the close of the calendar year.

6. **AWP discount and dispensing fee guarantees must be measured and reconciled annually on a component (brand, generic, retail, mail order) basis only with no surplus offsets, on a dollar for dollar basis with no limit, on a client-specific (not Book of Business) basis. Please confirm.**

   While pricing guarantees are measured/reconciled by component and without offsets from one component to another, all pricing guarantees are based on BCBSAZ's book of business.

7. **The PBM agrees to send all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the City's participants to the next PBM at no charge if the City terminates the contract with or without cause. Please confirm.**

   BCBSAZ will coordinate the open refill transfer file from Walgreens and the specialty prior authorization file from our PBM, Catamaran at no charge. However, an additional fee may apply for the new vendor receiving the files.

8. **The PBM agrees to obtain the City's approval for all member communication materials before distribution to members. Please confirm.**

   BCBSAZ confirms with the exception of time-sensitive notifications such as FDA notifications or tier change notices.

9. **The PBM will not automatically enroll the City in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from the City. Please confirm.**

   BCBSAZ confirms with the exception of time-sensitive notifications such as FDA notifications or tier change notices. BCBSAZ will not enroll the City's members in any new programs without written consent from the City.

10. **PBM agrees to a mid-contract-term market check, during the second quarter of the second contract year, conducted by an independent third party to ensure the City is receiving appropriate current pricing terms competitive with the industry based on its volume and membership, and <u>will improve pricing in the event that the City's contract terms are less than current.</u> New pricing must be implemented within 90 days of completion of the market check or signature of contract, in the third contract year. Acceptance of the new pricing will apply for the remainder of the Initial Term and will NOT result in extension of the contract. Please confirm.**

    BCBSAZ agrees to the mid-term market check. BCBSAZ will make decisions on improved pricing at the time the market results are available.

11. **With the exception of FDA directed market removals, the PBM agrees it will not remove a covered drug from the Formulary/Drug list, exclude coverage of a drug, or change the utilization management status (i.e., add a prior authorization, step therapy, or quantity limit) of any drug without written approval from the City. Please confirm.**

    Changes requiring member notification must be made in compliance with Department of Labor requirements, which BCBSAZ adheres to. BCBSAZ does not agree to obtain the City's approval prior to making drug tier changes to our program. BCBSAZ is offering our multi-tiered benefit program which applies to all of our at-risk business in addition to self-funded groups. Because a single program is used for all business, BCBSAZ is able to negotiate better rebate arrangements with pharmaceutical manufacturers while keeping our goal of lowest net cost.

12. No alterations to financial guarantees will be made if the City opts out of formulary drug exclusions. Please confirm.

The BCBSAZ standard pharmacy benefit program is an open program that covers all medications, with the exception of standard plan exclusions, at varying cost share levels. Large Groups, such as the City, who choose self-funding, may opt to include products that are standard plan exclusions (i.e. sexual dysfunction, fertility/infertility, weight loss, etc.). Financial guarantees are not impacted for self-funded groups that have exceptions to the standard program. Additionally, please note that the City will not have the ability to manipulate drug tier assignments.

13. The PBM agrees that it will not remove any participating network pharmacies that impact greater than 2% of the City's prescriptions without communicating to the City at least 60 days in advance of the scheduled change. If the change is not agreeable to the City, the City will have the right to terminate the agreement without penalty. Please confirm.

BCBSAZ confirms.

14. The PBM agrees to offer improved pricing terms to the City if greater than 2% of members are impacted by proposed changes to the participating pharmacy network. Please confirm.

If improved pricing is available, BCBSAZ will pass on to the City.

15. The PBM agrees to notify the City or its designee in advance of 90 days when a formulary drug is targeted to be moved to or from the preferred drug list. The PBM must provide a detailed disruption and financial impact analysis at the same time. Please confirm.

BCBSAZ will give 60 days' notice to members when members are negatively impacted. BCBSAZ is unable to provide notification to members whose cost shares would decrease due to a change or financial impact analysis of changes at this time.

16. Retail and mail order <u>brand</u> discount guarantees will <u>exclude</u>:

- **Compounds**
- **Single source generic claims**
- **Direct/paper claims**
- **Excess member copay amounts/ copay differential amounts**
- **Specialty claims**
- **OTC claims**

Please confirm.

BCBSAZ confirms for compounds, single source generic claims, direct/paper claims and specialty claims. BCBSAZ is unable to confirm for excess member copay amounts/copay differential amounts, as this is not in our agreement with Catamaran. BCBSAZ confirms for OTC claims, with the exception of OTC diabetic supplies.

17. Retail and mail order <u>generic</u> effective rate guarantees will <u>exclude</u>:

- **Compounds**
- **Direct/paper claims**
- **Excess member copay/ copay differential amounts**
- **Specialty claims**
- **OTC claims**

Please confirm.

BCBSAZ confirms for compounds, single source generic claims, direct/paper claims and specialty claims. BCBSAZ is unable to confirm for excess member copay amounts/copay differential amounts, as this is not in our agreement with Catamaran. BCBSAZ confirms for OTC claims, with the exception of OTC diabetic supplies.

18. PBM will respond in written to the initial audit claims no later than 30 days from receipt of findings. Please confirm.

BCBSAZ confirms.

19. The PBM agrees to send all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the City's participants to the next PBM at no charge if the City terminates the contract with or without cause. Please confirm.

BCBSAZ will coordinate the open refill transfer file from Walgreens and the specialty prior authorization file from our PBM, Catamaran at no charge. However, an additional fee may apply for the new vendor receiving the files.

20. The PBM agrees to provide online, real time, claim system access to the City or its designee, including access to historical claims data for up to three (3) years following termination of the agreement. Please confirm.

BCBSAZ does not offer "online, real time, claim system access," but does provide BlueInsight℠ for 24/7 online claim information report access which is updated monthly. Historical claim information is available following termination via BlueInsight for 12 months. Additional reporting can be provided beyond this 12 months following termination, with report format and frequency to be mutually determined.

21. PBM agrees to provide at least 90 days advance notice of any material change to:

a. Network Provider Panel Terminations

Pharmacy terminations other than store location closures, or closure by AZ Board of Pharmacy are not confirmed. If our vendor, Catamaran, terminates an Arizona store for other reasons, BCBSAZ will provide 30 day notice to affected members.

b. Formulary Additions and Removals

Not confirmed. BCBSAZ will make a decision to improve pricing as the termination occurs.

c. Changes to Member Communications

BCBSAZ confirms with the exception of time-sensitive notifications.

d. Changes to Mail Order facility (locations, systems)

BCBSAZ confirms.

e. Material Changes in Operations (lay offs, off-shoring services)

BCBSAZ does not anticipate outsourcing our member-facing services offshore to foreign workers. Member-facing processes (i.e., customer service, sales support and broker services) are performed locally at our offices in Arizona. Please be advised that BCBSAZ support has technological and back office operations with foreign workers.

Please confirm.

Responses to this offer will be deemed as part of the PBM contract.

COBRA Questionnaire

1. **Please clarify whether Blue Cross Blue Shield is offering the services of Sterling Administration for COBRA administration as part of its proposal or the City will need to enter into a separate agreement with Sterling Administration for the services.**

   The City will need to enter into a separate agreement with Sterling Administration for the COBRA services.

2. **If COBRA administration services through Sterling Administration will be provided under the contract between the City and BCBS, please provide the best fee quotation, including any multi-year rate/fee guarantees. The preference is for a multi-year rate/fee guarantee. For your convenience to submit your best offer, see the separate attachment for the fee forms in Excel format. Please return the completed Excel workbook with your proposal.**

   Not applicable.

Blue Cross Blue Shield Agreements

1. **Please provide a completed draft Administrative Service Agreement reflective of your best offer for the City's review.**

   Please refer to **Attachment 6** for the draft Administrative Service Agreement and Supplemental Terms and Conditions.

2. **Please provide a completed draft Maximum Aggregate and Specific Liability Agreement reflective of your best offer for the City's review.**

   Please refer to **Attachment 7** for the draft Incurred Stop Loss contract.

Blue Cross Blue Shield Exceptions to City Contract Terms and Conditions

The exceptions and proposed substitute language are in review. The City will provide responses for discussion as soon as possible.

BCBSAZ acknowledges.

CITY OF CHANDLER RFP SOLICITATION #HR5-948-3502
EXHIBIT 01 - SELF-FUNDING MEDICAL FEE QUOTATION FORM BAFO
SELF-FUNDED MEDICAL BENEFITS - CURRENT PLAN - ALL ACTIVES AND RETIREES

Please do not alter, add or delete rows. Complete yellow shaded areas only. Failure to complete the exhibit as requested may result in rejection of your offer. For each service requested, indicate a price PEPM. If a service does not have a separate price but is included in your base fees, indicate "included" in the pricing columns. If a service is not one that your firm offers, indicate "N/A" in the pricing

			1/01/2016 12/31/2016	1/01/2017 12/31/2017	1/01/2018 12/31/2018	1/01/2019 12/31/2019	1/01/2020 12/31/2020
ASO Fees (PEPM)	*Assumed Units*	*Unit Measure*	Medical	Medical	Medical	Medical	Medical
A. Base Administration Fees							
Medical Administration Fee - PPO *	1,520	PEPM	$52.16	$53.72	$55.33	$58.10	$61.01
Network Access	1,520	PEPM	included	included	included	included	included
Full Claim Fiduciary (Levels 1-3)	1,520	PEPM	included	included	included	included	included
Underwriting/Actuarial Services (setting contribution rates, etc.)	1,520	PEPM	included	included	included	included	included
Reporting	1,520	PEPM	included	included	included	included	included
Minimum Value Certification Provided	1,520	PEPM	included	included	included	included	included
Utilization Review (Precert, Concurrent & Retrospective Review, Case Mgmt.)	1,520	PEPM	included	included	included	included	included
Disease Management (Diabetes, Asthma, CAD, CHF, COPD, Arthritis, Depression & Low back pain) (1)	1,520	PEPM	included	included	included	included	included
Lifestyle Management (smoking cessation, stress mgmt, weight mgmt)	1,520	PEPM	included	included	included	included	included
24 hour Nurseline	1,520	PEPM	included	included	included	included	included
Healthy Babies/Healthy Pregnancy	1,520	PEPM	included	included	included	included	included
Online Health Risk Assessment	1,520	PEPM	included	included	included	included	included
ID Cards - laminated, black & white client logo	1,520	PEPM	included	included	included	included	included
Create Summary of Benefits Coverage	1,520	PEPM	included	included	included	included	included
Creation of Plan Document (2)	1,520	PEPM	N/A	N/A	N/A	N/A	N/A
Create, Print and mail (to Employee) Benefit Booklets	1,520	PEPM	included	included	included	included	included
Other (Specify)		PEPM	N/A	N/A	N/A	N/A	N/A
Other (Specify)		PEPM	N/A	N/A	N/A	N/A	N/A
PEPM Total Base Administration Fees (PPO)		PEPM	$52.16	$53.72	$55.33	$58.10	$61.01
B. Pharmacy Rebate Credit							
Pharmacy Rebate Credit	1,520	PEPM	-$12.00	$0.00	$0.00	$0.00	$0.00
C. Optional Administration Services (client may choose some or all)							
Disease Management programs other than under Base Admin above			N/A	N/A	N/A	N/A	N/A
Biometric Screening (Height/Weight/BMI/Blood Pressure/Cholesterol/Glucose)		Per Participant	included	included	included	included	included
Onsite Flu Shots		Per Participant	included	included	included	included	included
Mobile Onsite Mammography (3)			included	included	included	included	included
Wellness Services** (4)			included	included	included	included	included
Creation of Plan Document			N/A	N/A	N/A	N/A	N/A
Data Interface with Stop Loss Vendor		PEPM	N/A	N/A	N/A	N/A	N/A
Data Interface with COBRA Vendor		PEPM	N/A	N/A	N/A	N/A	N/A
Other (Specify)			$0.00	$0.00	$0.00	$0.00	$0.00
Other (Specify)			$0.00	$0.00	$0.00	$0.00	$0.00
Claim History transfer			$0.00				
D. Annual Allowances							
Wellness			$25,000.00	$25,000.00	$25,000.00	$25,000.00	$25,000.00
Trust Related Services			$25,000.00	$25,000.00	$25,000.00	$25,000.00	$25,000.00
Communications			$30,000.00	$30,000.00	$30,000.00	$30,000.00	$30,000.00
Other (Specify) Onsite Wellness Consultant			$100,000.00	$100,000.00	$100,000.00	$100,000.00	$100,000.00
Other (Specify)			$0.00	$0.00	$0.00	$0.00	$0.00

* Fees should reflect the cost of any future runout administration should the client terminate services with your firm.

** Indicate in comments section or attach a copy of what these programs are. Indicate your BOB ROI for each program.

Comments

(1) Arthritis, Depression & Low back pain are part of our case management program and included in our administrative fee.

(2) BCBSAZ prepare Summaries of Benefits and Coverage (SBCs) and member benefit-plan booklets, including any riders or amendments, in accordance with applicable state and federal laws. However, we do not produce a Summary Plan Description (SPD) but can provide language that the City can incorporate into its plan document.

(3) The cost of providing the onsite services is included in our adminstrative fee; however, the service/immunization is submitted as a member claim.

(4) Please refer to Attachment 1 for a HealthyBlue[SM] flyer, which provides a description of our wellness services.

The administration rates above assume BCBSAZ will retain all Rx rebates. Please see the BCBSAZ Rates and Assumptions in Attachment 2 for details.

Authorized Signature	
Vendor Name	Blue Cross® Blue Shield® of Arizona
Date	May 6, 2015
Contact Phone Number	(480) 258-2949

CITY OF CHANDLER RFP SOLICITATION #HR5-948-3502
EXHIBIT 02 - HSA ADMINISTRATION FORM BAFO

Vendor Name	Blue Cross® Blue Shield® of Arizona
Authorized Signature	
Date	May 6, 2015
Contact Phone Number	(480) 258-2949

**********PLEASE READ THE DIRECTIONS CAREFULLY BEFORE COMPLETING THE EXHIBIT**********

1. Please do not alter, add or delete rows unless specified (see # 4). Failure to complete the exhibit as requested may result in rejection of your offer.
2. Complete the fee/pricing cell for each service requested.
3. When entering the pricing in each fee cell for Years 1-5, please follow the directions below:
   a. If $0.00 is in the fee/pricing cell, the service is automatically considered included at NO additional cost to the client:
   b. If the fee/pricing cell is blank (no numerical dollar value), the service is automatically included at NO additional cost to the client; and
   c. If you do not provide any of the services, please type "N/A" in the fee/pricing cell for each service.
4. Please include ALL comments specific to your pricing on this exhibit in the Comment Box (below). Add rows to the Comment Box as needed.
5. Please do not refer to your response to clarify any of the services, pricing or comments included on this exhibit. All of your comments to support your pricing must be on this exhibit.
6. Set-up fees or one time implementation fees are highly discouraged but may be noted in the comments section.

HSA ADMINISTRATION	1/01/2016 12/31/2016	1/01/2017 12/31/2017	1/01/2018 12/31/2018	1/01/2019 12/31/2019	1/01/2020 12/31/2020
Per HSA Enrolled Employee Per Month	$2.70	N/A	N/A	N/A	N/A
Other Fees (Specify)	$0.00	$0.00	$0.00	$0.00	$0.00
Other Fees (Specify)	$0.00	$0.00	$0.00	$0.00	$0.00
Other Fees (Specify)	$0.00	$0.00	$0.00	$0.00	$0.00
Other Fees (Specify)	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL PEPM FEE	$2.70	$0.00	$0.00	$0.00	$0.00
Enrollment Assumptions					
# of Employees	610	610	610	610	610

Comments
Please refer to Attachment 3 for HSA employer and employee fees.

CITY OF CHANDLER RFP SOLICITATION #HR5-948-3502
EXHIBIT 04 - STOP LOSS RATE FORM BAFO
CURRENT PLAN DESIGN - ALL ACTIVES AND RETIREES

The City desires an incurred contract or a 12/24 contract. Please be sure to indicate below the dates you are proposing for incurred and paid

Contract Basis			
Incurred Period:		1/01/2016 - 12/31/2016	
Paid Period:		1/01/2016 - 12/31/2017	
Covered Expenses		Medical & Prescription Drugs	
Specific Stop Loss Deductible	**Lives**	**$300,000**	**$300,000**
Specific Stop Loss Premium Rates			
Employee/Retiree Only	424	$17.71	$17.71
Employee/Retiree + Spouse	261	$29.57	$29.57
Employee/Retiree + Children	230	$26.20	$26.20
Employee/Retiree + Family	605	$43.03	$43.03
Total Annual Premium	1,520	$567,432	$567,432
Aggregate Stop Loss		**110% (Current)**	**125%**
PPO/Rx Mature Expected Claims PEPM	1,520	**$1,039.67**	**$1,039.67**
Monthly Aggregate Attachment Factor PPO/Rx (PEPM)	1,520	**$1,143.64**	**$1,299.59**
Premium Rate	1,520	**$5.42**	**$2.43**
Employee/Retiree Only	424	$3.00	$1.35
Employee/Retiree + Spouse	261	$5.18	$2.32
Employee/Retiree + Children	230	$4.56	$2.04
Employee/Retiree + Family	605	$7.58	$3.39
Total Annual Premium	1,520	$99,104	$44,377

Does your proposal include any lasers? If yes, provide details in comments below.	**No.**
Do you require a disclosure statement? Include a sample if yes.	**BCBSAZ does not require a**
What is the maximum reimbursement under your specific stop loss policy?	**There is no SSL annual maximum**
What is the maximum reimbursement under your aggregate stop loss policy?	**There is no ASL annual maximum**
Does your stop loss policy cover all services payable in the underlying medical/rx plan?	**Yes.**
Are you willing to offer a second year rate cap? Describe in comments.	**No, our offer does not include a**

Comments

Please refer to the BCBSAZ Rates and Assumptions in Attachment 2, which illustrate tiered rates by plan.

Authorized Signature	
Vendor Name	Blue Cross® Blue Shield® of Arizona
Date	May 6, 2015
Contact Phone Number	(480) 258-2949

EXHIBIT B
SCOPE OF SERVICES

Please indicate your agreement to all Scope of Services below. List any exceptions, deviation or clarifications to any "no" response and fully explain your reason for marking it "no" in the "Deviation" section (Offer Section) of your response. (Yes = Agree; No = Disagree)

1. GENERAL:

All Minimum Requirements and Specific Requirements set forth above are incorporated herein.

	GENERAL REQUIREMENTS	YES	NO
A.	Contractor shall provide a proposal for administration of a self-funded Plan. The proposal shall include fully-integrated medical management and claims administration.	Yes	
B.	The proposal shall include support for wellness initiatives and support services for healthy lifestyles. Contractor must guarantee initial rate quotes, at a minimum, from January 1, 2016 through December 31, 2016. Upon completion of the contract term, Contractor shall provide communications and data support for a successful transition to the new contractor. Contractor shall provide final renewal rates, costs, and underwriting projections to the City at least six (6) months prior to the contract anniversary date, i.e. July 1.	Yes	
C.	Contractor shall agree to sign the City's Business Associate Agreement as written and provided prior to award.		No
D.	Contractor must complete the Financial Workbook, Offer and Acceptance Sheet, all Attachments, and Questionnaire.	Yes	
E.	Contractor shall provide with their "submission" any sample contract that requires signatures with their proposal. This sample contract should contain the following language: To the extent there is an inconsistency between the contract and the RFP, the "Solicitation" shall govern.		No

2. DATA AND REPORTING:

	DATA AND REPORTING:	YES	NO
A.	Contractor shall agree that all data shall be available to the City and shall provide such data in regular reporting intervals, as well as on an ad hoc basis, as requested by the City at no additional cost to the City.		No
B.	Contractor shall provide monthly claims data and reports no later than 21 working days following the end of the month. The month shall close on the last working day of each month. All reports will be provided within all Federal and State Legislative standards for privacy and in compliance with regulatory technology standards.	Yes	

	DATA AND REPORTING:	YES	NO
C.	Contractor shall provide reports as outlined in Reporting Section of the Questionnaire for both Medical and Pharmacy.	Yes	
D.	Contractor shall provide prescription drug utilization and cost information as outlined in item C above. Should additional reporting be required, Contractor shall provide within 30 days of the request at no additional cost to the City any and all data associated with claims payments, medical management, eligibility, and Incurred but not reported Lag reports as permitted via a valid Business Associate agreement held between the City and their respective vendors. No data shall be withheld as long as there is a "need to know" for purposes of plan management or rate setting.		No

3. ADMINISTRATION:

	ADMINISTRATION:	YES	NO
A.	Contractor shall provide all required services to all eligible members as determined by the City. This includes the ability for a member to change options (Red, White and Blue) outside of open enrollment for any reason that is adopted by the City as a permitted basis for the change. Participation is voluntary and Contractor shall not invoke any minimum participation requirements.		No
B.	Contractor shall provide all benefits and services as described in the Plan and in accordance with the current policies and procedures set within this contract and/or adopted during implementation. All current policies and procedures not documented within this RFP shall be established during implementation in writing by Contractor and modified to the satisfaction and approval of the City's implementation team. Contractor must agree to administer the Plan according to its terms (See Exhibit H for all benefit documents).	Yes	
C.	Contractor shall provide quality services, meeting or exceeding the City-approved industry standards as specified in the performance guarantee section of this RFP. Contractor shall take immediate corrective action and provide a written action plan, as requested by the City, should the City identify any issue related to poor quality or lack of responsiveness uncovered in any audit conducted, either internally or externally, of Contractor's required processes or procedures. This action plan shall clearly outline the corrective steps and timeframes for completion when services do not meet industry standards to include standards that are inappropriate, undesirable, and/or of poor quality, as identified by the City. Any additional resources required to support corrective actions shall be provided at no additional cost to the City. Corrective measures taken to ensure the City quality standards, reporting standards or performance standards shall be provided at no additional cost to the City through	Yes	

	ADMINISTRATION:	YES	NO
	fees or hidden charges.		
D.	Contractor shall provide training to all identified City personnel prior to open enrollment meetings.	Yes	
E.	Contractor shall provide staffing, as appropriate, to perform administrative work as determined by the City.		No
F.	Contractor shall provide resources to respond timely (as agreed to in implementation) to all inquiries related to quality assurance, corrective actions, deficiencies and/or inefficiencies in operations.	Yes	
G.	Contractor shall absorb all programming costs associated with data file transfers in current data file compliant formats.		No
H.	Contractor shall provide the necessary staff for Plan transitions, annual open enrollment(s), and/or any special open enrollments that the City deems necessary to administer the Plan.	Yes	

4. IMPLEMENTATION:

	IMPLEMENTATION:	YES	NO
A.	Contractor shall provide a team of individuals dedicated to implementing the provisions of this contract upon award. The implementation team shall include, but not be limited to: programmers; data analysts; project manager; account manager; enrollment specialists; and claims and member service staff.	Yes	
B.	Contractor shall provide a draft ID card sample to the City for approval on or before August 1, 2015. Contractor shall mail finalized approved ID cards to members 10 days before the beginning of each Plan year, and 15 days after notice for new hire and life event changes. The ID cards will be laminate, black and white without the City's logo. The cards must be mailed and shipping included in the cost of your proposed administrative fees.		No
C.	Contractor shall perform comprehensive system testing and quality assurance checks prior to the implementation date of September 1, 2015. Contractor shall report the results to the City. These checks shall be provided at no cost to the City.	Yes	

	IMPLEMENTATION:	YES	NO
D.	By the end of the implementation process, Contractor shall provide the City with an administrative manual in a mutually agreed upon format. The administrative manual shall include any operations required to effectively administer the Plan, as well as policies and procedures specifically required by the Plan document or summary plan description The administration manual shall be updated as needed by Contractor's account management team and as agreed to by the City throughout the term of the contract. The administrative manual and its updates shall be provided at no additional cost to the City.	Yes	
E.	Contractor shall ensure the customer call center is available 90 days before the implementation date for members transitioning from the current contractor, as well as for potential new members to call with questions about the City's program.	Yes	

5. TRANSITION OF CARE:

	TRANSITION OF CARE:	YES	NO
A.	Contractor shall provide a process for transition of care that is approved by the City during implementation. The transition-of-care shall apply to members who are currently in the middle of chronic and/or catastrophic treatment, scheduled to begin treatment, and/or require ongoing treatment from six months prior to the effective date of the contract through the end of the first contract year.	Yes	
B.	Transitional care shall be a covered benefit under the City's medical program as identified in the SPD/Plan Booklet provided by the prior contractor and any other existing contract. Contractor shall provide any necessary information, records, data, or documentation related to transition of care when a member switches between benefit options and upon termination of the contract.	Yes	
C.	Contractors, who consider the transition of care as part of their concurrent review/discharge planning procedures, shall also meet the guidelines established within the transition of care process and/or medical management contractor's guidelines.	Yes	
D.	Questions received from members and their families concerning transition of care shall be referred to Contractor.	Yes	
E.	Contractor shall furnish to the City the name, title and phone number of two individuals who shall coordinate and assure prompt resolution of transition-of-care issues. The City shall be notified with any changes to this information within 24 hours of any update.	Yes	
F.	Contractor shall report on all members who have been identified as needing transition of care. The report shall include but not be limited to: dates identified; status on outreach efforts; transition of care status; removal from transition of care reporting; and any other	Yes	

TRANSITION OF CARE:	YES	NO
information requested during the implementation phase.		
G. Contractor shall provide communication, resources, data and/or file transfers upon completion of any contract term to support a successful transition to a new contractor, at no additional cost to the City.	Yes	

6. CLAIMS ADMINISTRATION:

CLAIMS ADMINISTRATION:	YES	NO
A. Contractor shall have processes in place to adjudicate international claims, including computing currency conversion and translation to English.	Yes	
B. Contractor shall provide the City with a minimum of 12 months advance notice of any claim system conversion or change that may disrupt the current processes.	Yes	
C. Upon receiving claims missing information that prevent resolution or payment, Contractor shall pend claims for a period of not more than 60 days to allow time for additional information for processing.	Yes	
D. Contractor shall send any initial request for information within 5 working days after receipt of the claim, and shall send any second request for information within 21 calendar days thereafter. If quality standards, statues or regulations would be impacted by this requirement, Contractor shall specify and provide detail for approval to change this requirement in the Deviation section of the RFP response.		No

7. SURVEYS:

SURVEYS:	YES	NO
A. Contractor shall conduct an annual member satisfaction survey during the plan year, at no additional cost to the City. Such survey shall be for the purpose of assessing member satisfaction with Plan services. Contractor shall conduct an annual provider satisfaction survey during the plan year, at no additional cost to the City. Such survey shall be for the purpose of assessing provider satisfaction with Contractor.	Yes	
B. The survey documents and processes shall be subject to prior approval by the City.		No

8. ACCOUNT MANAGEMENT AND MEMBER SERVICE:

	ACCOUNT MANAGEMENT AND MEMBER SERVICE:	YES	NO
A.	Contractor shall respond to account issues and member service issues within one to two business days. If additional time is required, Contractor shall provide an action plan to resolve the issue within a specified timeframe.	Yes	
B.	Contractor shall provide documentation of a process for prompt issue resolution and maintain an issue log. Contractor shall provide the City access to an electronic tracking and resolution log of all open and closed City issues, in the required format agreed upon during implementation.	Yes	
C.	Contractor shall provide a dedicated fully-operational toll-free telephone line that is answered by a live person Monday through Friday during standard Arizona business hours. Calls outside of these hours shall be handled by voice mailbox or an equivalent system, and such calls shall be returned by a knowledgeable staff member by the end of the following business day.	Yes	
D.	Contractor shall ensure that members who have limited English proficiency, who speak Spanish only, or who are deaf or hearing impaired have access to communication services that enable them to utilize the phone lines.	Yes	
E.	Contractor shall provide an escalation process to assist in matters which cannot be resolved at the customer service level.	Yes	
F.	Contractor shall provide a dedicated team of professionals who shall be responsible to see that Contractor meets all contract requirements and provides all service deliverables. In addition the Contractor shall provide an account management team that is experienced in providing services for similar entities is trained in the City's Plan, is accessible to the City geographically, and with sufficient capacity and authority to respond to the City's issues in a timely manner.	Yes	
G.	Contractor shall attend in person quarterly and annual on-site program reviews, with weekly telephone calls, as requested by the City's benefits office.	Yes	

9. APPEALS AND DISPUTES:

	APPEALS AND DISPUTES:	YES	NO
A.	Contractor shall adhere to the claims, appeals, and dispute processes applicable to Third Party Administrators under Arizona law and as stipulated in the City's current Plan document section relating to such matters. Contractor shall administer all levels of claims appeals. Contractor shall comply with all timeframes and reporting on all levels of appeals.	Yes	

	APPEALS AND DISPUTES:	YES	NO
B.	Contractor shall maintain procedures for responding to appeals and disputes as well as reporting the responses and results to the City in aggregate reporting format as determined during implementation.	Yes	
C.	Contractor shall respond to any pre-service authorization request and appeal as stipulated in the City's current Plan document section relating to such matters. Contractor shall respond to all urgent care claims within three business days, pre-service claims within 15 calendar days, and all post-service claims within 30 calendar days after receipt.	Yes	

10. AUDIT:

	AUDIT:	YES	NO
A.	The City shall be granted access to all detailed claims history for no less than the three (3) completed plan years at no cost to the City. Older years must be archived for up to seven years and can be subject to fees.		No
B.	Contractor shall permit no less than one audit per year by a third party auditor selected by the City.		No
C.	100% of all records will be provided to the auditor at no cost to the City		No

	AUDIT:	YES	NO
D.	The City reserves the right to audit results for up to the three last complete plan years either for full claims or for a target selection/sample of records to validate plan provisions and financial accuracy		No
E.	Contractor shall allow for on-site follow up audits for a statistically valid sample number of claims		No
F.	The right to audit shall continue for up to 24 months after the termination of the contract.		No
G.	Contractor shall have the right to inspect and review our audit methodology and findings. All methods and findings are proprietary and confidential and cannot be shared with any third party other than by court order or prior written approval given by the City's Consultant (Segal).		No
H.	Contractor shall agree to full remuneration of validated errors discovered during the audit within a reasonable period of time after the audit is completed and closed [note – specific time frames can be added]	Yes	
I.	Contractor shall cooperate fully with the client and its auditor processes and take reasonable steps to ensure timely responses to all inquiries for data and findings review.	Yes	
J.	These rights shall survive any transition of claim paying processing duties to any third party or sub-contractor.		No
K.	Contractor shall provide full disclosure of its records and those of its subcontractors upon notice from the City and/or the City's selected auditor. Contractor shall cooperate with the auditors and waive any fees associated with obtaining access to the City's data and/or records.		No

	AUDIT:	YES	NO
L.	Contractor shall agree to allow the audit of Contractor's records and those of its respective subcontractors including, but not limited to: access to provider data/records; provider contracts; all types of provider fee schedules; customer service departments; claims departments; records to support network adequacy; appeals/grievances/disputes both from providers and/or members; quality assurance programs; systems data; reporting data; Medicare reclamation; rebate revenues and calculations; overpayments and underpayments; fraud hotline complaints; investigations and closing actions; shared cost savings, if the concept continues; COBRA and FSA billing and other records; abandoned collections and recoveries; eligibility records; fraud detection and preventative activities; performance guarantees; and reporting.		No
M.	Contractor shall complete a SAS 70 annually and provide a report on the results as requested by the City.	Yes	

11. ELIGIBILITY:

	ELIGIBILITY:	YES	NO
A.	The eligibility requirements for the City's active employees, eligible retirees and their dependents are outlined in this RFP. The City shall be the final authority in deciding member eligibility.	Yes	
B.	The City shall provide Contractor with a weekly eligibility file in an electric format containing sufficient information for Contractor to validate eligibility. Contractor shall accept eligibility in the format as submitted to Contractor by the City.		No
C.	Contractor shall load and reconcile weekly and monthly eligibility files within 24 hours of receipt.		No
D.	If Contractor uncovers any eligibility discrepancies within the file transfer (i.e., errors, duplicates, etc.), Contractor shall notify the City-designated individual via email within 48 hours of the data load.	Yes	

	ELIGIBILITY:	YES	NO
E.	Contractor shall establish appropriate FTP site(s) or other appropriate means, as required by the City to exchange eligibility data at the frequency established by the City.	Yes	
F.	City shall self-bill monthly fees/premiums based on the City's monthly eligibility data, and shall remit the amount due to Contractor (payment made via check). The City shall remit any monthly fees/premiums and claims in arrears to Contractor 30 days from the date the bill is received with no interest charge. Contractor shall agree to the most preferred method of billing as determined during implementation of this contract and approved by the City.		No
G.	Discrepancies of claims or fees other than those based upon eligibility file transfer resulting in variances of less than five percent (5%) shall be accepted by Contractor without dispute. Failure to provide written notice of a disputed discrepancy within the specified timeframe shall be considered Contractor's acceptance of the City's calculations, records, and payments.		No
H.	The City reserves the right to offset any premiums, fees or other remittances due to Contractor in order to collect performance penalties, overpayments resulting from incorrect calculations, eligibility adjustments, incorrectly paid claims, or other errors or adjustments identified by audit, analysis or other means. If no premiums, fees or other remittances are due the City, Contractor shall remit to the City any performance penalties assessed, any overpayments resulting from incorrect calculation, eligibility adjustment, incorrectly paid claim, or other errors or adjustments within 30 days after identification and communication of such claim to Contractor.		No
I.	The Contractor shall provide, at no cost to the City, collection of coordination of benefits (COB) information no less than twice per year. Contractor shall verify COB status based on the guidelines and frequency as stipulated by the City during implementation and for the full term(s) of this contract.		No
J.	Where applicable, Contractor shall verify disability status based upon the guidelines and frequency as stipulated by the City during implementation and for the full term(s) of this contract.	Yes	
K.	Contractor shall agree to communicate through HIPAA-compliant electronic sites to exchange data between themselves and any other required vendor as requested by the City.		No
L.	Contractor agrees to provide a report by December 15 following open enrollment each year identifying each dependent newly added (not previously enrolled).	Yes	

12. MEDICAL NETWORK:

	MEDICAL NETWORK:	YES	NO
A.	Contractor shall be responsible for all contracted networks and/or providers proposed by Contractor in its response to this RFP.	Yes	
B.	Contractor shall update the online provider directory every 96 hours for any changes reported by a provider.		No
C.	Contractor shall accept and review provider nominations on behalf of the City.	Yes	
D.	If a contracted medical network is impacted by a significant reduction in providers or facilities to the extent they may no longer be able to perform to the requirements of this contract, the City shall be notified in writing at least 90 days in advance or as soon as is reasonably possible:		
	(1) The City shall determine from the facts and circumstances what would constitute a significant change. At the City's option, members may be offered an opportunity to dis-enroll and/or select another provider;	Yes	
	(2) All providers servicing the area shall agree to accept enrollees seeking a new provider under such conditions.	Yes	
E.	Contractor shall adopt and disseminate practice guidelines that consider the needs of members and are:		
	(1) Based on reasonable medical evidence or a consensus of health care professionals in the particular field;	Yes	
	(2) Developed and/or adopted in consultation with contracting health care professionals;	Yes	
	(3) Reviewed and updated periodically within timeframes determined appropriate by Contractor and approved by the City; and	Yes	
	(4) Applied consistently to all members covered under the program.	Yes	
F.	Contractor shall provide monitoring and evaluation of all types of provider performance.	Yes	
G.	Contractor shall provide a network that includes a provider profiling program.		No
H.	Contractor shall provide provider tax identification numbers as requested by the City as allowed under federal and state privacy laws.	Yes	
I.	Contractor shall provide to the network of providers both toll-free telephone support and field service support. Contractor shall resolve provider issues that relate to the City's members in a timely fashion.	Yes	
J.	Contractor shall provide a comparison of their network providers with the current top providers as listed in the Financial Workbook	Yes	

MEDICAL NETWORK:	YES	NO
(Attachment E).		
K. Contractor shall assist members in disputes between provider contract and claims administration.	Yes	

13. PLAN MEMBER COMMUNICATION MATERIALS, ADVERTISEMENTS AND MARKETING MATERIALS:

PLAN MEMBER COMMUNICATION MATERIALS, ADVERTISEMENTS AND MARKETING MATERIALS:	YES	NO
A. Contractor shall submit all copies of member materials, web portal member communications and promotional materials for written approval by the City as well as submit those enrollment materials to the Department of Insurance (DOI), as required, for approval and their subsequent use in promoting the Plan to eligible enrollees. Materials include notification letters, error/correction letters, form letters for additions or changes to network newsletters, or any other written communication distributed in any fashion to 50 or more members.		No

14. COBRA ADMINISTRATION

COBRA ADMINISTRATION	YES	NO
A. Contractor must provide initial notice to each newly covered employee.	Yes	
B. Contractor must provide Election Notice document by mail.	Yes	
C. Contractor must provide Coupon Mailing/Billing statements to participants	Yes	
D. Contractor must provide mailing of rate change and open enrollment letters.	Yes	
E. Contractor must provide premium collection including have ACH payment capabilities.	Yes	
F. Contractor must provide termination of continuation coverage letters.	Yes	
G. Contractor must provide COBRA eligibility list to Medical TPA, PBM and UR firm, Dental, Vision, FSA and any other City vendors.	Yes	
H. Contractor must provide monthly reporting to the City.	Yes	

15. WELLNESS PROGRAMS & HEALTH SCREENINGS:

WELLNESS PROGRAMS:	YES	NO

	WELLNESS PROGRAMS:	YES	NO
A.	Contractor must provide Online Health Risk Assessment.	Yes	
B.	Contractor must provide 24/7 Nurse Call Line.	Yes	
C.	Contractor must provide on-site support for one Benefits Fair, one Health Fair and on-site biometrics screenings for up to 8 other events per year	Yes	
D.	Contractor must provide Onside Flu Shots.	Yes	
E.	Contractor must provide tracking system for completion of Health Risk Assessment, Biometrics and other wellness incentives	Yes	
F.	Can a plan participant opt-out of Health Coaching when they complete a Health Risk Assessment?	Yes	
G.	Contractor must provide Healthy Babies/Health Pregnancy Program.	Yes	
I.	Contractor must provide individual Biometric Screenings onsite at the City which include the following measurements/tests:		
	➢ Height	Yes	
	➢ Weight	Yes	
	➢ BMI	Yes	
	➢ Waist ratio	Yes	
	➢ Blood Pressure	Yes	
	➢ Cholesterol	Yes	
	➢ Glucose	Yes	

16. PUBLIC INFORMATION REQUESTS OR OTHER PUBLIC COMMUNICATIONS:

	PUBLIC INFORMATION REQUESTS OR OTHER PUBLIC COMMUNICATIONS:	YES	NO
A.	Contractor shall notify the City within one (1) business day of receipt of any public information written request regarding any information that relates to the City's benefit plans. Contractor shall review all responses with the City and obtain approval prior to the release or response of any inquiry.	Yes	
B.	Contractor acknowledges and agrees that CITY is a public entity subject to Arizona Public Records Law, A.R.S. § 39-121, *et. seq.* CITY may, without violating the provisions of this Agreement, release any documents or other information related to this Agreement. If Contractor designates certain documents as Confidential, CITY will notify Contractor within five (5) business days of any Public Request and allow Contractor five (5) business days	Yes	

PUBLIC INFORMATION REQUESTS OR OTHER PUBLIC COMMUNICATIONS:	YES	NO
to obtain an injunction in Maricopa County Superior Court barring disclosure of such document or other information. This does not apply to information or other information which: (1) is, at the time of disclosure, or thereafter becomes available to the public from a source other than the receiving party; (2) was known to the receiving party as of the time of disclosure; (3) is independently developed by the receiving party; (4) is subsequently learned from a third party not under a confidentiality obligation to the disclosing party; (5) is required to be disclosed pursuant to subpoena, court order, or government authority, whereupon receiving party shall promptly advise disclosing party prior to such disclosure, so that disclosing party may seek a protective order or other appropriate remedy.		

BCBSAZ Audit Requirements

Upon reasonable prior written notice to BCBSAZ and as mutually agreed upon during BCBSAZ's normal working hours, the City may audit the records of payments made to providers and other data specifically related to BCBSAZ's performance under this agreement. BCBSAZ agrees to provide reasonable assistance and information to the City's auditors without charge the City shall bear the costs of the audit provided that; however, if the City reveals a breach of this agreement, BCBSAZ will bear the costs of the audit. Any audit for any plan year must be both commenced and finalized within 12 months of the last day of the plan year being audited. BCBSAZ shall have no liability to pay the City any amounts as a result of any audit unless demand for payment based on such audit is received by BCBSAZ within 12 months of the date the claim was paid of denied. "Paid" includes both payment and/or application of benefits.

BCBSAZ audit requirements include:

1. BCBSAZ must receive a 30-day written notification of an audit for a maximum of 200 claims.
2. BCBSAZ reserves the right to designate the specific dates of availability for audit upon notification. In no event shall the audit period extend more than one year immediately preceding the commencement date of the particular audit. Both parties agree to follow any pertinent State and Federal laws.
3. No later than thirty days prior to audit commencement, client must supply BCBSAZ in a mutually-agreed format with a written audit scope outline and list of documents needed for audit.
4. BCBSAZ requires confidentiality statements to be signed by auditors and client representatives prior to audit.
5. Access to BCBSAZ's specific information may be available only with the assistance of a BCBSAZ representative, and hard copy documentation will be provided upon mutual agreement.

Above criteria must be met to proceed with audit.

6. If either BCBSAZ or client desires to utilize an outside auditing firm to perform the audit, both BCBSAZ and client must agree on the selection of the outside auditing firm. BCBSAZ will only approve auditors that are independent and objective and will not approve auditors paid on a contingency fee or other similar basis. The party requesting the audit will be responsible for the audit fees charged by the auditing firm. BCBSAZ agrees to support audit activity without charging the client for the time supporting the audit activity.
7. BCBSAZ shall be given the opportunity to respond in writing, to all audit findings, prior to the issuance of the final report.
8. Adjustments will be initiated on claim mispayments identified no more than one year from the paid date. Recoupments will be initiated on claims with an overpayment of greater than $35 and no more than one year from the paid date.

EXHIBIT A
PROPOSAL REQUIREMENTS
PROPOSAL EVALUATION CRITERIA
QUESTIONNAIRES

*****DO NOT ALTER THE QUESTIONS OR QUESTION NUMBERING*****

Answers to the questions must be provided in hard copy and MS Word format on CD or Flash Drive.

DO NOT PDF or otherwise protect the CD or Flash Drive.

- Provide answers to the questionnaires in MS Word format.
- Provide an answer to each question even if the answer is "not applicable" or "unknown."
- Answer the question as directly as possible.
  - If the questions asks "How many…" provide a number
  - If the question asks, "Do you…" indicate Yes or No **first**, followed by your additional narrative explanation.
- Lengthy responses may be truncated when displayed…to avoid this, be concise in your response. Use bullet points as appropriate. Reconsider how to word any response that exceeds 200 words in length so that the response contains the **most important points** you want displayed. Refer the reader to an appendix/attachment for further information.
- Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments.
- Offeror will be held accountable for accuracy/validity of all answers. Failure to provide required information may cause the proposal to be deemed non-responsive. Incomplete or inaccurate answers may result in the disqualification of the proposal.
- RFP responses will become part of the contract between the winning Offeror and the City.
- All references to "Client" in the questionnaire refer to the City.

General Proposal Requirements

In order for your proposal to be considered and accepted, your organization must provide answers to the questions presented in this RFP. Each question must be answered specifically and in detail. Reference should not be made to a prior response, or to your contract, unless the question involved specifically provides such an option. Provide an answer to each question even if the answer is "not applicable" or "unknown."

Answer the question as directly as possible.

- If the question asks "How many..." provide a number.
- If the question asks, "Do you..." indicate Yes or No followed by any additional narrative explanation.

Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments. However, direct responses to all of the RFP questions must be provided and will be looked upon favorably.

If your proposal is different in any way (whether more or less favorable) from that indicated in this RFP, clearly indicate where and explain the difference. If you do not, the submission of your proposal will be deemed a certification that you will comply in every respect (including, but not limited to, coverage provided, funding method requested, benefit exclusions and limitations, underwriting provisions, etc.) with the requirements set forth in this RFP.

If you are unable to perform any required service, indicate clearly: a) what you are currently unable to do, and, b) what steps will be taken (if any) to meet the requirement, the timetable for that process and who will be responsible for the implementation, along with that person's qualifications.

All products should be priced individually. If pricing terms are provided for combining services, show the pricing terms as a separate line item.

Financial Section: When displaying your proposed fees, the tables in the Financial Section included in this RFP must be used. Please note that pricing terms should be offered on a pass through (transparent) basis. Information provided in any other format will not be considered. Footnotes to the form(s) may be used to provide supplemental explanations, if necessary.

Network Disruption: A network disruption analysis is necessary in order to award a final contract. The lack of disruption from the current network will be a major factor affecting the outcome of this proposing process. In order to be considered, your organization must submit a network disruption analysis regarding your network and contracted pharmacies. The basis of this evaluation will include your organization's broadest, national network offering.

Minimum Contractual Requirements: The Minimum Contractual Requirement section will become part of the actual contract document. Agreement to the terms and language in this section will be a critical factor in Offeror evaluation and selection and an authorized binding signature will be required.

PROPOSAL REQUIREMENTS

This section of the RFP lists the items, which **require specific confirmations**. To be considered for selection, respondents shall meet the following requirements. Please indicate your agreement to all Scope of Services below. List any exceptions, deviation or clarifications to any "no" response and fully explain your reason for marking it "no" in the "Deviation" section (Offer Section) of your response. (Yes = Agree; No = Disagree)

1. MINIMUM REQUIREMENTS:

MINIMUM REQUIREMENTS	YES	NO
A. Be licensed to provide the services requested, in the State of Arizona, if services requested require such licensure.	Yes	
B. Must exhibit extensive experience in the field of the insurance and services being proposed.	Yes	
C. Must acknowledge or confirm that all parts of this RFP have been read and that the Proposal submitted is in accordance therewith.	Yes	
D. Must submit all answers to the scope requirements, questionnaire, required attachments, and specific details on any deviations from the requirements of this RFP. All answers must be in the order in which the questions are asked. Any deviations must be clearly explained in a separate section marked "Deviations" contained within your submission to this RFP.	Yes	
E. Must submit and return a signed Non-Disclosure statement (Attachment D) prior to receiving Exhibits or Attachments related to this RFP.	Yes	
F. Must submit a completed, signed Offer and Acceptance form. Form must be signed by an authorized company official with the authority to submit a proposal and enter into a binding agreement on behalf of the company.	Yes	
G. Comply with all term requirements in standard and special terms and conditions.		No
H. Funds for Services Contractor must provide the following:		
a. $25,000 for wellness	Yes	
b. $25,000 for Trust Related Expenses	Yes	
c. $30,000 for Communications paid to the City's consultant Segal	Yes	

2. SPECIFIC REQUIREMENTS:

SPECIFIC REQUIREMENTS	YES	NO
A. Effective Date and Term: The contract shall be first effective January 1, 2016. The Term of the contract shall be for one calendar year with six renewable terms. Multiple year pricing is highly recommended but not mandatory.	Yes	
B. Medical Benefit Requirements:		
(1) A match of the current level of benefits is required. Please review the Plan Documents provided. Deviations from the existing BCBS plans and summary benefits must be clearly explained in the Deviation section (Offer Section) of your RFP response in the order they appear in the exhibits and/or attachments.	Yes	
(2) To be considered as the primary provider, the network must have at least an 85% or better match to the current BCBS network of providers.	Yes	
(3) Contractors must offer coverage on an in-network basis to City employees, retirees and their respective dependents living outside of Arizona.	Yes	
(4) City employees must not be required to enroll in the Plan; however, those eligible will be required to submit a "waiver" form. Any employee who does not elect Plan coverage; however, will not be permitted to re-enroll until the next open enrollment period or until the employee has a qualified change of event as defined in the Plan Document or Summary Plan Description or the City's Human Resource policies and practices.	Yes	

SPECIFIC REQUIREMENTS	YES	NO
(5) No individual shall lose coverage solely on the basis of the change in Contractor.	Yes	
(6) Coverage shall continue for those members covered under the plan and not actively-at-work as stipulated in the Eligibility guidelines maintained in the City's Department of Human Resource via current policies and practices.	Yes	
(7) Benefits shall be paid to all members covered under the plan up to the stated policy limits indicated in the Plan Document, Summary Plan Description, or Insured Certificate effective on January 1, 2016 at 12:01a.m	Yes	
(8) Contractors must conduct a full dependent audit at the request of the City and at **no additional charge to the City.**		No

3. STOP LOSS (EXCESS INSURANCE) REQUIREMENTS

STOP LOSS (EXCESS INSURANCE) REQUIREMENTS	YES	NO
A. Contractor must provide and arrange for stop loss coverage for all plan options offered to City employees and their enrolled dependents.	Yes	
B. Stop loss coverage shall pay claims as specified in the specific and aggregate limits awarded.	Yes	
C. Should a member be covered under the plan, however be subsequently deemed ineligible for any reason, the stop loss coverage will apply.		No
D. The stop loss carrier will be required to attempt to recover any monies paid on behalf of the City for an ineligible member, but will not attempt to collect the re-imbursement from the City.		No
E. Stop loss coverage will be based upon a *fully incurred* contract that prospectively pays at the specific deductible level, as well as, the aggregate attachment point as awarded and renewed each anniversary the coverage is in effect.	Yes	
F. The Contractor will not impose a higher specific deductible on any single diagnosis, other than at the specific request of the City.	Yes	
G. Covered expenses include all claims paid at the network rate, or at R&C as determined by the Plan Document.	Yes	
If you answered "No" to any of the questions above, please provide an explanation below: C, D: Stop loss coverage applies only to eligible members covered under the benefit plan.		

4. CLAIM PAYMENT PROCEDURES AND DEADLINES:

	CLAIM PAYMENT PROCEDURES AND DEADLINES:	YES	NO
A.	The Contractor must pay claims in a timely manner.	Yes	
B.	The identification cards shall clearly indicate the mailing address for claims. The claim forms shall clearly indicate the mailing address for claims or alternatively, Contractor may provide pre-addressed claim envelopes for claim submission.	Yes	
C.	When a claim has been denied, in whole or in part, and the covered individual has filed an appeal, Contractor shall issue a response to the appeal no later than 30 days after the necessary information is provided by the member or obtained on behalf of the member for the appeal to be considered. "Necessary information" may include the physician's input but may not include a "peer review." When the file is complete, peer review and determination must be rendered within 60 days. A much shorter response time is desired. Minimum desired timeframes are as established by National "URAC" standards.	Yes	
D.	Payment system shall contain, at minimum, the following data and system edits to assure proper determination of eligibility and availability of data required by City:		
	1. Member name, social security number and member I.D. number, and date of birth	Yes	
	2. Employee's dependent coverage election, effective dates - start and end dates - of eligibility, for employees and dependents	Yes	
	3. Employee claim or dependent claim	Yes	
	4. Claim incurred date	Yes	
	5. Claim paid date. (A claim is paid on the date that Contractor mails the amount due to the covered individual or the provider.)	Yes	
E.	Contractor shall make personnel available to members for consultation on matters regarding this program. Contractor shall honor the City's right to question any claim in any case where the covered individual's rights under the Plan are in question.	Yes	

5. DENIAL OF ELIGIBILITY:

	DENIAL OF ELIGIBILITY:	YES	NO
A.	Contractor shall not deny any eligible person benefits to which otherwise entitled under the Plan, due to the error or omission of City and shall align the stop loss insurance requirements to match the City's Eligibility requirements.	Yes	

6. IMPLEMENTATION REQUIREMENTS:

	IMPLEMENTATION REQUIREMENTS:	YES	NO
A.	To properly implement the Plan by the effective must undertake the following implementation activities:		
(1)	Contractor must revise specimen certificate or plan document boilerplate to conform to City specifications depending on the services provided.	Yes	
(2)	Contractor must provide documents required in these specifications within 4 months of the effective date of coverage.	Yes	
(3)	Contractor must provide an allowance toward the customized design, preparation, production, and delivery of employee booklets that explain City's medical benefit program. City must have the opportunity to approve the design. The booklets must include the City's logo. Printing and mailing must be included in your proposed administrative fees.	Yes	
(4)	Contractor must provide customized enrollment forms or accept an electronic data file containing the current enrollment to be provided not later than October 31, 2015.	Yes	
(5)	Contractor must reconcile and audit member eligibility in monthly billings and quarterly audits.	Yes	
(6)	Contractor must send all enrollment/communication materials to employees via first class mail, unless otherwise authorized by City.	Yes	
(7)	Contractor shall provide and pay for all claims forms and checks, certificates of insurance, employee booklets, identification cards, announcement forms and any other forms required for proper administration of coverage.	Yes	

7. COMMISSIONS:

	COMMISSIONS:	YES	NO
A.	No commissions, bonus, or marketing fees shall be payable unless they do not change the price/cost of services proposed within this RFP and are approved in writing by City. Should any monies be payable to the consultant/broker they must be fully disclosed to City and approved by the City.	Yes	

8. EVIDENCE OF INSURABILITY:

	EVIDENCE OF INSURABILITY:	YES	NO
A.	No evidence of insurability shall be required except to the extent specifically provided for by City or by law.	Yes	

9. BOOKLETS:

	BOOKLETS:	YES	NO
A.	Contractor shall be responsible for drafting of the summary plan descriptions (booklets), and for printing the booklets. Cover artwork and paper stock should match that used by "City brochures." City shall provide camera-ready artwork for covers. All such materials shall be subject to review and modification by City.		No

10. IDENTIFICATION CARDS:

	IDENTIFICATION CARDS:	YES	NO
A.	Contractor shall prepare and print identification cards for distribution to members. It is preferred that employee identification numbers issued by City be used as the identification number if possible. Contractor shall mail identification cards within seven (7) to ten (10) days after City transmits the eligibility list or enrollment forms. For employees with family coverage, Contractor shall distribute a minimum of two identification cards. Identification cards must be mailed a minimum of ten (10) days prior to the effective date.		No

11. ENROLLMENT AND TRANSITION:

	ENROLLMENT AND TRANSITION:	YES	NO
A.	Contractor shall assist City in the initial enrollment process. Enrollment/Education meetings (as required by the City) shall occur at no more than five selected campuses with up to 15 meetings.. Contractor must assign a representative to attend employee meetings. The representative would, at the request of City, answer questions and/or make a brief presentation.	Yes	

12. CITY CONTRIBUTIONS:

	CITY CONTRIBUTIONS:	YES	NO
A.	City reserves the right to establish and modify, in its complete discretion, the percentage of premium contributed by employees.		No

13. RENEWALS:

	RENEWALS:	YES	NO
A.	Renewal quotations shall be required six (6) months prior to the end of the policy year (i.e., July 1).	Yes	

14. DEVIATIONS FROM RFP:

	DEVIATIONS FROM RFP:	YES	NO
A.	Contractor must provide a separate listing of each circumstance in which its proposal differs from any terms or conditions of this RFP or from the Plan. Failure to list such a deviation, exclusion, restriction or limitation shall result in that terms of the proposal being disregarded in favor of the correlative term(s) of the RFP or Plan. Deviations shall be clearly explained in your submission of the Offer Section of your proposal. **If a deviation is placed elsewhere in your proposal AND NOT listed in the deviations section the deviation will not be considered.**	Yes	

15. SIGNATURE:

	SIGNATURE:	YES	NO
A.	Each proposal must include a statement attesting that the information therein is complete and accurate that the individual signing on behalf of Contractor has the power to bind Contractor. Omission, inaccuracy, or misstatement may be sufficient cause for rejection of the proposal.	Yes	

Please indicate your agreement to all questions below. List any exceptions, deviation or clarifications to any "no" response and fully explain your reason for marking it "no" in the "Deviation" section (Offer Section) of your response. (Yes = Agree; No = Disagree)

GENERAL REQUIREMENTS	YES	NO
1. Contract has a length of one (1) year with the option to renew six (6) additional one year periods?	Yes	
2. All fees are guaranteed for a minimum of 12 months?	Yes	
3. Agree to submit your renewal to the City, or their designated Consulting firm, six (6) months prior to the January 1 renewal (i.e. July 1). Further, you agree that if the renewal deadline is not met, the City can impose a penalty of $500 per day for each day the deadline is not met?	Yes	
4. Have you proposed a single bundled package including, medical and pharmacy claims administration, medical and pharmacy preferred provider network, HSA administration, disease management, and utilization review/case management for medical and pharmacy, wellness services, stop-loss insurance, and COBRA administration?	Yes	
5. Agree that your proposal is not contingent on acceptance of other coverages (e.g. stop loss) or services outside the scope of this RFP.	Yes	
6. Your rates and fees are net of commissions.	Yes	
7. You agree to handle all levels of claims appeals.	Yes	
If you answered "No" to any of the questions above, please provide an explanation below:		

CONTRACTUAL	Indicate Confirmation: Yes or No	Explain any "No" response
1. **Termination Provisions**: The City may terminate the contract at any time by giving 30 days written notice. The successful Offeror may only terminate the contract by giving notice 120 days in advance. The City can terminate the contract without cause or financial penalty at any time during the duration of the contract.	No	Either Party may terminate the Agreement effective immediately in the event of a material breach of the terms of the Agreement by the other Party, but only if the breach is not cured within thirty (30) days after written notice of the breach is given to the breaching Party. Additionally, BCBSAZ may terminate this Agreement in the event of a material breach.
2. Do you agree that upon the termination of the agreement with the City, you will cooperate fully with the City and/or its subsequent service provider in order to effect an orderly transition of services from your organization to a subsequent service provider, at no added fee?	Yes	
3. **Size Variance Provision**: Any provisions, references, or guidelines relating to reevaluation of proposed fees due to variation in enrollment in the plan must not be less than 15% of the enrollment at the beginning of each plan year.	Yes	
4. **Right to Audit**: The City reserves the right to an independent audit by an auditor of their choice. Offeror agrees to not charge for any expense incurred by the Offeror for time necessary to prepare claim files. The cost of the third party to audit will be the responsibility of the City.	Yes	Please see **Section 9B** for BCBSAZ's audit requirements.
5. Subcontracting: a. List any services related to the Scope of Work of this RFP that you currently subcontract (or plan to subcontract for this contract) and the name of the vendor(s) to whom you subcontract.	Yes	Please see **Section 9C** for a subcontractor list.

CONTRACTUAL	Indicate Confirmation: Yes or No	Explain any "No" response
b. Unless otherwise explained in this RFP, do you agree that you will not subcontract for any services related to the Scope of Work, without the prior written approval of the City?	No	BCBSAZ is unable to agree to the City's request because as a hospital medical service corporation we have significant contracts with a wide range of providers, including healthcare providers, third party administrator reimbursement entities and specialty contracted healthcare provider arrangements. An example of a "third party administrator reimbursement entity" is an entity that provides mental health services to Contractor's customers. In addition, BCBSAZ has normal service arrangements with information systems providers such as Microsoft, EDS and the drug claims processor.
c. Do you understand that if you use subcontractors in the delivery of services under this proposal your firm is responsible for the timeliness, accuracy, privacy, comprehensiveness, and reporting components of the subcontractor's services?	Yes	
d. Explain any of your current contractual relationships with a third-party firm in which the third party firm will be paid by the City either directly or indirectly during the course of the contract with the City (e.g. % of savings).	Yes	BCBSAZ pays service fees to all of the vendors noted in the subcontractor list in **Section 9C**. These fees are built into our overall administration fees.
6. Do you agree that you will not assign or transfer the rights or obligations of the contract or any portion thereof, without the prior written approval of the City?	No	Contractor cannot agree to obtain the City's prior approval for all subcontracting but does agree not to subcontract all or substantially all of the scope of work under this Agreement without the City's express written consent.

CONTRACTUAL	Indicate Confirmation: Yes or No	Explain any "No" response
7. Do you agree to maintain proper licensure as required by any state law where it relates to the services that you will be performing for the City?	Yes	
8. Do you agree that the City will determine eligibility for coverage?	Yes	
9. Do you agree that your contract includes an indemnification/hold harmless clause to protect the City?	Yes	
10. Describe any pending or closed lawsuits against your organization in the past 5 years.	Yes	BCBSAZ is involved in certain litigation regarding benefits. While it is not possible to predict the outcome of litigation, based on the status of the existing lawsuits, we do not believe the current lawsuits will have a material adverse effect on the company.
11. **HIPAA Compliance:** All Offeror systems and services must comply with the HIPAA EDI, Privacy, and Security regulations at all times. Do you agree to maintain adherence to federal HIPAA Privacy and Security regulations as it relates to the personal health information you receive about the City's plan participants during the proposal, implementation, contract, and post-contract periods?	Yes	
12. Are you willing to sign a contract with the City that indicates your firm will pay fines the City may be assessed as a result of your firm's noncompliance with HIPAA EDI, Privacy and Security regulations and pay costs associated with remedy of any breach your firm initiates?	Yes	
13. Will you sign the Business Associate Agreement included as part of this RFP in the City's Sample Contract item 15?	Yes	We will sign the agreement as modified in Exhibit E and provided in **Section 5**.

QUESTIONNAIRE PART A CONTENTS:

GENERAL INFORMATION

NETWORK COMPOSITION, NETWORK LOCATION AND NETWORK CLAIMS PAYMENT

REPORTING

ADMINISTRATIVE SERVICES

BEHAVIORAL HEALTH

CLAIMS PROCESSING

CLAIM SYSTEM

UTILIZATION MANAGEMENT (UM) GENERAL ADMINISTRATION AND UTILIZATION MANAGEMENT PRE-SERVICE REVIEW

CASE MANAGEMENT

HDHP/HSA ADMINISTRATIVE SERVICES

DISEASE MANAGEMENT PROGRAMS

WELLNESS SERVICES

STOP LOSS COVERAGE

COBRA ADMINISTRATION

PERFORMANCE GUARANTEES

*Questionnaire begins on next page.

GENERAL INFORMATION	OFFEROR RESPONSE
1. Background information about your organization:	
a. Organization's name	Blue Cross® and Blue Shield® of Arizona (BCBSAZ)
b. Address of your corporate headquarters	2444 W. Las Palmaritas Drive Phoenix, AZ 85021
c. Address of the location that will service the City's account	8220 N. 23rd Avenue, Bldg. #2 Phoenix, AZ 85021
d. Does your firm have any local offices?	Yes. Arizona locations are as follows: • 2121 W. Chandler Boulevard, Suite 115 Chandler, AZ, 85224 • 2444 W. Las Palmaritas Drive Phoenix, AZ 85021 • 5285 E. Williams Circle, Suite 1000 Tucson, AZ 85711 • 1500 E. Cedar Avenue, Suite 56 Flagstaff, AZ 86004
e. Date your firm became operational	1939
f. Date your firm became operational for the services requested in this RFP (indicate your years of experience with EACH product you are proposing)	PPO – 1984 HSA/Saver – BCBSAZ began contracting with HealthEquity to administer HSAs for our group clients in 2009. HealthEquity's experience offering HSA administration services goes back to 2004. Pharmacy Benefit Management Services – 1998 Stop Loss Coverage – 1982
g. Ownership of your firm	BCBSAZ is an independent licensee of the Blue Cross and Blue Shield Association. BCBSAZ is independently operated, with its own board and management, and is regulated by the laws of the State of Arizona. BCBSAZ is a not-for-profit organization.
2. Describe the **OVERALL ACCOUNT MANAGER for the City**:	
a. Name:	Ken Muth
b. Title:	Strategic Relationship Executive, National and Large Group Sales
c. City and State:	Phoenix, AZ

GENERAL INFORMATION	OFFEROR RESPONSE
d. Hours Worked:	8:00 a.m. to 4:30 p.m.
e. Length of time in current position:	1 year
f. Length of time with Offeror:	6 years
3. Describe **the PRIMARY DAY TO DAY CONTACT** for the City:	
a. Name:	Colette Severns
b. Title:	Client Service Manager
c. City and State:	Phoenix, AZ
d. Hours Worked:	8:00 a.m. to 4:30 p.m.

GENERAL INFORMATION	OFFEROR RESPONSE	
e. Length of time in current position:	7 years	
f. Length of time with Offeror:	7 years	
4. What are the most recent ratings for your company by the following:	**Rating**	**Month/Year of Rating**
Standard and Poor's (S&P) Duff and Phelps A.M. Best Moody's	BCBSAZ is not publicly rated. We do, however, comply with the significant liquidity and capital requirements of the Blue Cross Blue Shield Association (BSBCA) and meet the Arizona Department of Insurance's (ADOI) Risk-Based Capital Standards. In addition, Weiss Ratings (formerly TheStreet.com Ratings, Inc.) reviews our annual health statement as filed with the ADOI and the National Association of Insurance Commissioners (NAIC). We received an A+ in March, 2014, and have consistently received an A+ rating for the last nine years.	
5. a. Has your organization acquired, been acquired by, or merged with another organization in the past 24 months?	No.	
b. Is your firm anticipating restructuring or reorganizing in the next two years? (Include any major staff relocations or office closings.)	No.	
c. What is your plan for continuance of principles in the event of a reorganization or restructuring?	BCBSAZ has no plans to reorganize or restructure in the foreseeable future.	
6. Would you agree to attend onsite client meetings during the year, as requested (at no additional cost to the City)?	Yes, we will continue to attend onsite meetings, as requested by the City, at no additional cost.	
7. Implementation:		

GENERAL INFORMATION	OFFEROR RESPONSE
a. What is the minimum amount of implementation lead-time you need in order to initiate the proposed services for the City?	As a current BCBSAZ group, the City would have minimal renewal processes and little to no disruption to its members. Colette Severns, your current Client Service Manager, is available to assist with any needs to ensure a smooth renewal. The City also has Client Implementation Managers, Trisha Posser and Scott Salisbury, who are instrumental in renewal implementations. Please refer to **Section 9D** for a proposed renewal implementation timeline.
b. List any transition issues the City should consider with respect to moving services from an existing vendor to your services.	The City will not experience any transition issues if it continues with BCBSAZ as its carrier.
c. Are there any specific administrative procedures or information that your firm will need from the City in order to implement your services?	Not applicable.
8. a. Indicate the toll-free telephone number for use by participants if they have questions about the network (if proposing third party).	This is not applicable because we are proposing our own network.
b. What are the days and hours of operation of this number?	Not applicable.
9. a. Indicate the toll-free telephone number for use by participants when they call customer service.	The City's participants will continue to use their dedicated number at (866) 595-5993.
b. What are the days and hours of operation of the customer service center that will service this City?	The City's participants can walk in to any of our locations in Chandler, Phoenix, Tucson or Flagstaff for claims and customer service. Representatives at all locations also are available to handle calls. BCBSAZ maintains business hours of 8 a.m. to 4:30 p.m. (Arizona time) Monday through Friday. Members can call after normal business hours and reach our Interactive Voice Response (IVR) system. The IVR system enables providers and members quick and easy access to claims status, eligibility and benefits. Members also can go online via azblue.com to access eligibility, benefits, provider status and claim status. The IVR and Web access are available 24 hours a day, 7 days a week.

GENERAL INFORMATION	OFFEROR RESPONSE
10. When a participant calls your customer service number, is there an option to listen to choices in Spanish?	Yes. BCBSAZ has a prompt to direct Spanish-speaking callers to internal Mi Consejero Azul personnel rather than outside translators. Mi Consejero Azul is a concierge service providing end-to-end information including pharmacy, enrollment, out of area inquiries, medical review and coordination of benefits (COB). Members may reach Mi Consejero Azul by calling the number on the back of the identification card and pressing *.
11. When a participant calls your customer service number, are representatives available to converse in Spanish?	Yes.
12. Indicate how your representatives address issues, when participants call your customer service number and ask questions about the PPO network.	
a. Provide direct answers to all issues.	Yes, our customer service representatives are empowered to handle all claims and customer service issues.
b. Provide a separate number to call for further assistance.	No.
c. Provide a warm direct transfer, without interruption, to experts who then provide answers.	No.
13. a. Do you have a local (Arizona) office to support the City's plan members with questions?	Yes, the City's members can walk in to any of our locations in Chandler, Phoenix, Tucson or Flagstaff for claims and customer service. Representatives at all locations also are available to handle calls.

GENERAL INFORMATION	OFFEROR RESPONSE
b. Who will the City contact when they have questions?	BCBSAZ will support the City from our Phoenix office. We provide a framework of employer support to meet and exceed our clients' implementation, pre-open enrollment, open enrollment and ongoing needs. The City can contact its local team, which includes the following: **Strategic Relationship Executive (SRE)** Your SRE, Ken Muth, maintains overall responsibility for the BCBSAZ account management team, acting in a consultative and collaborative role. Additionally, Ken assists with the creation and execution of multi-year strategic plans to help you achieve your long-term goals. **Client Service Manager (CSM)** Your CSM, Colette Severns, manages all service aspects of your account by working with your staff to facilitate plan activities and address detailed service needs. This includes support for group enrollment and ongoing employee benefit meetings and elevated claim inquiries. **Client Implementation Manager (CIM)** Your CIM, Trisha Posser and Scott Salisbury, serve as your main contact during renewals and manage the internal BCBSAZ implementation team to ensure a seamless renewal. **Health Promotion Executive (HPE)** Your HPE, Jessica Dunn, provides wellness consultation and acts as the subject matter expert in the development, implementation and evaluation of worksite wellness programming. The HPE's primary role is to create an individualized, comprehensive strategy designed to engage employees and meet the City's wellness goals and objectives.

GENERAL INFORMATION	OFFEROR RESPONSE
c. Will the City have a dedicated or designated team to help with questions? Please explain.	Yes, the City's benefit staff will have a designated account team to assist with renewals and ongoing needs. However, BCBSAZ does not assign specific claims examiners and customer service representatives per group. Prior to effective dates or when there are benefit changes, claims and customer service representatives are trained on specific benefits for groups. The City's members will not have to wait for an assigned team member to answer questions, as all representatives have been trained.
d. Describe how your customer service team will work with the City.	We are committed to performing exceptional customer service and claims processing for the City. Our claims and customer service staff are one in the same and first trained as processors that advance very methodically to perform all services. Our staff is empowered to assist members at the point-of-contact. Our claims and customer service processing and telephone systems enable us to efficiently and accurately process claims while servicing members. This includes assisting with all customer inquiries such as benefits eligibility, provider network and status of claims. Additionally, we use staff located statewide to serve as back up to any department, should unexpected absences occur. Members find it extremely beneficial having a local processing and service center where they receive face-to-face assistance from dedicated staff knowledgeable about their benefits as well as the surrounding communities.
14. Do you agree to attend and present the following onsite events at no cost the City? a. Annual Open Enrollment (up to 15 meetings)	Yes.
b. Provide on-site support for one Benefits Fair, one Health Fair and on-site biometrics screenings for up to 8 other events per year	Yes.
c. Annual Benchmark Report	Yes.

GENERAL INFORMATION	OFFEROR RESPONSE
15. Please provide a specimen ASO Agreement and PBM Signature Ready Contract.	Please refer to **Section 10A** for a sample contract, which the City will be required to sign.
16. Provide a list of fields (claims status and history, id cards, etc) that participants can view when they log on to your website	Our BlueNet℠ online member resources, located at azblue.com, include the following: **Claims and Benefits** • Review your coverage and plan • View claims status and detail • Track deductibles • Verify enrollment status • Update account information • Access Explanation of Benefits (EOB) statements **Online Resources** • Find a provider, healthcare professional, facility or pharmacy • Use the healthcare cost estimate tool • Use the hospital comparison tool • Check prescription drug costs with our copay calculator • Order ID cards and download forms **HealthyBlue® Health and Wellness Resources** • Take your My BluePrint℠ health assessment • Participate in the *WalkingWorks®* walking program • Read interactive health guides • Review the self-care guide • Access many other health-related tools and resources Please refer to **Section 10B** for further information on BlueNet.

NETWORK COMPOSITION	OFFEROR RESPONSE
1. What is the name of your network?	BCBSAZ PPO Network
2. a. In Arizona, does your organization contract directly with providers or indirectly through a contract with another organization?	We contract directly with all providers except chiropractors. We also subcontract for some mental health administration.
b. If the latter, what is the network name?	We have a contract with American Specialty Health, and we use their chiropractic network to administer chiropractic benefits. We have a contract with Magellan Health Services Inc. to administer some mental health services.
3. a. Outside Arizona, does your organization contract directly with providers or indirectly through another organization?	We will contract with providers in states bordering Arizona if the providers are in a contiguous county of a border state and there is a network need. BCBSAZ enrollees have access to the national BlueCard® provider network, which covers members residing or traveling outside of Arizona. BlueCard providers are contracted directly with Blue Plans throughout the United States.
b. If another organization, what is the name of the organization and what is the fee you pay for this service?	Members have access to the national BlueCard provider network, which covers members residing or traveling outside of Arizona. BlueCard providers are contracted directly with Blue Plans throughout the United States. BlueCard fees are included in the Attachment Point rate and are charged on the monthly invoice as a claim expense.
c. If there is a fee, is it included in your proposed administration fee or is it billed to the City?	BlueCard fees are included in the Attachment Point rate and are charged on the monthly invoice as a claim expense.
d. If billed to the City, what is the amount of the fee?	BlueCard fees are considered a claim expense and are noted on the monthly invoice. The fees will vary each month based on out-of-state claim activity. BlueCard fees for 2015 for an account with more than 1,000 enrollees consist of an administrative allowance of $9.75 per institutional claim, or $4.00 per professional claim, as well as an access fee of 2.67% of savings up to $2,000 per claim.
4. Do you offer reciprocity arrangements for members who travel outside the service area and need emergency treatment?	

NETWORK COMPOSITION	OFFEROR RESPONSE
a. Emergency treatment?	Yes, members have access to the national BlueCard provider network, which covers members residing or traveling outside of Arizona. Please refer to **Section 10C** for a BlueCard flyer for more information.
b. Non-emergency treatment?	Yes, members have access to the national BlueCard provider network, which covers members residing or traveling outside of Arizona. Please refer to **Section 10C** for a BlueCard flyer for more information.
5. In the state of Arizona, can your network providers deliver services for the following specialized treatment conditions?	**Please answer only Yes or No**
a. Care for major burns	Yes.
b. Organ transplants	Yes.
c. Bone marrow transplants	Yes.
d. Specialized cancer treatments such as Proton Beam Radiation	Yes.

NETWORK COMPOSITION	OFFEROR RESPONSE
e. Neonatal care	Yes.
f. Fertility treatments	Yes.
6. Is the Arizona Mayo Clinic a contracted provider in your network?	No, we have not included Arizona Mayo Clinic as a network provider; however, if requested we can add it as an in-network provider, subject to a rate adjustment. The Arizona Mayo Clinic is a contracted provider for transplants only.
7. Is the Arizona Mayo Hospital a contracted provider in your network?	No, we have not included Arizona Mayo Hospital as a network provider; however, if requested we can add it as an in-network provider, subject to a rate adjustment. The Arizona Mayo Hospital is a contracted provider for transplants only.
8. Does your network contract with Mayo Hospital in locations outside Arizona?	Yes.
9. Does your network contract with Mayo Clinics in locations outside Arizona?	Yes.
10. If the City were to add Mayo Clinic and Hospital to their plan(s):	
a. Would your medical administrative fee increase? If yes, provide the amount and an explanation for any increase.	No.
b. Would your specific stop loss premium rate increase? If so, please provide the amount.	Yes, it would increase 4.0%.
c. Would your aggregate stop loss premium rate increase? If so, please provide the amount.	Yes, it would increase 2.0%.
d. How much should the City anticipate their claims cost will increase with the addition of the Mayo Clinic and hospital and what would be the impact to the aggregate attachment factor(s)?	The City's claims cost and aggregate attachment factor will increase approximately 2.0% with the addition of the Mayo Clinic and Hospital.
11. Does your network contract with Cancer Treatment Centers of America?	No.
12. Does your network contract with Scottsdale/Lincoln Healthcare?	Yes.

NETWORK COMPOSITION	OFFEROR RESPONSE
13. Does your network contract with Gilbert Hospital?	No.
14. a. Does your network contract with "Centers of Excellence" for organ transplants?	Yes.
b. If so, please explain.	The Blue Cross Blue Shield centers of excellence program is Blue Distinction®. Blue Distinction Centers for Transplants (BDCT) consist of a national network of transplant centers that provide comprehensive transplant services through a coordinated, streamlined referral management program. All of the centers in the BDCT network meet specific participation criteria that consider not only provider qualifications and program process, but patient outcomes as well. Each of these facilities is designated for one or more of the following types of transplants: • Heart • Lung • Liver (deceased and living donor) • Pancreas (adult transplants only) • Bone Marrow/Stem Cell
c. Provide a list of those used in Arizona.	Mayo Clinic Arizona Hospital is a Blue Distinction for Transplant facility.
15. a. Do you anticipate a change in the size or location of your PPO network in the next year, which would affect the City's population?	No.
b. Outline anticipated network changes for:	
i. Physicians	No significant changes are anticipated.
ii. Hospitals	No significant changes are anticipated.
16. Indicate major hospital contracts scheduled for renewal in the next 12 months for:	

NETWORK COMPOSITION	OFFEROR RESPONSE
a. Maricopa County	Hospital contracts are evergreen and auto-renew each year, unless contract renegotiations are requested or they request to be terminated. BCBSAZ stipulates that either party may terminate the agreement, without cause, by providing the appropriate written notice to the other party. Also, providers may be terminated based on quality concerns or if a provider's license is revoked by the governing board. Although BCBSAZ cannot guarantee the participation of any particular provider, we will make our best efforts to contract with providers as requested.
b. Arizona (other than Maricopa County)	Hospital contracts are evergreen and auto-renew each year, unless contract renegotiations are requested or they request to be terminated. BCBSAZ stipulates that either party may terminate the agreement, without cause, by providing the appropriate written notice to the other party. Also, providers may be terminated based on quality concerns or if a provider's license is revoked by the governing board. Although BCBSAZ cannot guarantee the participation of any particular provider, we will make our best efforts to contract with providers as requested.
17. Indicate if any providers in your PPO network are compensated on a capitated basis, the types of services they provide, and the name of any exclusive entities that you contract with?	BCBSAZ has a capitation contract with American Specialty Health Network for our chiropractic network and Magellan for our Behavioral Services Administrator (BSA) for services from Biodyne.
18. List the PEPM or PMPM fees that will be charged to the City for each capitated service proposed?	For chiropractic, the PMPM rate(s) for chiropractic services applicable to the City is: $2.93 PMPM The PMPM capitated fee(s) BCBSAZ pays the chiropractic provider is: $2.62 PMPM For behavioral health services, the PMPM rate(s) the City pays BCBSAZ is: $2.13 PMPM for Red and Blue Plans The PMPM capitated fee(s) BCBSAZ pays the BSA is: PPO $1.94 PMPM for Red and Blue Plans

NETWORK COMPOSITION	OFFEROR RESPONSE
19. Are there any situations where the fee you charge for capitated services differs from what you pay the provider? If so, do you keep any overages or are those returned to the City?	Biodyne BCBSAZ contracts with a behavioral services administrator (BSA). The City currently provides these optional behavioral health services to its employees enrolled in the Red and Blue PPO plans. The BSA makes medical necessity determinations based on its own medical necessity criteria. Services through the BSA are only available in Arizona. Cost for services provided by the BSA, 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 BSA. The BCBSAZ allowance (the difference between the PMPM rate BCBSAZ charges the Employer and the capitated fee BCBSAZ pays the BSA) in effect as of the Employer's contract effective date may change over the course of the Employer's contract year if BCBSAZ negotiates a different rate with the provider during the Employer's contract year. The PMPM rate BCBSAZ charges the employer is subject to change by BCBSAZ upon 60 days prior written notice. The PMPM rate(s) the Employer pays BCBSAZ and the PMPM capitated fee(s) BCBSAZ pays BSA are only applicable to Arizona enrollment. Chiropractic Costs for covered services provided by a chiropractor to PPO, EPO and indemnity members will be paid by the Employer to BCBSAZ on a per member per month (PMPM) basis. The PMPM rate BCBSAZ charges the employer is subject to change by BCBSAZ upon 60 days prior written notice.
20. How many urgent care facilities do you have in your network that have after hours (nights and weekends) care within the zip code of 850 and 852?	We have 83 urgent care facilities with after-hours care within zip codes 850 and 852.
21. Indicate which "walk up" clinics are in your network.	We have the following retail clinics in our network: • MinuteClinic • Healthcare Clinic • The Little Clinic

NETWORK COMPOSITION	OFFEROR RESPONSE
22. All medical network pricing must be provided on a transparent/pass through basis.	Yes, BCBSAZ's provider discounts are transparent and fully passed through to the City and its members.

23. Please complete the following chart on the terms of these key providers (please insert an X for the appropriate payment arrangement (i.e. DRG, Per Diem, Discount of Charge)

Name of Key Provider	When is the Next Scheduled Contract Negotiations Date	Date Next Contract Expires for the PPO	DRG	Per Diem	Discount off Charges
Banner Desert Medical Center	4/1/16	No expiration date – evergreen	X		
Chandler Regional Hospital	2/1/16	No expiration date – evergreen	X		
St. Joseph's Hospital and Medical Center	2/1/16	No expiration date – evergreen	X		
Gilbert Banner Gateway	4/1/16	No expiration date – evergreen	X		
St. Luke's Medical Center	5/1/15	No expiration date – evergreen	X		
Scottsdale/ Lincoln Healthcare	8/1/16	No expiration date – evergreen	X		
Gilbert Hospital	N/A (not contracted)	N/A (not contracted)	N/A		

NETWORK COMPOSITION	OFFEROR RESPONSE
24. Please describe any international coverage you provide for plan participants who travel or live outside the United States.	BCBSAZ participates in a BlueCard® Worldwide process to adjudicate international claims, which includes currency conversion and translation to English. BlueCard Worldwide provides access to doctors, hospitals and other healthcare professional around the world. To locate an international provider, or for translating foreign languages and submitting claims, your employees can call 1-800-810-BLUE (2583) or call collect at 1-804-673-1177. Employees can also find this information on the BlueCard program and a link to the BlueCard Doctor and Hospital Finder at bcbs.com.

NETWORK LOCATION	OFFEROR RESPONSE
1. How is continuity of care maintained if the City were to change to your organization?	As the incumbent carrier, the City would not experience any transition or continuity of care issues if it renews with BCBSAZ.
2. Using the number of employees on the census, please provide a Geo Access report based on the criteria below and further indicate the locations (city, town, state, and zip code) where your network **does** and **<u>does not</u>** have coverage.	Please refer to **Section 9E** for the requested GeoAccess reports.
a. 2 PCPs within 10 miles (include family practice, general practice, internal medicine, pediatricians and OB/GYN)	99.6% of employees meet the PCP access criteria.
b. 2 Specialists within 10 miles	99.6% of employees meet the specialist access criteria.
c. 1 Hospital within 10 miles	96.1% of employees meet the hospital access criteria.
3. Please submit an electronic copy of your medical provider directory. The electronic copy of your Maricopa County network provider directory for your PPO network are to be based on the following file specifications: • File format: Excel (preferred), Access, or ASCII text file	Please refer to **Section 10D** for an electronic copy of the PPO provider network for Maricopa County.
• Provider last name (Please do not put generation indicator i.e. Jr. III…or designation such as MD or DC, etc. in this field)	
• Provider first name (Please do not combine first and last names in the same field)	
• Provider middle initial	
• Street address (Only include physical locations, not billing addresses such as P.O. Box)	
• City	

NETWORK LOCATION	OFFEROR RESPONSE
• 5-digit zip code (Some zip codes start with 0. Please do not use number format which deletes the 0)	
• Tax ID Number (preferred) or National Provider ID	
• Type of provider (primary care, chiropractor, hospital, etc.)	
• **Degree (MD, DO, DPM)**	
• Network Indicator (if proposing different networks for the 3 tiers)	
• **Facilities should be shown in a separate list from professional providers**	
The Offeror may also include any other fields that are in its data files but only the fields listed are required.	

NETWORK CLAIMS PAYMENT	OFFEROR RESPONSE
1. a. Are there any penalties incurred by the City when claims payments do not occur within a certain number of days (i.e., the discount is not valid if claims are not paid within 30 days of when submitted)?	No.
b. What other penalties should the City be aware of that are included in your contracts?	There is a $500 charge to the in-network provider if the provider does not obtain precertification. There is a $500 charge to the member if an *out-of-network* provider fails to obtain precertification.
2. List all of the scenarios in which your discounts cannot be applied to bills submitted by network facilities or physicians (e.g., workers comp, third party liability, etc.).	Provider contractual rates do not apply to non-covered services. If a provider has a member sign a waiver for services that could be deemed as experimental or investigational, then the provider is allowed to collect billed charges. When there are services to which a member is entitled under a benefit plan and also covered under another group health plan, BCBSAZ and the provider will cooperate to coordinate benefits. The total of all payments will not exceed the provider's billed charges.
3. Do you actively negotiate out-of-network claims on behalf of the plan or do you only apply your out-of-network reimbursement level?	BCBSAZ provides large claim negotiation services for non-network expenses for specific cases approved by the Medical Director. An additional fee is not applicable for this service.

4. Please complete the table below.

Tests	Allowed to be Completed in a Providers Office (Yes/No)	Discuss when a provider is unable to provide the test in the office	Are test results displayed in member's website?
Throat Cultures	Yes	Patient is referred to a facility (i.e., retail health center, urgent care center, hospital).	No
Blood Pressure	Yes	Patient is referred to a facility (i.e., retail health center, urgent care center, hospital).	No
Blood Draws	Yes	Patient is referred to a lab facility.	No
X-Rays	Yes	Patient is referred to a radiology facility.	No
EEG	Yes	Patient is referred to a radiology facility.	No

NETWORK CLAIMS PAYMENT		OFFEROR RESPONSE	
EKG	Yes	Patient is referred to a radiology facility.	No

5. Please complete the following table as it relates to annual trend factors.

	Self Funded 2013 Medical & Rx Trends	Self Funded 2012 Medical & Rx Trends
Actual Trend Factors PPO (Maricopa County, AZ)	Arizona (including medical and Rx): 11.0%	Arizona (including medical and Rx): 11.0%
Forecasted Trend Factors PPO (Maricopa County, AZ)	Arizona (including medical and Rx): 11.0%	Arizona (including medical and Rx): 11.0%

REPORTING					
1. Do you agree to provide the following reports as identified in the table below? Please indicate if your report is available online to the City (and/or their consulting firm). Please include sample reports.					
Report Type	**Monthly**	**Quarterly**	**Annually**	**Offeror Response (Y or N)**	**Online Access (Y or N)**
Enrollment (subscriber/member) by plan option, by coverage tier for each employer	X			Y	Y
Paid Claims (Medical and Pharmacy)					
➢ By Plan Option	X			Y	Y
➢ By Type (medical fee for service, capitated, Rx)	X			Y	Y
➢ By Status (Active, Retiree, COBRA)	X			Y	Y
➢ By Member Cost-Sharing by Plan Option	X			Y	Y
➢ Overpayments BCBSAZ is willing to discuss.		X		N	N
Large Claim Report - $50,000 with diagnosis					
➢ By Plan Option	X			Y	Y
➢ By Status (Active, Retiree, COBRA)	X			Y	Y
Other Claims Reports (Medical and Pharmacy)					
➢ Claims Lag		X		Y	Y
Network Utilization					
➢ In-Network	X			Y	Y
➢ Out-of-network	X			Y	Y
➢ Out-of-State	X			Y	Y

REPORTING					
Utilization Management					
➢ Precertification			X	N	N
➢ Case Management BCBSAZ provides detailed utilization management reporting on an annual basis. We may be able to provide other customized case management reports, subject to mutually agreeable report formats.			X	Y	Y
Wellness Programs					
➢ Utilization			X	Y	N
➢ ROI Savings BCBSAZ considers wellness programs part of our value-added HealthyBlue suite of services; therefore, BCBSAZ does not report separate wellness ROI savings to our large employer groups.			X	N	N
Disease Management					
➢ Utilization Risk Stratification (baseline and YTD)			X	Y	N
➢ Clinical Goals Compliance			X	Y	N
➢ ROI Savings BCBSAZ considers disease management part of our value-added HealthyBlue suite of services; therefore, BCBSAZ does not report separate wellness ROI savings to our large employer groups.			X	N	N
Stop Loss Reports					
➢ Identify when participants have accumulated paid claims greater than or equal to 50% of the specific stop loss, including primary diagnostic code.	X			Y	Y

REPORTING					
➢ Provide pended claims.	X			N	N
➢ Large Claims Report including Case Management Status			X	Y	Y
Medical Utilization Benchmarks (Client Industry Specific and Book of Business)					
➢ Client Industry Specific			X	Y	Y
➢ Book of Business			X	Y	Y
Other Reports					
➢ Vendor Payments (e.g. stop-loss, PBM, etc.)	X			N	N
COBRA Reports					
➢ Comprehensive COBRA admin tracking, Premiums Collected	X			Y (through Sterling)	
➢ Performance Guarantee Reporting		X			N/A
Ad Hoc Reporting Capabilities					
➢ Ability for the City to generate Ad Hoc Reports	Determined by the City			Y	Y

2. Will the above information be provided online to allow the City or its Consultant to drill down on the data?	Yes. Our reporting tool BlueInsight℠ offers the ability to drill down on the data. BlueInsight enables our clients to track medical, dental and pharmacy claims-utilization data and to perform aggregate or detailed-level data analysis. Its features allow quick identification of issues, trends and variations from benchmarks. By identifying cost and utilization data, groups are empowered to manage insurance plans to meet their unique and specific needs. Please see **Section 10E** for a BlueInsight brochure and sample reports.

ADMINISTRATIVE SERVICES	OFFEROR RESPONSE
1. a. Do you have the ability to administer claims based on the City's current plan designs (please review Section 5 Current/Historical Information item 1. Current Medical Benefit Plan Design) and will not ask the City to alter any of their plan of benefits in order to accommodate your computer systems? Please answer yes or no only after you have carefully reviewed the benefit designs	Yes, we can continue to administer the City's current plan designs without any member disruption to benefits.
b. If no, list all the benefits that will **NOT** be able to be adjudicated by your claims system without some modification in **Offer Section – Deviations** and indicate your proposed alternative. Do not simply indicate your standard benefit provisions will apply.	Not applicable.
c. Are you able to administer a High Deductible Health Plan with HSA?	Yes, we can continue to administer the City's current HDHP with the HSA.
2. Indicate how you manage Coordination of Benefits (COB): a. Pre-payment or post-payment?	We manage COB post-payment.

ADMINISTRATIVE SERVICES	OFFEROR RESPONSE
b. What procedures do you perform to determine the presence of other coverage (e.g., use claim detail, open enrollment query, annual query, etc.)?	BCBSAZ follows National Association of Insurance Commissioners (NAIC) guidelines to coordinate benefits for medical claims and determine which carrier is primary and which is secondary. During enrollment, we require members to complete an application and provide Coordination of Benefits (COB) information, if applicable. If BCBSAZ is primary, the claim is adjudicated immediately; if secondary, a copy of the primary carrier's explanation of benefits (EOB) is requested from the member to determine payment. If no COB is indicated, we process claims in accordance with standard procedures and pay as primary. If COB is later identified, BCBSAZ pursues COB retrospectively. Our corporate policy is to "pay and pursue." We will send a query letter to the member and an inquiry to the other carrier. If we determine that the other carrier should have paid as primary payer, we will seek reimbursement of overpayment. We do not coordinate benefits for prescription claims processed at retail pharmacies.
3. How is your staff informed of new State or Federal legislation affecting a health plan or benefit (e.g., medical, pharmacy, etc.)?	State and federal legislation updates are provided via periodic internal and external meetings and electronic communications.
4. Are your written communication materials bilingual?	Yes. BCBSAZ prepares Summaries of Benefits and Coverage (SBCs) in both English and Spanish. Many of our health and wellness materials currently are available in Spanish. We have found that it is more advantageous to meet with clients and determine what their specific needs are so we can ensure the necessary materials are available in Spanish.
5. Please provide a sample of the monthly claims billing and administrative fees invoice.	Please refer to **Section 10F** for the sample invoices.
6. Please provide a sample of the monthly accounting report for all fees paid.	Please refer to **Section 10F** for the sample report.

ADMINISTRATIVE SERVICES	OFFEROR RESPONSE
7. Can you accept eligibility files in electronic format?	Yes. BCBSAZ enables groups that have HR systems or use other online enrollment software to send enrollment via a secure file transfer protocol (SFTP) site, which is provided to the group or vendor. Clients can send eligibility files using the standard HIPAA 834 EDI file layout, an 834 flat file, 834 XML format or a proprietary file. Eligibility files are generally received on a weekly basis but also can be sent daily, bi-weekly or monthly. Full files are preferred. Once the electronic file is received, BCBSAZ will make the appropriate changes to our membership system.
8. Do you have a secure web-based eligibility system the City's staff may use to upload eligibility?	Yes, we have an online enrollment application, which allows Group Benefit Administrators (GBAs) and those with rights assigned by the GBA to submit adds, changes and deletions electronically through the BlueNet employer portal at azblue.com. Please refer to **Section 10B** for a BlueNet employer flyer.
9. Does your system allow the City to add and delete employees from eligibility?	Yes.
10. Does your system support on line real time eligibility inquiries by the City?	Yes, this is available via the employer portal.
11. Please describe your banking requirements.	BCBSAZ offers a unique banking arrangement, using our own funds to pay the City's claims and then requesting reimbursement for claims paid. This arrangement eliminates the need for the City to have a separate bank account to pay claims. We also offer two different ways for the City to pay administration fees and claims costs: wire transfer or through our employer portal. Our clients find this saves administrative time, reduces banking fees and provides assurance that payments are made based upon actual claims incurred.

ADMINISTRATIVE SERVICES	OFFEROR RESPONSE
12. If you fail to take appropriate actions to pay and send claims to the stop loss insurer within the required timeframe, do you agree to financially reimburse the City for the lack of stop loss reimbursement the City will have incurred?	Under the current arrangement, BCBSAZ is both the medical claims administrator and stop loss vendor; therefore, reimbursements of stop loss violations take place automatically. The reimbursements are in the form of a claims credit on a subsequent monthly claims invoice. A monthly notification of claimants exceeding a predetermined level, usually 50 percent of the specific stop loss level will be delivered to the group along with its monthly claims invoice. If another stop loss insurer is used, BCBSAZ will not commit to financial responsibility until we are provided details of filing requirements. If a BCBSAZ competitor is awarded the stop loss, the following applies. BCBSAZ forwards to the stop loss carrier a monthly notification of claimants exceeding a pre-determined level–usually 50 percent of the specific stop loss level. If the stop loss carrier requests a different level, BCBSAZ will be able to comply. If a competitor of BCBSAZ is awarded the stop loss coverage for members administered by BCBSAZ, we will be unable to guarantee that we would provide all requested claims detail to the competitor.
13. Indicate which reinsurance/stop loss carriers with whom you are approved to work.	BCBSAZ is willing to work with any stop loss carrier, with the exception of vendors owned by health insurance companies.
14. Are all of your additional fees and charges not covered under your basic fees detailed on the Excel Financial Workbook (Attachment E)?	Yes. Incurred claims could include BlueCard access fees which are charged only on claims incurred out of state. BlueCard access fees allow BCBSAZ clients to enjoy Blue Cross Blue Shield negotiated discounts at a national level.
15. The City's plan includes subrogation. Please explain who provides these services and the cost for subrogation services you are proposing.	BCBSAZ provides subrogation service through a contracted third-party vendor, SCIOinspire Corp. Our vendor's fee is 25 percent of all subrogation recoveries. BCBSAZ does not receive any compensation for subrogation services.
16. If a provider makes a mistake with handling a transition/continuity of care case what will you do to assist the plan participant in seeking the appropriate care?	Our Transition of Care Program outreaches to patients before they are discharged to ensure that proper transition and continuity of care occurs and reduces the number of readmissions.

BEHAVIORAL HEALTH	OFFEROR RESPONSE
1. Do you have the ability to maintain an eligibility database for pre-certification of services?	Yes, our system can auto-adjudicate claims based on pre-certification, authorization, referrals and provider status for both in- and out-of-network claims. The information is used to verify eligibility, benefit level, network provider status, medical criteria and pricing.
2. Can you provide 24-hour telephonic access, seven days a week, to crisis mental health and substance abuse triage and counseling by trained, licensed professionals, with all calls logged?	PPO enrollees have access to behavioral health benefits through BCBSAZ and Biodyne, our Behavioral Services Administrator (BSA). HSA enrollees have access to behavioral health benefits through BCBSAZ. PPO: Yes, Biodyne/Magellan has a 24-hour crisis line. PPO/HSA: Members can call our Nurse on Call line, which is available 24 hours a day, seven days per week.
3. Please confirm your providers are skilled in the management of the array of mental health and substance abuse diagnoses, including but not limited to child abuse, rape, sexual harassment, culturally diverse issues, conduct disorder, psychoses, sex/marital issues, ADD, etc.	Yes.
4. Do you have the ability to adequately service ethnic/culture/native language diversity?	Yes.
5. It is important that continuity of care be maintained. Please describe how you will handle transition issues with respect to moving Behavioral Health and Substance Abuse services from the current vendor to your firm.	As the City's current vendor, there will not be any continuity of care issues if it renews with BCBSAZ.
6. Indicate the type(s) of providers that currently have contracts with your network:	
a. Physicians, counselors, all mental health and substance abuse specialties except.	Yes.
b. Mental health/substance abuse hospital(s).	Yes.
c. Other ancillary providers (describe).	Other types of providers, contracted through

ADMINISTRATIVE SERVICES	OFFEROR RESPONSE
	BCBSAZ and Biodyne, include: • Master Therapy • Licensed Clinical Social Worker • Psychiatric Nurse Practitioner • Behavioral Analyst • Residential Treatment Center • Eating Disorders Facility

ADMINISTRATIVE SERVICES	OFFEROR RESPONSE
7. What type of cases or specialized treatment conditions cannot be provided by the hospitals in your network (i.e., anorexia, bulimia, severe psychosis, commitment)?	All types of cases and treatment conditions can be provided by the facilities in the BCBSAZ and Biodyne networks.
8. Where can these services be provided?	This is not applicable as all types of cases and treatment conditions are provided by the hospitals in the BCBSAZ and Biodyne networks.
9. Describe where assessment and therapy sessions will take place (in a central location, at individual office locations, etc.).	Assessment and therapy sessions could take place in inpatient or outpatient settings, in individual offices, or care facilities, depending on the situation and needs of the member.
10. Do you currently have an adequate number of staff to provide counseling services to the City? If not, do you propose expanding your staff to adequately cover?	Yes, as the incumbent, BCBSAZ has been providing the requested services to the City for more than four years and will continue to provide our same level of excellent customer service. We evaluate our staffing needs continually and adjust as necessary to ensure adequate staffing at all times.
11. In what situations will a counselor or provider provide onsite assistance to patients at the emergency department or other locations?	Onsite assistance will be provided in an emergency or crisis situation.
a. Is this service included in your basic fees?	Yes, when in-network providers are utilized.
b. If not, please outline any fees.	Member benefits would apply.
12. Exhibit G to this RFP is a Census of the City's employee and retirees. Are there any areas where your providers are not available using the criteria of 2 providers within 10 miles and 1 hospital within 10 miles?	For the PPO plan, 1.4% of employees do not meet the provider access criteria, and 37.1% of employees do not meet the hospital access criteria. For the HSA plan, 1.5% of employees do not meet the provider access criteria, and 37.1% of employees do not meet the hospital access criteria. Please refer to **Section 9E** for the PPO and HSA behavioral health GeoAccess reports.

CLAIMS PROCESSING	OFFEROR RESPONSE
GENERAL INFORMATION	
1. Regarding your client base in the office proposed to service the City:	
a. Number of cities you currently serve at this location.	We service all cities in Arizona.
b. Number of total lives that these clients represent.	There are nearly 309,000 members in our large groups.
c. On average, how long have these clients been under contract with you?	Our large group clients have been with us, on average, for 6.5 years.
2. Do you agree to provide summary and claim level line item detailed accumulator data to the City's next firm at the termination of your contract at no additional charge within 30 days of the date of your termination?	We provide a Termed Deductible Report 30 days after a group terms at no additional charge. However, the report is at the summary (member) level and not the at the claim level.
3. Does your EOB include:	
a. Specific instructions on exactly HOW to appeal?	Yes.
b. Specific information on the timeframes for appealing?	Yes.
c. Attach a copy of the front and back of the EOB you plan to use for the City.	Please refer to **Section 10G** for a sample EOB.
d. Provide a copy of the information you send to explain how a claim can be appealed.	Please refer to **Section 10H** for appeals information.

CLAIMS PROCESSING	OFFEROR RESPONSE
4. Claim Appeals	
a. Please confirm your services include all appeal levels communicating to the City when appropriate.	Yes.
b. What is your process for coordinating with independent external appeal organizations?	BCBSAZ conducts the first two levels of appeals in-house; however, members may request an independent review organization (IRO) review for any level. We contract with three URAC-accredited IROs, and coordination may include level one specialty review, as well as levels 2-3 external review. We have processes in place to receive timely response from the IRO's.
c. Indicate the name and address of the Independent Review Organizations (IRO) used by your firm.	We use the following IROs: • Advanced Medical Reviews, Inc. 10780 Santa Monica Blvd, Suite 333 Los Angeles, CA 90025 • AllMed Health Care Management Inc. 621 SW Alder St, Suite 740 Portland, OR 97205 • MCMC LLC 300 Crown Colony Drive, Suite 203 Quincy, MA 02169
d. Is there a cost for use of the IRO's?	All levels of appeals are included in our administrative fee.
e. If yes, has it been included in your administrative fee or will it be billed to the City?	Not applicable.
f. If billed to the City, what is the fee?	Not applicable.
SYSTEM CAPABILITIES	

CLAIMS PROCESSING	OFFEROR RESPONSE
5. a. Do you have an automated method to identify and recover overpayments?	No, our method to identify overpayments is not automated; however, our method to recover overpayments is generally automated. Any overpayments collected by BCBSAZ will be returned to the City (note that not all recovery attempts are successful). We have extensive procedures for recovery of overpayments and payments made in error. If the amount is thirty-five dollars ($35) or more, BCBSAZ will: 1. Send a series of letters to the recipient requesting return of the overpayment; 2. If possible, offset the amount against future payments; 3. Refer uncollected debts to an outside collection agency; 4. Involve our special investigations unit if it appears that potential fraudulent activity occurred; and 5. Credit the account with the funds collected net of any collection agency fees. BCBSAZ or our outside vendor may not be able to recover the overpayment in the following situations: • BCBSAZ does not pursue collection of amounts less than $35.00. • Some of our provider contracts limit the amount of time we have to collect claims paid after termination. • Arizona Revised Statutes prevent us from recovering erroneously paid claims more than one year from the date paid. • Bankruptcy regulations prevent us from recovering erroneously paid claims from someone who has filed bankruptcy. • Similar provisions may apply to claims administered via the national BlueCard program.
b. Do you use a subcontracted vendor to identify and recover overpayments?	Yes. If BCBSAZ is unable to collect the debt, we will use an outside vendor, Vengroff, Williams and Associates, for recovery.

CLAIMS PROCESSING	OFFEROR RESPONSE
c. If you use a subcontracted vendor, is the cost borne by the City or part of your administration fees?	The recovery fees are 25 percent on the first $2,000 or less or 20 percent on amounts in excess of $2,000 collected per claim. These charges are passed on to the group; BCBSAZ will return recovered amounts to the group, net amounts retained by the collection agency or third-party vendor.
6. For claims that need additional information in order to adjudicate (such as needing an operative report, ER visits notes, ambulance records, student status, etc.):	
a. Do you pend those claims, or deny/close the claims?	If we require additional information to process a claim, we will pend the claim.
b. How long can a claim be listed as pended before you bring resolution to that claim?	A pended claim will remain pending in our system for a maximum of 45 days. If no information is received at that time, the claim is denied with a reason of "no records received."

CLAIMS PROCESSING	OFFEROR RESPONSE
PROCESSING TIME	
7. Based on the most recent 6 months, indicate:	
a. **Average number of calendar days to process a clean claim** from date received (including the time the claim is with the clearinghouse) to the date a check is issued to the provider/patient.	Our average clean claim processes in 4 days.
b. **Average number of calendar days to process a claim** from date received (including the time the claim is with the clearinghouse) to date EOB is sent to patient.	98.18% of claims are processed within 14 days.
c. What percent of all claims submitted (regardless of information provided on claim) have been processed (from date received to date EOB is issued) **within 14 calendar days**?	98.18% of claims are processed within 14 days.
d. What percent of all claims submitted (regardless of information provided on claim) have been processed (from date received to date EOB is issued) **within 30 calendar days**?	99% of BCBSAZ claims are processed within 30 days.
REIMBURSEMENT PROCEDURE	
8. In the absence of specific direction from the City, for non-network claims, indicate how you usually determine allowable charges for the following services. Indicate if you pay as billed or cut back the billed amount to an allowed charge using a database.	**Indicate if "paid as billed" or if a database is used indicate "database"**
a. Medical and surgical professional fees	Out-of-network reimbursements are based on BCBSAZ's fee schedule.
b. Assistant Surgeon fees	Out-of-network reimbursements are based on BCBSAZ's fee schedule.
c. Anesthesia professional fees	Out-of-network reimbursements are based on BCBSAZ's fee schedule.
d. Acute inpatient hospital	Out-of-network reimbursements are based on BCBSAZ's fee schedule.

CLAIMS PROCESSING	OFFEROR RESPONSE
e. Medical equipment	Out-of-network reimbursements are based on BCBSAZ's fee schedule.
f. Orthotic devices and prosthetics	Out-of-network reimbursements are based on BCBSAZ's fee schedule.
g. Outpatient hospital claims like endoscopy, PET scans, cath lab	Out-of-network reimbursements are based on BCBSAZ's fee schedule.
h. Ambulatory surgery	Out-of-network reimbursements are based on BCBSAZ's fee schedule.
i. Emergency Room	For emergency claims, BCBSAZ processes the claim using the BCBSAZ-allowed amount and applies in-network deductible and coinsurance. If a member receives emergency services from a non-contracted facility or professional provider, BCBSAZ will use the allowed amount to calculate the member's cost share on the provider's billed charges.
j. Emergency Room Physician fees	For emergency claims, BCBSAZ processes the claim using the BCBSAZ-allowed amount and applies in-network deductible and coinsurance. If a member receives emergency services from a non-contracted facility or professional provider, BCBSAZ will use the allowed amount to calculate the member's cost share on the provider's billed charges.
9. In lieu of the City's plan specific guidelines, do you have internal standard operating procedures for:	
a. Reimbursement of multiple surgical procedures performed through the same incision during one operation.	Yes, BCBSAZ applies incident surgical procedure editing in the claims processing software.
b. Reimbursement of multiple surgical procedures performed through separate incisions during one operation, (such as 3 procedures on the right foot and 3 procedures on the left foot during the same operative date of service).	Yes, BCBSAZ applies incident surgical procedure editing in the claims processing software.

CLAIMS PROCESSING	OFFEROR RESPONSE
c. If the City has specific guidelines for multiple surgical procedures that differs from your standard, can your system accommodate?	We are willing to work with the City to see if our system can accommodate the City's guidelines.
10. Describe what, if any, hospital bill audit procedures are in place to detect mischarges and inappropriate charges on hospital bills and/or the miscoding of DRGs.	BCBSAZ runs all inpatient hospital claims systematically through a grouper licensed to BCBSAZ to determine the correct DRG and does not automatically pay based on the DRG provided by the Hospital on the submitted claim. Specific DRG codes are identified which edit for pre-payment review to validate proper coding. We also suspend specific DRG claims where the discharge occurs within 24 hours of admission. When appropriate, medical records are requested and reviewed for proper coding. Specific DRGs are flagged to suspend for review and validation of coding. Hospital claims are included in routine claims audits. Internal Audit performs monthly routine claims audits and verifies that Diagnosis-Related Group (DRG) or other pricing methodology is correct and that benefits were applied correctly. BCBSAZ has a pre-payment review process to review hospital provider claims of $70,000 or more prior to releasing payment. This review is performed by Internal Audit. Additionally, BCBSAZ contracts with a hospital bill audit service to audit facility outpatient reimbursement. This is done by verifying accuracy of hospital charges against medical records. This review includes verification of charges and services to physician orders.
11. Is your interface with UM vendors (for decisions on precertification, length of stay, case management, and UR-negotiated fee discounts) electronic or paper?	When BCBSAZ elects to work with any outside vendor, all interfaces are electronic.
12. How do you administer subrogation for self-funded Cities (pay and pursue or pursue and pay)?	We pay and pursue for subrogation.

CLAIM SYSTEM	OFFEROR RESPONSE
1. a. Have you implemented a new claims system in the last 12 months?	No. BCBSAZ uses the MetaVance claims system from HPES. We implemented MetaVance Release version 2.9i in May 2012. This contained approximately 250 improvements, including HIPAA 5010 and ICD-10 enhancements, productivity enhancements and enhancements for different functional areas.
b. Are you planning to implement a new claims system in the next 24 months?	No.
c. Do you anticipate any major enhancement to your claims system in the next 12 months?	No, we continually make upgrades to our processing system throughout the year.
2. Do you have the ability to provide to the City (and/or their consulting firm) online access to your claims reporting systems?	Yes. Reports will continue to be available to the City using BlueInsight℠, our online reporting tool that is updated on the 20th of each month. BlueInsight is designed to provide comprehensive and flexible healthcare reporting and data management capabilities. The tool removes guesswork from managing the City's healthcare plan, offering hundreds of online reports and data elements to the client's authorized users. BlueInsight offers the ability to track medical, dental and pharmacy claims-utilization data and to perform aggregate or detailed-level data analysis. Its features allow quick identification of issues, trends and variations from benchmarks. By identifying cost and utilization trends, groups are empowered to make informed decisions to meet their unique and specific needs. Please see **Section 10E** for a sample BlueInsight brochure and report.
3. Do you capture/store the following data in your claims system:	
a. Group/policy number	Yes.
b. Client ID number	Yes.
c. Employee ID number or other unique identifier	Yes.
d. Claimant ID number or other unique identifier	Yes.

CLAIM SYSTEM	OFFEROR RESPONSE
e. Claimant relationship: employee, retiree, spouse and child	Yes.
f. Claimant gender/sex	Yes.
g. Claimant date of birth	Yes.
h. Separate claims data for COBRA (self-pay) participants.	No.
i. Provider name	Yes.
j. Provider type code	Yes.
k. Provider ID number (TIN and/or NPI)	Yes.
l. Provider address, city, state, zip code	Yes.
m. Type of Service	Yes.
n. Charged/billed amount	Yes.
o. Allowed amount	Yes.
p. Deductible, coinsurance and copay amount	Yes.
q. Discount amount	Yes.
r. Ineligible amount	Yes.
s. Paid amount	Yes.
t. Claim processed/paid date	Yes.
4. Explain what system you use and how you track and document inquiries from claimants.	BCBSAZ's Customer Service Representative's create what is called a "contact" on our MetaVance claims system for every call they receive. This information is documented with the date of the member's call, who called and the questions asked.

UTILIZATION MANAGEMENT (UM) GENERAL ADMINISTRATION	OFFEROR RESPONSE
1. What is the name of, and who owns, the UM firm you are proposing for the City?	BCBSAZ provides UM services in-house.
2. Indicate the location of the UM/Case Management office that will serve the City.	Our UM/Case Management office is located in Phoenix, Arizona.
3. Identify those individuals who will be responsible for the day-to-day service contact with the City.	Vickie Filson, Utilization Management Supervisor, will be the City's day-to-day service contact for UM services.
4. Describe how your firm assures confidentiality of medical information received during the UM process.	BCBSAZ has specific procedures and protocols in place throughout the UM process to ensure that we comply with all HIPAA privacy regulations.
5. Is your firm currently URAC accredited for utilization management services?	Yes. BCBSAZ was surveyed in January 2015 and was found to be 100 percent compliant with the URAC standards resulting in full accreditation status through January 2018.
6. Do you agree to notify the stop loss carrier of potentially large claims as they arise in the course of these services?	Yes. When a large claimant is identified one of our Senior Medical Directors will review the large claimants for appropriateness of care and services, Case Management engagement and overall plan. The Senior Medical Director will respond back to Case Management, acknowledging update and giving recommendations. The Senior Medical Director then will send an email notification to the sales team, actuarial, Chief Medical Office and the Vice President of Medical Management, Wellness, Health Services Innovation. Sales can then provide a report to the City and its stop loss carrier. If BCBSAZ continues as both the medical claims administrator and stop loss vendor, reimbursements of stop loss violations will take place automatically. The reimbursements are in the form of a claims credit on a subsequent monthly claims invoice. A monthly notification of claimants exceeding a predetermined level, usually 50 percent of the specific stop loss level, will be delivered to the group along with its monthly claims invoice.

UTILIZATION MANAGEMENT PRE-SERVICE REVIEW	OFFEROR RESPONSE
1. Does your firm perform pre-service review (also known as precertification, prior authorization) of proposed elective health care services?	Yes.
2. Which of the following services are reviewed under your pre-service review program:	**YES/NO**
a. Elective inpatient medical/surgical admissions	Yes.
b. Elective outpatient surgery	No.
c. Diagnostic services	No.
d. Durable medical equipment (DME)	No.
e. Corrective appliances/prosthetics	No.
f. Skilled nursing facility (SNF)	Yes.
g. Home health/home enteral, infusion therapy	Yes.
h. Musculoskeletal services (e.g., chiropractic)	No, however our third party vendor, ASHN, may pre-cert these services – see Chiropractic below.
i. Medical services (e.g., physical therapy, Dr.'s office visits)	No.
j. Psychiatric admissions (acute and residential)	Yes.
k. Psychiatric outpatient therapy services	No for BCBSAZ network providers; yes for Biodyne providers.
l. Substance abuse (e.g., detox, rehab.)	Yes.
m. Chiropractic Care	Yes for ASHN providers.
n. Other	

UTILIZATION MANAGEMENT PRE-SERVICE REVIEW	OFFEROR RESPONSE
3. Indicate which of the following your precertification program includes an analysis and determination of:	**YES/NO**
a. Appropriate level of care (e.g., inpatient versus outpatient)	Yes.
b. Reasonable length of stay (LOS) for inpatient confinement	Yes for long-term acute care, acute rehabilitation, skilled nursing facilities and other facilities paid on a per diem basis.
c. Actual medical necessity and appropriateness of the surgery or service being requested.	Yes.
d. Necessity for the services of an assistant surgeon with each operative procedure analysis	Yes.
e. Necessity for a proposed preoperative hospital day	Yes.
f. Necessity for a proposed 23-hour observation stay following outpatient surgery	No.

UTILIZATION MANAGEMENT PRE-SERVICE REVIEW	OFFEROR RESPONSE
g. Other: Explain	We also precertify the following: • Behavioral and mental health outpatient services from the behavioral services administrator, if available under your benefit plan • Inpatient dental services or procedures • Lifestyle education and management services, biofeedback and hypnotherapy, available only through the behavioral services administrator • Medications covered under the "Specialty Self-Injectable Medication" benefit, certain medications covered under the "Retail and Mail Order Pharmacy" benefit (if these medications are available under your benefit plan), and certain medications covered under the "Home Health/Home Infusion" benefit. The current list of specific medications that require precertification is available at azblue.com and is subject to change at any time without prior notice. • Organ, tissue or bone marrow transplants and stem cell procedures • Requests for services by an out-of-network provider for the in-network cost-share • Services directly associated with a cancer clinical trial
4. a. Would you agree to attempt to redirect pre-service callers to an appropriate in-network provider?	Yes.
b. If unable to redirect to an appropriate in-network provider would you document why not?	Yes.
c. Are there any instances when a service would be paid even if precertification were not obtained?	Yes.
5. Indicate the toll-free number and minimum hours of operation of your switchboard:	**Hours of Operation / Time Zone**
➢ Monday - Friday	8:00 a.m. to 4:30 p.m.

UTILIZATION MANAGEMENT PRE-SERVICE REVIEW	OFFEROR RESPONSE
➢ Saturday and Sunday	BCBSAZ offers weekend and holiday extended RN coverage for precertification requests related to immediate discharge planning. Hours will be extended to 8:00 p.m. on Friday and 8:00 a.m. to 4:30 p.m. on Saturday, Sunday and Holidays.
➢ Holidays	BCBSAZ offers weekend and holiday extended RN coverage for precertification requests related to immediate discharge planning. Hours will be extended to 8:00 p.m. on Friday and 8:00 a.m. to 4:30 p.m. on Saturday, Sunday and Holidays.
6. What type of system is available for receipt of pre-service calls before/after your normal working hours?	**Check One Only**
a. Answering machine with recorded message given	
b. Answering machine will accept receipt of messages	Calls received after hours, on weekends, or on holidays via the dedicated Care Management (for chronic/catastrophic health management) line are connected to an answering machine. The caller is instructed to leave a message, and the call is returned the next business day.
c. Answering service to receive messages	
d. Open 24 hours a day	
e. No provisions, except during normal business hours	

UTILIZATION MANAGEMENT PRE-SERVICE REVIEW	OFFEROR RESPONSE
7. Do you agree to perform telephonic concurrent review on applicable inpatient admissions, redirect to in-network providers (when possible), and refer to case management for additional follow up?	Yes, BCBSAZ concurrent review nurses call all members who are discharged from acute rehabilitation facilities, skilled nursing facilities and long-term acute facilities and select members discharged from acute care settings. The utilization management (UM) staff calls the member to: • Determine that the member is adjusting following discharge • Assess the need for home health care services, if not already in place • Verify that follow-up appointments were made as ordered at the time of discharge • Verify that durable medical equipment and/or medications needed are available • Assist the member in finding in-network providers • Refer to case management when appropriate
8. Describe the method and frequency of notification from your firm to the claims administrator about the cases that have received your pre-service review and concurrent review services.	BCBSAZ is proposing both claims administration and utilization management; therefore, all precertification and concurrent review information is entered real-time directly into the BCBSAZ claims processing system.

CASE MANAGEMENT	OFFEROR RESPONSE
(1) Does your firm perform case management?	Yes.
(2) How do you find cases to case manage?	Our URAC-accredited case management program identifies members through a variety of referral sources and triages through care coordination. Referral sources include direct phone calls from members/family and providers, internal referrals from other departments within BCBSAZ, online Web referrals, 24/7 Nurse On Call, and reporting mechanisms including hospital admission notifications, emergency room admission notifications, predictive modeling tools, claims data, high resource/utilization reports, authorizations and referrals from customer service.
(3) What types of cases do you identify for case management?	BCBSAZ case manages many conditions, but the most common situations include, but are not limited to the following: 1. Organ transplants 2. Endocrine dysfunction disorders (i.e., diabetes with complications) 3. Respiratory disorders (i.e., ventilator dependency, major trauma cases) 4. Neurological conditions/disorders (i.e., cerebrovascular accident (CVA), paraplegia/quadriplegia/hemiplegia) 5. Autoimmune disorders 6. Malignancies with or without metastasis 7. Placement in long-term acute care facilities, skilled nursing facilities, home health, or hospice 8. Hospitalizations that require continuous stay in any critical setting exceeding 10 days duration and multiple admissions during a quarter/year
(4) Describe the method and frequency of notification from your firm to the claims administrator about the cases that have received your case management services.	BCBSAZ is proposing both claims administration and case management; therefore, all notification is real time.

CASE MANAGEMENT	OFFEROR RESPONSE
(5) Do you agree to notify the claims administrator **PROMPTLY** of potentially large claims that you identify through your pre-service and case management activity?	Yes.
(6) During case management, do you agree to direct the patient and/or their health care providers to use in-network services?	Yes.
(7) Do you agree to provide the stop loss carrier case manager notes, course of treatment, pre-certification of hospital stays, surgeries or transplants approximately 60 days prior to the plan anniversary date?	This is not applicable, as BCBSAZ's proposal is to provide case management services, as well as medical and stop loss administration.

HDHP/HSA ADMINISTRATIVE SERVICES	OFFEROR RESPONSE
1. a. What is the name of the HSA administrator (i.e. the Medical TPA, a contracted partner)?	BCBSAZ is contracted with HealthEquity® to offer HSA administration. HealthEquity services are enhanced by claims and enrollment data integration between BCBSAZ and HealthEquity.
b. Are you a qualified HSA trustee or custodian?	Yes, HealthEquity is a non-bank trustee approved by the IRS.
c. Please explain the basis for your qualifications and the dates of qualification.	The date of HealthEquity's approval as a non-bank trustee was February 27, 2006. HealthEquity satisfied all U.S. Treasury Department requirements for approval, including: 1. State and date of incorporation 2. Continuity 3. Established location 4. Fiduciary experience 5. Financial responsibility 6. Capacity to account 7. Fitness to handle funds 8. Rules of fiduciary conduct Fidelity bond 9. Fidelity bond 10. Net worth
2 How long have you provided HSA administration services?	BCBSAZ first contracted with HealthEquity in 2009 to administer HSAs for its large group clients. Founded in 2002, HealthEquity is a personal healthcare financial services company that administers more than 100,000 healthcare accounts for 250,000 account holders and their dependents. Clients include Fortune 500 companies and thousands of small employers, via relationships with more than 30 health plan partners.

HDHP/HSA ADMINISTRATIVE SERVICES	OFFEROR RESPONSE

3. a. What information or administration services for HSA's are available on your website?	Members will continue to utilize a single sign-on from our online member portal to HealthEquity's member portal. HealthEquity offers a full-featured website to provide online employer information and HSA administration services, including:
	• Insurance Information
	• Employee Enrollment
	• Creating a coverage intent
	• Modifying an Employee's Coverage
	• Using the Employee Listing
	• HSA Contributions
	  ○ Making contributions
	  ○ Uploading a file
	  ○ Saved values
	  ○ Contribution calculator
	• Pay Invoices
	• Accessing Past Payments
	• Accessing Pending Payments
	• Modifying Employer Information
	• EFT Setup
	• Login Settings
	  ○ Adding logins
	  ○ User roles
	  ○ Email settings
	  ○ Reset user password
	  ○ Modify a login
	  ○ Inactivate a login
	• Reports
	  ○ Employee account summary report
	  ○ HSA account status report
	  ○ Contribution reports (Tax year & calendar year)
	  ○ Potential over contribution report
	  ○ PPD account numbers report
	• Employee Alerts
	• HSA Payroll Deduction Process
	
	For more information, please refer to **Section 10I** for the employer portal guide.

HDHP/HSA ADMINISTRATIVE SERVICES	OFFEROR RESPONSE
b. What tools are available to employees in order to review their claims, HSA account balances, determine cost of services, etc.?	Employee portal highlights include: • Online Payments to Providers (view claims data from BCBSAZ and pay provider with just a few clicks) • View Pending Payments • Online Reimbursements to Self • View Claims • Make Online Contributions • Contribution History • Transaction History (including debit card transactions) • Account Statements • Investment Desktop (trades via Charles Schwab with minimum balance) • Mobile app
4. Do you have a call center available to answer questions telephonically?	Yes. HealthEquity's member services team is available 24/7 to assist members with questions or provide education regarding their account(s).
5. Name the qualified HSA custodians/trustees (e.g. banks and insurers) with which you have a relationship and describe that relationship.	HealthEquity has been designated by the IRS as a non-bank trustee or custodian, which means they serve as the custodian and perform record-keeping for HSAs. A bank depository is used to deposit the funds, providing customers protection under FDIC. Communications will always originate from the vendor. They will have no need to interact with the depository. Our integration with HealthEquity includes: • Claims data • Enrollment data • Member portal single sign on BCBSAZ will continue to bill the City; however, the City will continue to work directly with HealthEquity to facilitate the funding of HSAs.

HDHP/HSA ADMINISTRATIVE SERVICES	OFFEROR RESPONSE
6. What services and reporting can the City and its employees expect from the HSA custodian/trustee?	HealthEquity provides an extensive portfolio of reporting to enhance the HSA experience for the City and its employees. The City can access on-demand reporting at any time through the HealthEquity employer portal. These reports will allow visibility for account status, card status, claims payments and plan funding. To comply with HIPAA requirements, these reports will suppress specific claim information. They can also send these reports via FTP or secure email. Please refer to **Section 10J** for sample reports. For employers with HSAs, the following reports are available: • Employee account summary • HSA account status • Contribution (tax year) • Contribution (calendar year) • Potential over contributions • PPD account numbers (optional for those clients set up for PPD) • Past payments report Employees can access the following: • Transaction history and claims history (can be downloaded in Excel format) • Tax forms 1099-SA and 5498-SA • A monthly statement The above information is archived, going back to the date the HSA was opened, for convenient access by the employee.
7. Explain the payroll and transfer of funds process from the employer to the bank.	The employer works with HealthEquity to provide contributions (both employer and employee dollars) as separate file feeds either directly from the employer or through support vendors.
8. Is a debit card available to plan participants?	Yes.

DISEASE MANAGEMENT PROGRAMS	OFFEROR RESPONSE
1. For the Disease Management Programs, indicate that you have included information in your response regarding all of the programs you are offering to the City.	HealthyBlue is BCBSAZ's integrated program that offers a total population health strategy to motivate our members to make healthier lifestyle choices, manage their risks and/or conditions to achieve the lowest health risk level possible. It is an integrated approach to managing the health status across the continuum of care: wellness and prevention, acute, chronic, and catastrophic. BCBSAZ's disease management programs provide personalized health support to help members modify their behaviors, change unhealthy lifestyles and better adhere to proven, evidence-based care guidelines. We provide NCQA-accredited disease management for all major chronic conditions, including: • Diabetes • Asthma • Maternity • Chronic Obstructive Pulmonary Disease (COPD) • Coronary Artery Disease (CAD) • Heart Failure (HF) BCBSAZ also offers self-help devices to qualified members in programs for HF, COPD and diabetes. The devices are a targeted intervention for qualified members that are in need of items such as scales for HF and other biometric devices. Real-time data is sent to the monitoring center. Outbound calls are initiated, if necessary, based on the data. Any significant findings are reported to the member's provider via our provider's report.

DISEASE MANAGEMENT PROGRAMS	OFFEROR RESPONSE
2. What methods and measures will you use to determine the effectiveness of your Disease Management Program with the City?	BCBSAZ provides a disease management outcomes report that captures the prevalence of disease for the total identified eligible population, measured by the following clinical performance indicators: • Disease-specific for each condition • Utilization indicators (i.e., emergency room (ER) visits, ER re-visits, hospital admissions and hospital re- admissions) • Financial performance indicators (i.e., per member per month costs) Please refer to **Section 10K** for a sample report.
3. Are you willing to include performance guarantees based on the effectiveness of your Disease Management Program? Please explain your response.	As the City's current carrier, BCBSAZ will continue to provide the programs and services it has come to expect. We are willing to work with the City to propose a disease management program performance guarantee if there are any areas the City would like us to improve upon.
4. Please check all of the disease management programs included in your proposal in the chart below:	

Conditions		Conditions	
Vascular:		**Neuro-Geriatric:**	☐
Heart failure	☒	Geriatrics	☐
Diabetes – adult & pediatric (CAD)	☒	Migraines	☐
Peripheral artery disease (PAD)	☐	Seizures	☐
Hypertension – adult & pediatric (high blood pressure)	☐	Parkinsonism	☐
Cerebrovascular disease/stroke (CVA)	☐	**Cancer:**	
Hyperlipidemia (high cholesterol)	☐	General cancer*	☐
Pulmonary:		Breast cancer	☐
Asthma – adult & pediatric	☒	Lung cancer	☐
Chronic obstructive pulmonary disease (COPD)	☒	Lymphoma/leukemia	☐
Orthopedic/Rheumatologic:		Prostate cancer	☐
Osteopenia*	☐	Colorectal cancer	☐
Osteoporosis	☐	**Renal:**	
Osteoarthritis* (OA)	☐	Chronic kidney disease	☐
Rheumatoid arthritis (RA)	☐	End stage renal failure	☐
Chronic lower back pain	☐	**Other:**	

Gastrointestinal:		Weight management – adult & pediatric	☐
Gastro esophageal reflux disease (GERD)	☐	Cystic Fibrosis – adult & pediatric	☐
Peptic ulcer disease	☐	HIV	☐
Inflammatory bowel disease (IBD) (Crohn's disease)	☐	Hypercoagulable state	☐
Chronic hepatitis	☐	Sickle cell disease – adult & pediatric	☐
		Depression*	☐
List Other Disease Programs Covered			
Maternity Management	X		
Coronary Artery Disease	X		

*Addressed as a co-morbid condition

WELLNESS SERVICES	OFFEROR RESPONSE
1. What methods and measures will you use to determine the effectiveness of your Wellness Services offered to the City?	BCBSAZ provides multiple reports for the HealthyBlue program from an overview of health risks and clinical outcomes to estimating productivity and risk changes for your employees. These reports are a valuable resource to evaluate the programs, prioritize specific program activities that are likely to have the greatest impact on future healthcare costs and communicate the value of your wellness program. Sample reports include: • **My BluePrint℠ Management Report**—This report provides aggregate data on the wellness of your employees who completed the My BluePrint Health Assessment. The City will receive a detailed report focused on assessing the wellness of its employees. BCBSAZ will personally deliver the report to the City, explain its contents and provide customized recommendations based on the data in the report. The City can use this report as a benchmark to offer programs and services to improve the wellness of employees and increase their productivity. We will continue to assist the City in enhancing its wellness program, based on the information in the report and our extensive health promotion and wellness experience. As always, respecting the privacy of employees who complete the health assessment is very important. Therefore, individual employee data in the report is anonymous, yet still provides crucial information to the City. • **Wellness Savings Cohort Report**—This report estimates healthcare and productivity savings from shifts in risk levels. This report can be provided if there are 50+ of the same My BluePrint Health Assessment completers in each year. Please refer to **Section 10L** for sample reports.

WELLNESS SERVICES	OFFEROR RESPONSE
2. Are you willing to include performance guarantees based on the effectiveness of your Wellness Services? Please explain your response.	As the City's current carrier, BCBSAZ will continue to provide the programs and services it has come to expect. We are willing to work with the City to propose a wellness program performance guarantee if there are any areas the City would like us to improve upon.
3. Will you provide the City with a minimum of a $25,000 wellness budget? If not, please indicate the dollar amount.	Yes, BCBSAZ agrees to provide a $25,000 wellness budget for the policy period 1/1/2016-12/31/2016.
4. Optional Services: On-Site Wellness Consultant	
a. Can you provide an on-site Wellness Consultant?	No, however we are proposing a $100,000 allotment for the City to use toward hiring an employee or consultant for the position.
b. Describe the qualifications of the on-site consultant.	BCBSAZ will provide a Health Promotion Executive (HPE) to collaborate with the Wellness Consultant hired by the City.
c. Describe the responsibilities of the on-site consultant.	The HPE will assist the City's Wellness Consultant in planning a strategy that optimizes the use of the BCBSAZ HealthyBlue tools and resources.
d. Describe services the on-site consultant will provide to the Human Resources staff.	Your HPE, Jessica Dunn, currently provides wellness consultation and acts as the subject matter expert in the development, implementation and evaluation of worksite wellness programming. Her primary role is to create an individualized, comprehensive strategy designed to engage employees and meet the City's wellness goals and objectives.
e. Describe services the on-site consultant will provide to City employees.	Not applicable.
f. Describe how you will track ROI for the City. What will you measure and how will you report this information to City Management?	Not applicable.
g. Describe goals for the on-site consultant in years 1, 3, 5 and 7.	Not applicable.
h. Is there an additional cost to the City for the on-site consultant? If so, please provide the total annual cost.	BCBSAZ is proposing a $100,000 allotment for the City to use toward hiring an employee or consultant for the position.

STOP LOSS COVERAGE	OFFEROR RESPONSE
1. Indicate what legal entity is providing the stop loss coverage, and their relationship to the administrator.	BCBSAZ's proposed rates are contingent upon BCBSAZ as the claims administrator and stop loss carrier.
2. a. Has your organization read and do you agree to administer stop loss insurance in accordance with the plans as described in the attachments?	Yes.
b. If no, please explain any deviations.	
3. Describe any underwriting contingencies.	BCBSAZ's proposed administrative rates are contingent upon BCBSAZ being the medical and pharmacy benefit administration carrier and stop loss carrier.

STOP LOSS COVERAGE	OFFEROR RESPONSE
4. Describe your renewal calculation.	For our renewal rating process, BCBSAZ develops expected claims using a combination of methods, including manuals and experience rating. The credibility level will vary based on enrollment in BCBSAZ-administered plans and number of months of experience. All applicable factors are used to develop expected claims costs, administrative and stop loss fees for the group's rating/policy period. Pooling charge levels are developed on a pooled basis taking into consideration the total block of business, not just one group's claims experience. We consider the following factors when developing renewal rates: • Claim diagnosis • Date of diagnosis • Severity of condition • Claims frequency • Prognosis • Demographics As described above, at renewal, premiums will be based on, among other factors, large claim experience, manual rates, and expected aggregate claims in addition to other factors. The rating methodology could vary depending on the number of enrollees in the BCBSAZ-administered plans.
5. Do you agree to administer stop loss insurance in accordance with the plans' experimental and medically necessary definitions, as described in the plans?	Yes, BCBSAZ's stop loss coverage will follow the underlying medical contract benefits. BCBSAZ does not standardly cover experimental procedures.
6. Are there any individuals being excluded from coverage, or provided different or limited coverage under your contract?	No individuals are being excluded from coverage or provided different/limited coverage under our contracts.
7. If awarded the stop loss contract, do you require completion of a disclosure document?	No, we do not require the completion of a disclosure document.
8. Does your contract allow you to limit or exclude coverage on covered persons at renewal?	No, our stop loss contract does not allow us to limit or exclude coverage on covered persons at renewal.

STOP LOSS COVERAGE	OFFEROR RESPONSE
9. Do you require a disclosure statement be completed at renewal?	No, we do not require disclosure statements be completed at renewal.
10. If a disclosure statement is required to be completed, what is the maximum number of days in advance of the effective date it can be completed?	BCBSAZ does not require disclosure statements be completed at renewal.
11. Will you accept the data from the claims payor directly?	Our offer assumes that BCBSAZ is the claims administrator, so an outside claims payer is not needed.
12. Define clearly the terms and conditions of your contract as they apply to termination.	Our provider contracts allow for submission of valid claims up to one (1) year after the date of service. As BCBSAZ will serve as both the medical claims administrator and stop loss vendor, reimbursements of stop loss violations will take place automatically (after coordination with the data provided by the pharmacy claims administrator). Upon termination of the group contract, a 24-month claims run-out period will apply.
13. After termination, what is the maximum number of days allowed for submission of a valid claim that was incurred within the contract period?	Our provider contracts allow for submission of valid claims up to one (1) year after the date of service. As BCBSAZ will serve as both the medical claims administrator and stop loss vendor, reimbursements of stop loss violations will take place automatically (after coordination with the data provided by the pharmacy claims administrator). Upon termination of the group contract, a 24-month claims run-out period will apply.

STOP LOSS COVERAGE	OFFEROR RESPONSE
14. Does your program include access to transplant centers of excellence so the City can utilize any pre-negotiated discounts?	Yes. The Blue Cross Blue Shield centers of excellence program is Blue Distinction. Blue Distinction Centers for Transplants (BDCT) consist of a national network of transplant centers that provide comprehensive transplant services through a coordinated, streamlined referral management program. All of the centers in the BDCT network meet specific participation criteria that consider not only provider qualifications and program process, but patient outcomes as well. Each of these facilities is designated for one or more of the following types of transplants: • Heart • Lung • Liver (deceased and living donor) • Pancreas (adult transplants only) • Bone Marrow/Stem Cell
15. What is your current leveraged trend for a $300,000 deductible?	Leverage trend for a $300,000 specific stop loss level is currently 20.2%.

COBRA ADMINISTRATION	YES	NO
1. Are the following services included in your contract:		
a. Election Notice/Enrollment Applications?	Yes	
b. Coupon mailing/billing statement?	Yes	
c. Premium Collection?	Yes	
d. Notice of Termination?	Yes	
e. Monthly Reporting to the City?	Yes	
f. Weekly Paid-Thru Reporting to Vendors?	Yes	
g. Submission of Premium Payments to the City or its designate?	Yes	
h. ACH Deductions of Premiums?	Yes	
i. Mailing of Rate Change Letters and annual Open Enrollment election notification?	Yes	
j. Termination of continuation coverage letters?	Yes	
k. COBRA eligibility lists to Medical administrator, PBM and UR firm)?	Yes	
l. Quarterly reports demonstrating whether your organization has met the performance standards submitted with your proposal?	Yes	
2. Will you provide an 800 number for participants?	Yes	
3. Is there an additional cost for the number? (detail on fee sheet)		No
4. Does your proposal include a copy of the participant satisfaction survey you use regarding feedback on your COBRA administration performance?		No

COBRA ADMINISTRATION	YES	NO
5. What kinds of reports are available?	The City will have access to several reports, including current Qualified Beneficiaries (QBs) summary report, current amounts, new plan member (NPM) report, generated letters detail report, a client remittance report and benefit plan report. Please refer to **Section 10M** for sample reports.	
6. How do you notify current continuants and individuals in a pending COBRA election status of Open Enrollment?	Current continuants and individuals are provided a form to fill out.	

COBRA ADMINISTRATION	YES	NO
7. What are the top five complaints you receive about COBRA transactions?	Because clients are assigned a dedicated Client Manager who works with the group and QBs, many complaints are not received. Account set up requires 10 days, and some clients would like less days.	
8. Do you include HIPAA Certificate of Creditable Coverage for COBRA coverage notices in your standard fees?	Yes.	
9. What has been your telephone average speed to answer for the location you propose would handle this employer's business:		
a. 2013 average speed in seconds	5 seconds	
b. 2014 (ytd) average speed in seconds	4 seconds	

COBRA ADMINISTRATION	YES	NO
10. What has been your average telephone abandonment rate for the location you propose would handle this City's business.		
a. 2013 abandonment rate	1%	
b. 2014 (ytd) abandonment rate	0%	
11. Indicate performance guarantees and amounts you are willing to put at risk.	Performance goals are provided on page 7 of Sterling's COBRA proposal in **Section 10N**. However, there are no amounts at risk proposed.	
12. Please confirm you will accept full fiduciary responsibility for administration of COBRA on behalf of the City. For example, if your company makes an error in sending a Notice to a plan participant in a timely manner then your company will accept full fiduciary responsibility.	Yes.	
13. Please provide a sample copy of the contract for COBRA administrative services.	Please refer to **Section 10O** for an employer application and agreement.	
14. Please confirm that your organization will administer COBRA for all lines of coverage for the City including medical, dental, vision, FSA, EAP, etc.	Yes.	
15. Please detail the annual cost of your organization's services to the City for initial and ongoing services assuming a total of 1,408 employees with a 15% rate of turnover for each of the 6 Fiscal Years (FY16, FY17, FY18, FY19, FY20 and FY21)	Assuming 1,408 employees, the flat fee is $6,885, which is due at the beginning of each plan year.	

COBRA ADMINISTRATION	YES	NO
16. Please detail the annual cost of any additional services available to the City.	Additional services are as follows: •$150 flat fee for carrier notifications •$150 flat fee for carrier payments •$2,000 flat fee for open enrollment suite or $15 per packet Please refer to **Section 10N** for Sterling's proposal details.	

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	Customer/Member overall satisfaction - the satisfaction level conveyed by CITY members.	95% or greater in year one; 98% or greater in subsequent years	See Deviations		
			Implementation		
2	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	$20,000

	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
3	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 provided to and agreed upon by the City.	Measured group specific We will work with the City to develop a mutually agreed upon implementation plan.	N/A	$20,000
Client Services and Account Management					
4	Monthly Eligibility Reconciliation	60 business days or less	Measured group specific	Quarterly	$20,000
5	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 Percentage of claims processed incorrectly vs. correctly, based on BCBSAZ standard auditing procedures.[1]	Quarterly	$20,000

BCBSAZ Notes:

- Total of all risk measures cannot exceed $100,000.
- The above stated performance guarantees will be effective for the contract period 1/1/2016-12/31/2016.
- The Performance Guarantee payout does not include stop loss premiums, claims reimbursement amounts, vendor interface fees, capitated claim payments, etc.
- 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 would be payable annually on the 15th of the month following the 90-day period. BCBSAZ will not be required to pay a penalty for Performance Guarantees if the group is in default of its contract with BCBSAZ and/or has not paid all claims and premiums by the date due.

[1] If BCBSAZ fails to perform in accordance with these Guarantee(s) for two (2) consecutive reporting periods after the Guarantee(s) are effective, BCBSAZ will refund or credit the group up to the amount at risk per measure during the time period which BCBSAZ did not meet the performance guarantee(s).

QUESTIONNAIRE PART B CONENTS :

PHARMACY BENEFIT MANAGEMENT

MINIMUM CONTRACTUAL REQUIREMENTS

The following are the City's core requirements. Offerors' responses to this section will be heavily weighted in the selection process. Please include your responses within this form. Indicate "yes" or "no" as to your organization's ability to comply.

BCBSAZ's pharmacy benefits administration (PBM) quote is contingent upon selection of BCBSAZ medical coverage. BCBSAZ's PBM services are not available on a stand-alone basis.

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
1. The City will have the right to terminate the PBM with or without cause given a 60-day notice period after the initial 12-month period has elapsed, without penalty to the City.	**Yes**	
2. The resulting contract will contain a provision allowing the City a 10-day grace period to fund claims. **BCBSAZ generates claim invoices on approximately the 15th of every month, with payment due by the end of that month.**	**Yes, with enhancement**	
3. Definitions (You agree to the following contract definition)		
a. "Pass Through" and "Transparent" - PBM agrees to pass-through 100% of negotiated discounts with network pharmacies at the point-of-service and to provide auditing protocol enabling tracking of individual claims back to original pharmacy network contract documents. The PBM agrees to disclose details of all programs and services generating financial remuneration from outside entities. Additionally, the PBM agrees to pass through 100% of ALL rebate revenue earned. **BCBSAZ agrees to pass through 100% of the network discounts we receive from our Pharmacy Benefit Manager, Catamaran, under our "Pass Through" / "Transparent" pricing arrangement.** **Catamaran does not agree to provide City of Chandler (the City), or any of its agents or designees, access to its contracts with pharmacy providers. Catamaran does not agree to provide audit rights to the City.** **BCBSAZ's agreement with Catamaran includes Pharmacy Audit services; BCBSAZ agrees to pass all claim audit information, specific to the City's member claims, to the group. There is a 25% recovery charge for all audit services.** **Per the City's request, BCBSAZ will continue to provide a per employee per month (PEPM) administrative fee credit in lieu**	**Yes** Auditing will be performed on a calendar year basis for BCBSAZ's entire book of business. The PEPM pharmacy rebate credit (offset) to the administration rate is based on the City's actual amount of pharmacy rebates for the most current 12 months (available reporting).	

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
of BCBSAZ remitting any rebates attributable to drug utilization by the City's participants. The PEPM pharmacy rebate credit (offset) to the administration rate is based on the City's actual amount of pharmacy rebates for the most current 12 months (available reporting). Please refer to the self-funded rates and assumptions in Section 7.		
b. "Rebates" - Compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons, including, but not limited to, incentive rebates categorized as mail order purchase discounts; credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that PBM receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access.	**Yes**	
4. The PBM agrees to a seven-year Initial term with a three-year pricing guarantee effective January 1, 2016, with the option to renew annually. No automatic renewal language will appear in the contract. **BCBSAZ agrees to a two-year pricing guarantee, but is unable to agree to a three-year guarantee because our current contract with our PBM, Catamaran, ends 12/31/17. Additionally, the following stipulation applies.** **The City agrees that BCBSAZ may unilaterally change the guarantees in the event of one or more of the following:** - **Any government imposed change in federal, state or local law that significantly impacts BCBSAZ's agreement with BCBSAZ's PBM, Catamaran** - **A change in the scope of services to be performed by Catamaran under BCBSAZ's agreement with Catamaran** - **A change of more than 20% in the total number of memberships subject to BCBSAZ's agreement with Catamaran** - **Changes made to the industry AWP benchmark**		**No**
5. The PBM agrees that no financial penalty for non-renewal will apply, even during the first year of the Initial term. **Not applicable. BCBSAZ is submitting a bundled quote including medical and pharmacy administration. Group Master Contract terms will apply.**		**No**

	MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
6.	The PBM contract will provide 180-days advance notice of renewal rates (after three-year Initial Term), which shall then be subject to negotiation and written agreement between the parties.	**Yes**	
7.	The PBM agrees to a mid-contract term market check, during the second quarter of the second contract year, conducted by an independent third party to ensure the City is receiving appropriate current pricing terms competitive with the industry (as compared to other PBMs) based on its volume and membership, and will improve pricing in the event that the City's contract terms are less than current. **Should the City desire a market check clause, BCBSAZ will discuss and mutually agree upon language during the implementation and contract negotiation phase. However, we do not charge a pharmacy administrative fee and our pharmacy pricing terms are directly passed to the client based upon our contract with Catamaran. As such, they will remain firm as outlined.**		**No**
8.	The PBM agrees to implement new pricing within 90 days of completion of the market check or signature of contract. Acceptance of the new pricing will apply for the remainder of the Initial Term and will NOT result in extension of the contract, unless requested by the City. **We do not charge a pharmacy administrative fee and our pharmacy pricing terms are directly passed to the client based upon our contract with Catamaran. As such, they will remain firm as outlined.**		**No**
9.	The City or its designee will have the right to audit, with an auditor of its choice, (for both claims and rebate audits), with full cooperation of the selected PBM, the claims, services and pricing and/or rebates to verify compliance with all program requirements and contractual guarantees. **Notwithstanding any other agreement to the contrary, in the event the City has a right to audit the enrollment and/or claims, any audit for any plan year must commence and finalize within twelve (12) months of the last day of the plan year being audited. Pharmacy network agreements are not available to audit on a group level basis; however BCBSAZ does audit an appropriate sample of payments on a BCBSAZ book of business level and can share these results with the City.** **Audit is subject to the audit requirements noted in Section 9B. Additionally, a 200 pharmacy claim limit applies to the following:** 1. **approved and denied utilization management reviews** 2. **clinical program outcomes** 3. **appeals**		**No**

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
10. The audit provision shall survive the termination of the agreement between the parties for a period equivalent to the Initial Term of the contract. **Notwithstanding any other agreement to the contrary, in the event the City has a right to audit the enrollment and/or claims, any audit for any plan year must commence and finalize within twelve (12) months of the last day of the plan year being audited. Pharmacy network agreements are not available to audit on a group level basis; however BCBSAZ does audit an appropriate sample of payments on a BCBSAZ book of business level and can share these results with the City.** **Audit is subject to the audit requirements noted in Section 9B. Additionally, a 200 pharmacy claim limit applies to the following:** 1. **approved and denied utilization management reviews** 2. **clinical program outcomes** 3. **appeals**		**No**
11. The City or its designee will have the right to conduct an audit at any time during the year, at any point during the contract term, and the selected PBM will provide all documentation necessary to perform the audit. **Note, audit activity is subject to our audit requirements as noted in Section 9B.** **BCBSAZ agrees to provide reasonable assistance and information to the City's auditors without charge.** **A limit of 200 pharmacy claim limit applies to the following:** 1. **approved and denied utilization management reviews** 2. **clinical program outcomes** 3. **appeals** **NCPDP fields are confidential and proprietary and may not be released. Appropriate access to MAC rates may not be available depending upon the City's final pricing arrangement selection. Wholesaler agreements are not applicable.** **Additionally, pharmacy network agreements are not available to audit on a group level basis; however BCBSAZ does audit an appropriate sample of payments on a BCBSAZ book of business level and can share these results with the City.**		**No**
12. The City or its designee will have the right to audit up to 36 months of claims data at no additional cost to the City. **Any audit for any plan year must be both commenced and finalized within 12 months of the last day of the plan year being audited. BCBSAZ shall have no liability to pay the City any amounts as a result of any audit unless demand for payment**		**No**

	MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
	audited. BCBSAZ shall have no liability to pay the City any amounts as a result of any audit unless demand for payment based on such audit is received by BCBSAZ within 12 months of the date the claim was paid or denied. "Paid" includes both payment and/or application of benefits.		
13.	All costs incurred by the PBM to comply with the audit (e.g. data, access, evaluation) shall be the responsibility of the PBM. **Audit activity is subject to our audit requirements as noted in Section 9B. BCBSAZ agrees to provide reasonable assistance and information to the City's auditors without charge.**	**Yes**	
14.	All pricing submitted will **NOT** be contingent on participation in any proposed clinical management programs, group medical or behavioral health programs proposed by you or any other vendor other than programs that are requested by the City. Further, the pricing guaranteed in the Financial Section of this RFP reflects a) the PBM's broadest national network and b) the PBM's broadest formulary or preferred drug listing, without any drug coverage exclusions unless otherwise authorized or requested by the City. **BCBSAZ's pharmacy benefits administration (PBM) quote is contingent upon selection of BCBSAZ medical coverage. BCBSAZ's PBM services are not available on a stand-alone basis.**	**Yes**	
15.	All rebate revenue earned by the City will be paid to the City in the form of a per employee per month credit to the medical administrative fee, regardless of their termination status as a client. **Per the City's request, BCBSAZ will provide a per employee per month administrative fee credit in lieu of BCBSAZ remitting any rebates attributable to drug utilization by the City'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 the City. BCBSAZ shall not remit any rebate payments to the City. Please refer to the self-funded rates and assumptions in Section 7.**	**Yes**	
16.	The PBM agrees to send all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the City's participants to the next/successor PBM at **NO** charge if the City terminates the contract with or without cause (with no charges being deducted from the implementation allowance for creating/sending the file to IT).		**No**

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
BCBSAZ does not absorb the costs for clients leaving BCBSAZ.		
17. Brand and Minimum Generic Discount Guarantees for retail, mail and specialty shall be defined as follows: (Aggregate Ingredient Cost/Aggregate AWP).		
a. Aggregate Ingredient Cost prior to application of plan specific co-payments will be the basis of the calculation.	**Yes**	
b. Aggregate AWP will be from a single, nationally recognized price source for all claims. *Please indicate source.*	**Yes** MediSpan	
c. Dispensing Fees are not included in the Aggregate Ingredient Cost.	**Yes**	
d. Both the Aggregate Ingredient Cost and Aggregate AWP from the actual date of claim adjudication will be used.	**Yes**	
e. Aggregate AWP will be the date sensitive, 11-digit NDC of the actual product dispensed.	**Yes**	
f. Both non-MAC, MAC, single-source and multiple source generic products are to be included in the generic guarantee measurement.	**Yes**	
g. Compounds, OTC claims, zero balance claims, usual and customary claims, and claims with ancillary charges will be excluded from the guarantee measurements for retail and mail order components. **Over-the-counter diabetic supplies are also excluded from the calculation; zero balance claims are NOT excluded from the calculation.**	**Yes, with deviation**	
h. The guarantee measurement must exclude the savings impact from DUR programs, formulary programs, utilization management programs, and/or other therapeutic interventions.	**Yes**	
i. Any shortfall between the actual result and the guarantee will be paid, dollar-for-dollar, to the City within 60 days of the end of the measurement period. **Discounts and dispensing fees will be measured annually on a calendar year basis and on BCBSAZ's entire, applicable book of business. Payments for any shortfalls will be made within 120 days after the close of the calendar year.**		**No**
j. Measurement will be performed annually via independent audit utilizing date-sensitive AWP derived from a single, nationally recognized price source for all claims. **Catamaran calculates pricing discounts for BCBSAZ's entire book of business. This is then audited by an independent**	**Yes**	

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
third party audit company selected by BCBSAZ.		
18. The City will be notified of any switch to the source of the aggregate AWP with at least a 180-day notice. In the event that a switch is made that is not price neutral, the City will have the right to terminate the contract with no penalty.	**Yes**	
19. Each distinct pricing guarantee will be measured and reconciled on a component (e.g. retail brand, retail generic, mail order brand, mail order generic, and specialty) basis only and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by the City. **Surpluses in one component may not be utilized to offset deficits in another component.** **BCBSAZ agrees that offset surpluses in one category will not be used against shortfalls in other categories. Each pricing measure will be based on BCBSAZ's contractual rate agreement with the City by dispensing component (retail brand, retail generic, mail order brand, mail order generic and specialty). The reconciliation is based on BCBSAZ's book of business and is not group specific.**	**Yes** based on BCBSAZ book of business (not group-specific)	
20. Per employee per month credits will be applied to the medical administrative fee upon signature of: 1) the Letter of Agreement/Intent pricing document OR 2) Pricing Implementation Document OR 3) contract.	**Yes**	
21. Per employee per month credits will not be withheld for execution of annual contract amendments. The City is entering in to a multi-year agreement and needs no annual renewals/amendments signatures for payments of credits.	**Yes**	
22. The PBM agrees to provide Retail/Mail Order unit cost equalization to the City, meaning that Mail Order unit costs prior to member cost sharing, dispensing fees, and sales taxes charged to the City will be no greater than those at Retail.		**No**
23. The PBM agrees to produce a date-sensitive comparison report showing unit costs charged to the City at a GCN-level, and reimburse the City on a dollar-for-dollar basis for all instances where mail order unit costs exceed retail unit's costs. Report and reconciliation will be provided on a quarterly basis.		**No**
24. The PBM agrees to obtain the City's approval for all member communication materials before distribution to members.		**No**
25. The PBM will not automatically enroll the City in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from the City.		**No**

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
BCBSAZ does not agree to obtain the City's approval prior to making drug tier changes to our program. Program design and drug tier changes are determined by BCBAZ's Pharmacy and Therapeutics (P&T) Committee. BCBSAZ is offering our multi-tiered benefit program which applies to all of our at-risk business in addition to ASC groups. Because a single program is used for all business, BCBSAZ is able to negotiate better rebate arrangements with pharmaceutical manufacturers while keeping our goal of lowest net cost in sight. **Changes requiring member notification must be made in compliance with Department of Labor requirements, which we adhere to. Any changes that would be of a negative impact would result in notification direct to affected members prior to any changes being put in place.**		
26. PBM agrees to hold the City harmless for any HIPAA Violations made by the PBM or its Network Pharmacies. **BCBSAZ's contract contains a mutual indemnification and hold harmless if either party fails to perform its obligations under the contract.** **BCBSAZ's PBM, Catamaran, agrees.**	**Yes**	
27. The PBM agrees the contract will provide that the City will be provided with a list of each separate vendor that is used to fulfill the PBM's duties as Claims Fiduciary to the Plan. That list must be complete on the inception of the contract and it must be updated within 30 days of any change in the vendors listed or in the duties performed by a vendor. It will contain at least the following information: **BCBSAZ will accept claims and appeals fiduciary responsibility provided we are the ultimate decision-maker for each.** a. The name of the vendor with whom you have a contractual arrangement. **BCBSAZ pharmacy appeals and grievances process is the same as the medical process (please see Section 10H for details). BCBSAZ members have two internal levels of review, and one external level of appeal, performed by the Arizona Department of Insurance (DOI) or an independent review organization (IRO). BCBSAZ contracts with the following three IROs: Advanced Medical Reviews, Inc., AllMed Health Care Management Inc. and MCMC LLC**	**Yes**	
b. A complete description of the duties that vendor will fulfill on the City's account **BCBSAZ will accept claims and appeals fiduciary responsibility provided we are the ultimate decision-maker for each.**	**Yes**	

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
BCBSAZ adjudicates claims in accordance with the provisions of the plan and our claim guidelines. We also review member appeals of denied claims and make the final determination as to whether the claim is covered. **When BCBSAZ is the claim fiduciary, the plan sponsor cannot overrule the determination. If we deny an appeal and the member files suit claiming that our coverage decision was in error, we will defend the decision and bear the legal costs of the defense.** **Additionally, we are responsible for providing relevant documents supporting the claim denial (e.g., medical reports, independent medical examination reports, etc.) if requested in connection with an appeal of a denied claim.**		
c. If the City is to be directly charged for the services, a description of the basis for the charges that will be levied and an estimate of the annual cost for such service. A cost accounting for all such vendor service is to be supplied to the City quarterly within 45 days of the close of the quarter.	**Yes** Not applicable; there is no additional charge for claims and appeals fiduciary responsibility (it is included within the overall administrative fee)	
28. The PBM agrees if it will receive any remuneration from the vendor used in fulfillment of the PBM's duties as Claims Fiduciary, as a result of the payments made by the City to the vendor, to disclose all such remuneration to the City, regardless of its form, on a quarterly basis within 45 days of the end of the quarter.	**Yes** (not applicable, as BCBSAZ does not receive any payments or remuneration fitting this description)	
29. The PBM will agree to defend claims litigation based on its decisions to deny coverage for clinical reasons. **When BCBSAZ is the claim fiduciary, the plan sponsor cannot overrule the determination. If we deny an appeal and the member files suit claiming that our coverage decision was in**	**Yes**	

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
error, we will defend the decision and bear the legal costs of the defense. **Additionally, we are responsible for providing relevant documents supporting the claim denial (e.g., medical reports, independent medical examination reports, etc.) if requested in connection with an appeal of a denied claim.**		
30. PBM agrees to provide dedicated account resources (defined as resources designated solely to the City) including, but not limited to, an implementation manager, strategic account executive, clinical director - pharmacist, account manager, claims advocate and an underwriter/financial analyst. *Please include biographies in attachments.* **BCBSAZ has provided designated account resources, including an experienced Client Implementation Manager (Scott Salisbury and Trisha Posser), a Strategic Relationship Executive (Ken Muth), a Clinical Director and Pharmacist (Chris Hogan, R.Ph.), a Client Service Manager who will also act as the group's claims advocate (Colette Severns), an Underwriter (Anita Ortiz) and a Health Promotion Executive (Tara Cosentino). Please see Section 9F for biographies of these designated account resources.**	**Yes**	
31. The PBM will be responsible for collecting any outstanding member cost shares for prescriptions dispensed through the mail order facility. The PBM will not invoice the City for any uncollected member cost shares.	**Yes**	
32. The PBM will not withhold any financial recoveries from audits performed on the contracted pharmacy network including mail order and specialty pharmacies. Any recoveries will be disclosed and credited to the City. **There is a 25% fee associated with all pharmacy network audit recoveries.**	**Yes**	
33. The PBM agrees to provide an Implementation Credit to the City on a Per Member basis. **Not applicable. BCBSAZ is the incumbent carrier.**		**No**
34. With the exception of FDA recalls or other safety issues, the PBM agrees not to remove any drug products, brand or generic, from the City's formulary or preferred drug listing without notification and prior approval from the City. **BCBSAZ does not agree to obtain the City's approval prior to making drug tier changes to our program. BCBSAZ is offering our multi-tiered benefit program which applies to all of our at-risk business in addition to self-funded groups. Because a single program is used for all business, BCBSAZ is able to negotiate better rebate arrangements with pharmaceutical manufacturers**		**No**

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
while keeping our goal of lowest net cost. Changes requiring member notification must be made in compliance with Department of Labor requirements, which BCBSAZ adheres to.		
35. No alterations to financial guarantees will be made on formulary drug exclusions. The City has the right to opt in or opt out of any formulary drug exclusions without penalty.		**No**
36. The PBM agrees to notify the City or its designee 90 days in advance of when a formulary drug is targeted to be moved to or from the preferred drug list. The PBM must provide a detailed disruption and financial impact analysis at the same time. No greater than two percent (2%) of participants will be disrupted by any formulary deletions or all deletions in total, on an annual basis. **BCBSAZ does not agree to obtain the City's approval prior to making drug tier changes to our program. BCBSAZ is offering our multi-tiered benefit program which applies to all of our at-risk business in addition to self-funded groups. Because a single program is used for all business, BCBSAZ is able to negotiate better rebate arrangements with pharmaceutical manufacturers while keeping our goal of lowest net cost. Changes requiring member notification must be made in compliance with Department of Labor requirements, which BCBSAZ adheres to.**		**No**
37. The PBM agrees to provide an Implementation Credit to the City on a Per Member basis. **Not applicable. BCBSAZ is the incumbent carrier.**		**No**
38. The PBM will agree to fund a Pre-Implementation Audit (up to $30,000) to be conducted at least 60 days prior to the start of claims adjudication. The PBM will work with the auditor to run test claims in a test environment utilizing the City's actual plan parameters. **Not applicable, as BCBSAZ is the incumbent carrier. We are offering a $180,000 overall allotment for the 2016 policy year, as noted within our medical proposal, which the City may use for any purpose they desire.**	**Yes**	
39. The PBM will agree to fund an annual Audit (up to $30,000) to be conducted following each calendar year. **We are offering a $180,000 overall allotment for the 2016 policy year, as noted within our medical proposal, which the City may use for any purpose they desire.**	**Yes**	
40. The PBM agrees that it will not remove any participating network pharmacies that impact greater than 2% of the City's prescriptions without communicating to the City at least sixty (60) days in advance of the scheduled change. If the change		**No**

	MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
	is not agreeable to the City, the City will have the right to terminate the agreement without penalty.		
41.	The PBM agrees to offer improved pricing terms to the City if greater than 2% of members are impacted by proposed changes to the participating pharmacy network.		**No**
42.	The PBM will provide draft SPD language for any clinical programs that are to be implemented.		**No**
43.	The PBM must be able to administer a 90-day retail prescription drug benefit.	**Yes**	
44.	The PBM agrees to provide weekly and/or monthly data transmissions (may include feeds to data warehouses) to chosen vendors at no charge and two full, annual electronic claims files, in NCPDP format, at no charge as needed. PBM will also interact/exchange data with all vendors as needed at no additional charge. **As our pharmacy benefit management program is only offered when medical administration is selected, this is not applicable for pharmacy, medical disease management, care management, etc.**	**Yes** based on BCBSAZ being awarded both medical and pharmacy	
45.	The PBM agrees to provide online, real time, claim system access to the Fund or its designee, including access to historical claims data for up to three (3) years following termination of the agreement. **BCBSAZ uses a single claim adjudication system (Catamaran's RxClaim). While BCBSAZ is unable to provide access to it, the City and its designee will have online, real-time access to our in-depth reporting and analytics system, BlueInsight℠, during the term of the contract. Additionally, BCBSAZ provides online, real time eligibility inquiries via the employer portal on azblue.com at no additional cost.**		**No**
46.	The PBM agrees to accept daily eligibility files with a 2-hour (same day) turnaround on the file error report. **BCBSAZ provides online, real time eligibility inquiries via the employer portal on azblue.com at no additional cost. BCBSAZ accepts updates at azblue.com in a real time format and processes them in an overnight cycle. Emergent issues can be updated directly into the pharmacy system immediately during normal working hours by contacting the assigned BCBSAZ Eligibility Representative.**	**Yes**	
47.	PBM agrees to absorb any programming or other administrative costs to meet any existing or future requirements of the Affordable Care Act.	**Yes**	

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
48. PBM agrees the City will have the ability to "carve-out" specialty drug pricing and service terms without penalty or changes to the financial guarantees. **BCBSAZ is not offering a provision allowing the City to renegotiate or "carve out" specialty medications. Current specialty medication information (including a list and applicable discounts) may be seen in Section 9G.**		**No**

CONTRACTUAL EXPECTATIONS

The following are the City's expectations of how the topics below will be addressed in the final, executed contracts with the City. Please complete this form and include it within your response. Indicate "yes" or "no" as to your organization's ability to comply. An explanation of your "yes" or "no" response may be requested during the proposal evaluation process.

CONTRACTUAL EXPECTATIONS	YES	NO
1. Definitions		
a. AWP (Average Wholesale Price) is based on date sensitive, 11-digit NDC as supplied by a nationally-recognized pricing source (i.e., First DataBank, Medi-Span) for retail, mail order, and specialty adjudicated claims (Subject to outstanding litigation).	**Yes**	
b. Member Copay - Members will pay the lowest of the following: plan copay/coinsurance, plan-negotiated discounted price plus dispensing fee, usual and customary (U&C), or retail cash price.	**Yes**	
c. The City eligibility and claim data - All eligibility and claims records are the sole property of the City and must be made available upon request to the City and its representatives. Selling or providing of the City's data to ANY outside entities must be approved in advance, reported on a monthly basis and all income derived must be disclosed and shared per agreement with the City. Even if PBM has not "sold" the data, it is NOT free to use the data for analyses that they publish or provide to outside industries. **BCBSAZ agrees, provided that claim data is the property of the City to the extent the data does not contain confidential, trade secret and/or information considered proprietary by BCBSAZ.**	**Yes**	
d. Paid Claims - Defined as all transactions made on eligible members that result in a payment to pharmacies or members from the City or the City member copays. (Does not include reversals and adjustments.) Each	**Yes**	

CONTRACTUAL EXPECTATIONS	YES	NO
unique prescription that results in payment shall be calculated separately as a paid claim.		
e. Members - All eligible employees and their eligible dependents enrolled under the City prescription benefit program.	**Yes**	
2. The City will not be held responsible for time or miscellaneous costs incurred by the PBM in association with any audit process including, all costs associated with providing data, audit finding response reports, or systems access provided to the City or its designee by the PBM during the life of the contract. *Note: This includes any data required to transfer the business to another vendor and money collected from lawsuits and internal audits.* **BCBSAZ agrees to support audit activity without charging the client for the time supporting the audit activity. BCBSAZ's standard audit requirements, found in Section 9B, apply.** **BCBSAZ does not absorb the costs for clients leaving BCBSAZ.**		**No**
3. The PBM agrees to a 30-day turnaround time to provide its response to claims audit findings.		**No** Our goal is to respond within 30 days; however, this may vary based on the audit findings.
4. All applicable administrative fees will be on a per paid claim basis as defined in 5.2.d definitions.	**Yes** Not applicable; BCBSAZ does not charge a pharmacy administrative fee when pharmacy benefits are bundled with our medical program.	
5. There are NO additional fees (beyond those outlined in the Financial Section) required to administer the services	**Yes**	

CONTRACTUAL EXPECTATIONS	YES	NO
outlined in this RFP. Any mandatory fees, including clinical and formulary program fees, must be clearly outlined in the Financial Section.		
6. All applicable fees include the cost of claims incurred/filled during the effective dates of this contract regardless of when they are actually processed and paid (run-out).	**Yes.** On a 12/24 basis, BCBSAZ will perform run-out claims administratio n for 24 months following contract termination.	
7. The PBM agrees to adjudicate prescription claims for compound medications with the same dispensing fees and logic associated with traditional claims. **Discounts and the dispensing fees will be measured annually on a calendar year basis and on BCBSAZ's entire, applicable book of business. Compounds, specialty claims, direct member reimbursements, COB claims, OTC claims (except OTC diabetic supplies) and claims with ancillary charges (e.g., flu shots and vaccines) will be excluded from the calculation.**		**No** Multi Ingredient Compounds are priced on a per component basis. A $10 dispensing fee applies.
8. The PBM will NOT implement, administer, or allow any program that results in the conversion from lower discounted ingredient cost drug products to higher ingredient cost drug products or increases member's cost share without the prior written consent of the City or its designee. **BCBSAZ agrees with the exception of drug tier changes where the product moves to a higher cost share tier. This will result in a higher cost to the member.** **BCBSAZ does not agree to obtain the City's consent prior to making tier changes as these are made at the discretion of BCBSAZ's P&T Committee.**	**Yes**	
9. The PBM mail order service must notify each affected individual and the City or its designee prior to substituting products that will result in higher member co-pay.	**Yes**	
10. The City reserves the right to review, edit, or customize any communication from the PBM to its membership. **BCBSAZ's program design and drug tier changes will be made as determined by BCBAZ's P&T Committee. BCBSAZ is offering our**		**No**

CONTRACTUAL EXPECTATIONS	YES	NO
multi-tiered benefit program which applies to all of our at-risk and self-funded business. Because a single program is used for all business, BCBSAZ is able to negotiate better rebate arrangements with pharmaceutical manufacturers, while keeping our goal of lowest net cost. **Changes requiring member notification must be made in compliance with Department of Labor requirements, which we adhere to. Any changes that would be of a negative impact would result in notification direct to affected members prior to any changes being put in place.**		
11. PBM agrees to notify the City and its members at least 60 days prior to the addition of a drug to the specialty drug list and at least 90 days prior to a deletion of a drug from the specialty drug list. The City reserves the right to approve any addition to the specialty drug list.		**No**
12. The City will have the ability to annually renegotiate and/or "carve-out" specialty drug pricing and service terms. **BCBSAZ is not offering a provision allowing the City to renegotiate or "carve out" specialty medications. Current specialty medical discounts may be seen in Section 9G.**		**No**
13. All pricing will be effective and guaranteed for the term of the agreement (excluding the renegotiated specialty pricing) and will not include adjustments for claims volume shifts amongst the various provider channels (e.g., mail utilization rates decline or 90-day retail utilization increases). **BCBSAZ agrees to a two-year pricing guarantee, but is unable to agree to a three-year guarantee because our current contract with our PBM, Catamaran, ends 12/31/17. Additionally, the following stipulation applies.** **The City agrees that BCBSAZ may unilaterally change the guarantees in the event of one or more of the following:** **- Any government imposed change in federal, state or local law that significantly impacts BCBSAZ's agreement with BCBSAZ's PBM, Catamaran** **- A change in the scope of services to be performed by Catamaran under BCBSAZ's agreement with Catamaran** **- A change of more than 20% in the total number of memberships subject to BCBSAZ's agreement with Catamaran** **- Changes made to the industry AWP benchmark** **BCBSAZ is not offering a provision allowing the City to renegotiate or "carve out" specialty medications. Current specialty medical discounts may be seen in Section 9G.**		**No**

CONTRACTUAL EXPECTATIONS	YES	NO
14. The PBM agrees to grandfather the City's current formulary for up to 90 days following the contract effective date.	**Yes** Not applicable, as BCBSAZ is the incumbent carrier.	
15. The PBM agrees to provide online, real time, claim system access to the City or its designee, including access to historical claims data for up to three years following termination of the agreement. **BCBSAZ uses a single claim adjudication system (Catamaran's RxClaim). While BCBSAZ is unable to provide access to it, the City and its designee will have online, real-time access to our in-depth reporting and analytics system, BlueInsight℠, during the term of the contract. Additionally, BCBSAZ provides online, real time eligibility inquiries via the employer portal on azblue.com at no additional cost.**		**No**
16. The PBM agrees that all future edits required because of plan design changes implemented by the City shall be completed, after testing, by the PBM within 45 days of request/advisory by the City.	**Yes** For mutually agreed-upon clean edits, BCBSAZ will test all plan design changes upon completion of programming.	
17. All customer service call recordings and notes between the PBM and the City's members will be property of the City.		**No** BCBSAZ is unable to accommodate due to HIPAA Privacy laws.
18. The PBM agrees to document 100% of the City's customer service calls through call recordings and call notes. PBM will forward written transcripts of calls at the City's request within two business days of the request being made.		**No** BCBSAZ is unable to accommodate due to HIPAA Privacy

CONTRACTUAL EXPECTATIONS	YES	NO
		laws.
19. The City reserves the right to access all call recordings or call notes from customer service calls with its members. PBM agrees to allow the City the right to request call recordings and/or notes at any time.		**No** BCBSAZ is unable to accommodate due to HIPAA Privacy laws.
20. The PBM agrees to allow the City access to its member website with a dummy login prior to the go-live date.	**Yes** The dummy login for the BlueNet℠ member and employer portals are below. **Member** Login: mtrails1 Password: password1 **Employer** Login: adamrice Password: password1	
21. The PBM will provide the City with a virtual tour of its CSR system and any custom messaging system. **BCBSAZ customer service is managed by Catamaran. Demos are not available for their CSR system.**		**No**
22. The PBM agrees to, at minimum, quarterly calls to review customer service issues. The PBM agrees to allow the City to review customer service quality issues to the resolution endpoint.	**Yes**	
23. The PBM agrees to a minimum of one annual meeting with call center executives to discuss services regarding enrollment and member issues. **As our pharmacy benefit management program is only offered when medical administration is selected, the City would meet**	**Yes**	

CONTRACTUAL EXPECTATIONS	YES	NO
with appropriate BCBSAZ managers who oversee the call center program. An annual benchmark report and meeting will be provided by the account management team.		
24. The PBM agrees to provide daily data transmissions (may include feeds to data warehouses) to the medical administrator vendors at no charge and two full, annual electronic claims files, in NCPDP format, at no charge as needed. PBM will also interact/exchange data with all vendors as needed at no additional charge. **As our pharmacy benefit management program is only offered when medical administration is selected, this is not applicable for pharmacy, medical disease management, care management, etc.**	**Yes** based on BCBSAZ being awarded both medical and pharmacy	
25. The PBM will provide electronic access to monthly claims information by medical plan offering to the City and/or its designee(s).	**Yes**	
26. The PBM agrees to review and negotiate the pricing applied to newly introduced generic drugs annually.		**No**
27. The PBM will respond to and incorporate future Health Care Reform changes in full compliance with the law and at no additional cost to the City.	**Yes**	
28. The PBM agrees to no additional charges for any retroactive claims reprocessing and member reimbursements due to retroactive plan design adjustments.		**No**
29. The PBM agrees to adjudicate prescription claims for compound medications with the same dispensing fees and logic associated with traditional claims. **Discounts and the dispensing fees will be measured annually on a calendar year basis and on BCBSAZ's entire, applicable book of business. Compounds, specialty claims, direct member reimbursements, COB claims, OTC claims (except OTC diabetic supplies) and claims with ancillary charges (e.g., flu shots and vaccines) will be excluded from the calculation.**		**No**
30. The PBM shall indemnify, defend and hold harmless the City, its officers, directors, employees and agents from and against any and all claims, actions, demands, costs, and expenses, including reasonable attorney fees and disbursements, as a result of a breach by the PBM of any of its obligations under the Agreement or arising out of the negligent act or omission or willful misconduct of the PBM or its employees or agents.	**Yes** BCBSAZ's contract contains a mutual indemnificatio n and hold harmless if either party	

CONTRACTUAL EXPECTATIONS	YES	NO
	fails to perform its obligations under the contract.	
31. The PBM acknowledges that it is compliant with the Electronic Data Interchange ("EDI"), Privacy and Security Rules of the Health Insurance Portability and Accountability Act ("HIPAA"), and will execute the appropriate Business Associate Addendum ("BAA") as provided by the City. PBM also agrees that in the event of a privacy violation or data breach, that the PBM will notify the City and the impacted members to a breach and provide any required remedies.	**Yes**	
32. The PBM agrees that this Agreement or any of the functions to be performed hereunder shall not be assigned by either party to another party, absent advance notice to the other party, and written consent to said assignment, which consent shall not be unreasonably withheld. In the event either party shall not agree to an assignment by the other party, then this agreement shall terminate upon the effective date of said assignment. **BCBSAZ is unable to agree as BCBSAZ subcontracts for the delivery of certain pharmacy services. Catamaran, our subcontracted PBM vendor, provides the pharmacy claims platform, pharmacy claims adjudication, pharmacy network contracting, pharmacy customer service, pharmacy audit, mail order through Walgreens and exclusive specialty pharmacy through BriovaRx.** **BCBSAZ reserves the right to change subcontractors as long as services provided are equal to or better than those required under the Contract.**		**No**
33. The PBM must agree that in the event of a dispute between the parties, about the payment or entitlement to receive payment, or any administrative fees hereunder, the PBM and the City shall endeavor to meet and negotiate a reasonable outcome of said dispute. In NO event shall PBM undertake unilateral offset against any monies due and owed to the City, whether from manufacturer rebates, credit adjustment or otherwise. **BCBSAZ does not charge a pharmacy administrative fee when pharmacy benefits are bundled with our medical program. Additionally, per the City's request, BCBSAZ will provide a PEPM credit to the administrative fee in lieu of remitting actual earned rebates.**		**No**

CONTRACTUAL EXPECTATIONS	YES	NO
In the event of any dispute, BCBSAZ will endeavor to negotiate a reasonable outcome with the City. **BCBSAZ will not unilaterally offset amounts that are in dispute. Invoices including disputed amounts should still be paid by the due date, net of the disputed amount. BCBSAZ retains the right to offset for the non-disputed amount as outlined in our group master contract, which may be seen in Section 10A.**		

FINANCIAL SECTION

Offerors are required to complete all financial forms as instructed. Offerors should provide proposed fees and guarantees separately for each year of the three-year contract, so that the City's pricing terms keep pace with expected market trends. We ask all Offerors to provide a pass through (transparent) pricing proposal as described in this RFP.

Please note this is a pass through (transparent) arrangement. The services provided should include, but should not be limited to, the services referred to in the "PBM Services to be Provided" section.

1. Administrative Fees

Complete the following Administrative Fee Tables:

***NOTE: BCBSAZ agrees to a two-year pricing guarantee, but is unable to agree to a three-year guarantee because our current contract with our PBM, Catamaran, ends 12/31/17. Additionally, the following stipulation applies.**

The City agrees that BCBSAZ may unilaterally change the guarantees in the event of one or more of the following:

- **Any government imposed change in federal, state or local law that significantly impacts BCBSAZ's agreement with BCBSAZ's PBM, Catamaran**
- **A change in the scope of services to be performed by Catamaran under BCBSAZ's agreement with Catamaran**
- **A change of more than 20% in the total number of memberships subject to BCBSAZ's agreement with Catamaran**
- **Changes made to the industry AWP benchmark**

PASS THROUGH (TRANSPARENT) PROPOSAL ADMINISTRATIVE FEES	RESPONSE		
1. Complete the following Administrative Fee Table	1/1/2016-12/31/2016	1/1/2017-12/31/2017	1/1/2018-12/31/2018 *See NOTE above

PASS THROUGH (TRANSPARENT) PROPOSAL ADMINISTRATIVE FEES	RESPONSE					
Retail/Mail Administrative Fee	$0.00	per paid claim	$0.00	per paid claim	**$ n/a (not offered)**	per paid claim
	BCBSAZ does not charge a PBM administrative fee when pharmacy benefits are bundled with our medical program.				**n/a (not offered)**	
Services to be included in fees above: *Toll Free Phone Lines*	**Y**		**Y**		**n/a (not offered)**	
Monthly Data Feeds to the City or Designee(s)	**Y** Not applicable, as pharmacy is only available when bundled with medical.		**Y** Not applicable, as pharmacy is only available when bundled with medical.		**n/a (not offered)**	
Prospective /Concurrent/Retro DUR	concurrent: **Y** prospective/ retrospective: **N (not offered)**		concurrent: **Y** prospective/ retrospective: **N (not offered)**		**n/a (not offered)**	
Standard Reports	**Y** via BlueInsight		**Y** via BlueInsight		**n/a (not offered)**	
Ad Hoc Reports	**Y**		**Y**		**n/a (not offered)**	
I D Cards	**Y** as part of medical ID card		**Y** as part of medical ID card		**n/a (not offered)**	
COB Program	**N (not offered)**		**N (not offered)**		**n/a (not offered)**	
Mandatory Mail Program	**Y**		**Y**		**n/a (not offered)**	
Dose Optimization Program	**N (not offered)**		**N (not offered)**		**n/a (not offered)**	
Prior Authorization Program	**Y**		**Y**		**n/a (not offered)**	
Step Therapy Program	**Y**		**Y**		**n/a (not offered)**	
Quantity Limitations	**Y**		**Y**		**n/a (not offered)**	
Custom System Overrides	**Y**		**Y**		**n/a (not offered)**	
Annual EOB Statements	**N (not offered)**		**N (not offered)**		**n/a (not offered)**	

PASS THROUGH (TRANSPARENT) PROPOSAL ADMINISTRATIVE FEES	RESPONSE		
Retro Termination Letters	**Y**	**Y**	**n/a (not offered)**
Group Coding	**Y**	**Y**	**n/a (not offered)**
Drug Notification Letters	**Y**	**Y**	**n/a (not offered)**
Formulary Administration/Management	**Y** for our standard 3- and 4-tier program	**Y** for our standard 3- and 4-tier program	**n/a (not offered)**
ID Cards	**Y** as part of medical ID card	**Y** as part of medical ID card	**n/a (not offered)**
Pharmacy Directories and other member materials	directories: **Y (online only)** other member materials: **Y (standard)**	directories: **Y (online only)** other member materials: **Y (standard)**	**n/a (not offered)**
Standard 1st level appeals processing	**Y**	**Y**	**n/a (not offered)**
Standard 2nd level appeals processing	**Y**	**Y**	**n/a (not offered)**
Urgent appeals processing	**Y**	**Y**	**n/a (not offered)**
Overrides	**Y**	**Y**	**n/a (not offered)**
Audit Recovery Fees	**Y** BCBSAZ retains 25% of pharmacy network audit recoveries	**Y** BCBSAZ retains 25% of pharmacy network audit recoveries	**n/a (not offered)**
Services not included in fees above (i.e., services marked "N" above) (show fees separately):	**Not applicable; see above.**		**n/a (not offered)**
2. Detail all services and supplies to be provided under your basic fees that are not included in your response to question one.	Not applicable; all are detailed above. BCBSAZ offers additional programs, including customized programs, should the City be interested. Costs, if applicable, would be discussed depending on the request.		
3. Will there be any additional charges if plans/benefits are restructured or new classes of eligible members are added? If so, how are these charges	BCBSAZ does not charge a PBM administrative fee when pharmacy benefits are bundled with our medical program.		

PASS THROUGH (TRANSPARENT) PROPOSAL ADMINISTRATIVE FEES	RESPONSE
determined and state amount of charges?	In the event of restructuring of plans / benefit designs, or the addition (or deletion) of classes of eligible members, BCBSAZ reserves the right to re-rate for our medical rates, in accordance with our medical ASC contract. Any reevaluation would be determined utilizing experience rating methodology to determine the amount of the charges (if any).
4. Confirm that postage is included in all mail order prescriptions and any mailings.	BCBSAZ confirms for standard shipping; members requesting expedited shipping may be charged an additional cost.
5. Confirm that quoted fees include postage paid mail order envelopes for member prescription submission.	BCBSAZ confirms for pharmacy.
6. Confirm that mail order and specialty drug dispensing fees will remain constant throughout the contract term and will not be increased due to changes in postage charges.	BCBSAZ confirms.
7. Detail all data related services included under the base administrative fees including ad hoc reporting, electronic claims files, plan design options, custom mailings, etc.	Our clients can obtain pharmacy utilization reporting through BlueInsight℠. Please see the BlueInsight material in **Section 10E**. BCBSAZ will make numerous pharmacy reports available to the City, both online and in a non-electronic format. There are standard, pre-set formats as well as dynamic reporting functions to allow for ad hoc customization. These additional reports are available at the summary level, as well as at the claimant or detail level. BCBSAZ updates the reports on a monthly basis (20th of each month) to allow for trending on an ongoing basis.
In addition, detail any data-related service fees not included in the base administrative fees.	Due to our extensive reporting tool, which includes dynamic reporting functions, the need for ad hoc reporting should be minimized. BCBSAZ agrees to run up to 15 ad hoc reports for the City for the first year at no additional cost. After the first year, customized reports per the group's specifications may or may not require additional fees. The number of hours and resources required will determine the amount of the fee, if any. All ad hoc reports will be discussed and priced based on reporting requirements requested.
8. Confirm that multi-language communication phone line support is	Confirmed. BCBSAZ's PBM, Catamaran, has Member Service Representatives (MSR) who speak Spanish. They

PASS THROUGH (TRANSPARENT) PROPOSAL ADMINISTRATIVE FEES	RESPONSE
included in the base administrative fee. List the languages available to the City's members speaking to your customer service representatives.	can also support over 200 languages via Language Line Solutions℠. LanguageLine Solutions, offered by LanguageLine, LLC, offers interpreters for over 200 other languages.

2. Prescription Drug Pricing

AWP Reimbursement Basis - Complete the following tables using the drug reimbursement that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. All guarantees **must** be based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback.

PASS THROUGH (TRANSPARENT) PROPOSAL

Year 1 (1/1/2016-12/31/2016)

All pricing noted below is considered by BCBSAZ to be confidential, proprietary and/or trade secret.

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply ~~Up to 30 days~~ up to 83 days		AWP Discount Retail Supply ~~31-90 days~~ 84-90 days*		AWP Discount Mail Supply ~~1-90 days~~ >84 days	
Brand Drugs[1]						
Discount from AWP[2] for all brands	**15.30%**		**22.00%**		**25.00%**	
Dispensing Fee Per Rx	**$1.40**	per Rx	**$0.00**	per Rx	**$0.00**	per Rx
Generic Drugs[3]						
Discount from AWP for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	**MAC Generics**: 78.75%** **Non-MAC Generics: 15.30%**		**MAC Generics**: 78.75%** **Non-MAC Generics: 15.30%**		**MAC Generics**: 82.25%** **Non-MAC Generics: 25.00%**	
Dispensing Fee Per Rx	**$1.40**	per Rx	**$0.00**	per Rx	**$0.00**	per Rx
Rebates[4]	**Per the City's request, BCBSAZ will provide a per employee per month (PEPM) administrative fee credit in lieu of BCBSAZ remitting any rebates. Please refer to the rates and assumptions in Section 7.**					
Three Tier Plan – Per Rx (brand & generic)**	**$12.00** PEPM					

1 Including both single source and multi-source brands.
2 Post September 26, 2009 AWP rollback
3 Including single-source generics.
4 100% of rebates must be passed through on a per employee per month basis, as a credit to the Medical administrative fee.

BCBSAZ Notes:

*BCBSAZ has shown discounts for our broadest network, as requested. For Retail-90, these discounts apply at any in-network pharmacy. BCBSAZ also offers a Walgreens-only Retail-90 option with improved discounts and would be pleased to present pricing, discounts and additional information should the City desire.

**MAC discount from AWP is offered as an effective overall Generic discount (Ingredient Cost) and includes all MAC and non-MAC drugs, including single source generic products.

Regarding the pricing guarantee: the City agrees that BCBSAZ may unilaterally change the guarantees in the event of one or more of the following:

- Any government imposed change in federal, state or local law that significantly impacts BCBSAZ's agreement with BCBSAZ's PBM, Catamaran
- A change in the scope of services to be performed by Catamaran under BCBSAZ's agreement with Catamaran
- A change of more than 20% in the total number of memberships subject to BCBSAZ's agreement with Catamaran
- Changes made to the industry AWP benchmark

These discounts and the dispensing fees will be measured annually on a calendar year basis and on BCBSAZ's entire, applicable book of business. Compounds, specialty claims, direct member reimbursements, COB claims, OTC claims (except OTC diabetic supplies) and claims with ancillary charges (e.g., flu shots and vaccines) will be excluded from the calculation.

All AWP discounts are based on Post-Rollback Average Wholesale Price.

Specialty drug specific discounts are available in **Section 9G** and only apply when the drug is dispensed by BCBSAZ exclusive Specialty Pharmacy provider, BriovaRx.

Year 2 (1/1/2017-12/31/2017)

All pricing noted below is considered by BCBSAZ to be confidential, proprietary and/or trade secret.

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply ~~Up to 30 days~~ up to 83 days		AWP Discount Retail Supply ~~31-90 days~~ 84-90 days*		AWP Discount Mail Supply ~~1-90 days~~ >84 days	
Brand Drugs[1]						
Discount from AWP[2] for all brands		**15.30%**		**22.00%**		**25.00%**
Dispensing Fee Per Rx	**$1.40**	per Rx	**$0.00**	per Rx	**$0.00**	per Rx
Generic Drugs[3]						

Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	**MAC Generics**: 79.00%** **Non-MAC Generics: 15.30%**		**MAC Generics**: 79.00%** **Non-MAC Generics: 15.30%**		**MAC Generics**: 82.50%** **Non-MAC Generics: 25.00%**	
Dispensing Fee Per Rx	**$1.40**	per Rx	**$0.00**	per Rx	**$0.00**	per Rx
Rebates[4]	**Per the City's request, BCBSAZ will provide a per employee per month (PEPM) administrative fee credit in lieu of BCBSAZ remitting any rebates. Please refer to the rates and assumptions in Section 7.**					
Three Tier Plan – Per Rx (brand & generic)	**The PEPM pharmacy rebate credit (offset) to the administration rate is based on the City's actual amount of pharmacy rebates for the most current 12 months (available reporting). This will be reviewed and determined as part of the Year 2 renewal.**					

1 Including both single source and multi-source brands.
2 Post September 26, 2009 AWP rollback
3 Including single-source generics.
4 100% of rebates must be passed through on a per employee per month basis, as a credit to the Medical administrative fee.

BCBSAZ Notes:

*BCBSAZ has shown discounts for our broadest network, as requested. For Retail-90, these discounts apply at any in-network pharmacy. BCBSAZ also offers a Walgreens-only Retail-90 option with improved discounts and would be pleased to present pricing, discounts and additional information should the City desire.

**MAC discount from AWP is offered as an effective overall Generic discount (Ingredient Cost) and includes all MAC and non-MAC drugs, including single source generic products.

Regarding the pricing guarantee: the City agrees that BCBSAZ may unilaterally change the guarantees in the event of one or more of the following:

- Any government imposed change in federal, state or local law that significantly impacts BCBSAZ's agreement with BCBSAZ's PBM, Catamaran
- A change in the scope of services to be performed by Catamaran under BCBSAZ's agreement with Catamaran
- A change of more than 20% in the total number of memberships subject to BCBSAZ's agreement with Catamaran
- Changes made to the industry AWP benchmark

These discounts and the dispensing fees will be measured annually on a calendar year basis and on BCBSAZ's entire, applicable book of business. Compounds, specialty claims, direct member reimbursements, COB claims, OTC claims (except OTC diabetic supplies) and claims with ancillary charges (e.g., flu shots and vaccines) will be excluded from the calculation.

All AWP discounts are based on Post-Rollback Average Wholesale Price.

Specialty drug specific discounts are available in **Section 9G** and only apply when the drug is dispensed

by BCBSAZ exclusive Specialty Pharmacy provider, BriovaRx.

Year 3 (1/1/2018-12/31/2018)

Note: BCBSAZ agrees to a two-year pricing guarantee, but is unable to agree to a three-year guarantee because our current contract with our PBM, Catamaran, ends 12/31/17.

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days		AWP Discount Retail Supply 31-90 days		AWP Discount Mail Supply 1-90 days	
Brand Drugs[1]						
Discount from AWP[2] for all brands		**n/a** %		**n/a** %		**n/a** %
Dispensing Fee Per Rx	$ **n/a**	per Rx	$ **n/a**	per Rx	$ **n/a**	per Rx
Generic Drugs[3]						
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)		**n/a** %		**n/a** %		**n/a** %
Dispensing Fee Per Rx	$ **n/a**	per Rx	$ **n/a**	per Rx	$ **n/a**	per Rx
Rebates[4]						
Three Tier Plan – Per Rx (brand & generic)	$ **n/a**	per employee per month	$ **n/a**	per employee per month	$ **n/a**	per employee per month

1 Including both single source and multi-source brands.
2 Post September 26, 2009 AWP rollback
3 Including single-source generics.
4 100% of rebates must be passed through on a per employee per month basis, as a credit to the Medical administrative fee.

3. Are <u>any</u> prescriptions excluded from the guaranteed prescription drug and specialty pharmacy program pricing as described in your responses in the Financial Sections above? If so, describe in detail, and provide a minimum guaranteed AWP discount for these prescriptions at both retail and mail, and indicate, based on the City's attached prescription drug claims information for July 2013 through June 2014, the percent retail and mail AWP excluded for these prescriptions from your guarantees. Otherwise, your above responses will be assumed applicable to **<u>all</u>** prescriptions.

   Yes, certain prescriptions are excluded from the guaranteed pharmacy network discounts, as follows:

   1. Compounds: same as noted above with a $10 dispensing fee per prescription
   2. Specialty Pharmacy Program claims: Specialty drug specific discounts are available in **Section 9G** and only apply when the drug is dispensed by BCBSAZ exclusive Specialty Pharmacy provider, BriovaRx
   3. Mail order claims: discount noted above only applies with a day supply greater than 84.
   4. OTC claims (except OTC diabetic supplies, which are included as noted above): subject to different discounts (if any) than noted above

5. Claims with ancillary charges (e.g., immunizations): same as noted above with $25 administration fee per prescription
6. COB and direct member reimbursements: may be subject to different discounts than noted above

Prescription Type:_____	Retail	Mail
Minimum Guaranteed AWP Discount	n/a	n/a
Rx Type's AWP as a Percent of all AWP	n/a	n/a
Prescription Type:_____	**Retail**	**Mail**
Minimum Guaranteed AWP Discount	n/a	n/a
Rx Type's AWP as a Percent of all AWP	n/a	n/a
Prescription Type:_____	**Retail**	**Mail**
Minimum Guaranteed AWP Discount	n/a	n/a
Rx Type's AWP as a Percent of all AWP	n/a	n/a

4. Please confirm your proposed drug type designation or classification (e.g. brand, generic) source (i.e. First DataBank, Medi-Span, Redbook, Other). If other, please specify.

   MediSpan

Allowances

Allowance	Description	Response
Pre-Implementation Audit	Place the flat dollar ($) amount you are offering the City to be used to conduct a pre-implementation audit.	**Not applicable. BCBSAZ is the incumbent carrier. We are offering a $180,000 overall allotment, as noted within our medical proposal, which the City may use for any purpose they desire.**
Implementation	Place the $ (dollar) Per Member amount or the flat dollar ($) amount you are offering the City.	**Not applicable. BCBSAZ is the incumbent carrier. We are offering a $180,000 overall allotment, as noted within our medical proposal, which the City may use for any purpose they desire.**
Audit	Place the dollar ($) Per Member amount or the flat dollar ($) amount you are offering the City to be used annually to verify the City is receiving discounted costs and major services as contracted as well as 100% of rebates.	**We are offering a $180,000 overall allotment, as noted within our medical proposal, which the City may use for any purpose they desire.**

5. Utilizing the claims file provided and based on the broadest preferred drug list (with no exclusions or clinical programs), complete the table below based on the proposed pricing.

Proprietary, Confidential and/or Trade Secret

The Pharmacy Savings Report (repricing summary for passthru model) is located in **Section 9H**. Results requested are summarized in the table below.

Type	Total AWP/WAC* Cost ($)	As a Percentage (%) of Total AWP/WAC* Cost
RETAIL		
Total Brand Drugs (AWP)	$ 3,465,587.71	84.70%
Total Generic Drugs (AWP)	$ 3,644,119.87	21.48%
Projected Rebate Revenue (WAC)	see note 1	see note 1
MAIL		
Total Brand Drugs (AWP)	$ 314,478.78	75.00%
Total Generic Drugs (AWP)	$ 418702.10	17.97%
Projected Rebate Revenue (WAC)	see note 1	see note 1
SPECIALTY	**see note 2 regarding specialty discounts**	
Total Brand Drugs (AWP)	$ 314,839.85 (see note 3)	15.80% (see note 3)
Total Generic Drugs (AWP)	not applicable (see note 3)	not applicable (see note 3)
Projected Rebate Revenue (WAC)	see note 1	see note 1

BCBSAZ Notes:

1. Per the City's request, BCBSAZ will continue to provide a per employee per month (PEPM) administrative fee credit in lieu of BCBSAZ remitting any rebates attributable to drug utilization by the City's participants. The PEPM credit amount is $12.00 overall (it is not delineated by retail/mail/specialty). The PEPM pharmacy rebate credit (offset) to the administration rate is based on the City's actual amount of pharmacy rebates for the most current 12 months (available reporting).
2. Specialty drug specific discounts are available in **Section 9G** and only apply when the drug is dispensed by BCBSAZ exclusive Specialty Pharmacy provider, BriovaRx.
3. Specialty Drugs, as defined by the current benefit design, were excluded from repricing. As the incumbent vendor, even with a change in model from traditional to passthru, the specialty drug discounts will remain the same. The City's current utilization indicates only brand specialty drug utilization.

6. Confirm the pricing above reflects:

	Yes	No
All guarantees are calculated using the date sensitive AWP based on the 11-digit NDC of the actual product dispensed	**Yes**	

	Yes	No
All-in generic guarantee inclusive of single-source generics	**Yes**	
Drugs with an "Insufficient Supply" are included in the guarantees **BCBSAZ doesn't do partial fills, so in the event a pharmacy didn't have sufficient supply to complete an order, the pharmacy bills the claim for the FULL quantity, dispenses the quantity they have in stock, then does a partial fill to the member to make their order 'whole.' These are included in the guarantee.**		**No**
Member Cost Share at the point-of-sale (for retail and mail) is based on the lowest of the plan copay/coinsurance, usual and customary charges, negotiated discounted ingredient cost plus dispensing fee or retail cash price **Submitted Usual and Customary cost (U&C) is being interpreted by BCBSAZ to be the same as the retail cash price.**	**Yes**	
All guarantees are calculated before the application of member cost share	**Yes**	
All guarantees are stand-alone with no offsetting (within or across channels)	**Yes**	
Any guarantee shortfalls are paid on a dollar-for-dollar basis	**Yes**	

BCBSAZ Notes:

Discounts are based BCBSAZ book of business.

These discounts and the dispensing fees will be measured annually on a calendar year basis and on BCBSAZ's entire, applicable book of business. Compounds, specialty claims, direct member reimbursements, COB claims, OTC claims (except OTC diabetic supplies) and claims with ancillary charges (e.g., flu shots and vaccines) will be excluded from the calculation.

Mail order discounts only apply for claims with a day supply >84.

All AWP discounts are based on Post-Rollback Average Wholesale Price.

Specialty drug specific discounts are available in **Section 9G** and only apply when the drug is dispensed by BCBSAZ exclusive Specialty Pharmacy provider, BriovaRx.

Generic Drugs - Dispensing Rates

1. Complete the table below for contract Years 1, 2, and 3. Note that generic dispensing rate includes only true instances of generic dispensing (i.e., exclude multi-source brand drugs dispensed under member-pay-difference plan designs).

   Not applicable; BCBSAZ is not offering a guaranteed generic dispensing rate.

Guaranteed GDR	Retail ≤ 30 days	Retail >30 days	Mail Order
1/1/2016-12/31/2016	**n/a (not offered)**	**n/a (not offered)**	**n/a (not offered)**
1/1/2017-12/31/2017	**n/a (not offered)**	**n/a (not offered)**	**n/a (not offered)**
1/1/2018-12/31/2018	**n/a (not offered)**	**n/a (not offered)**	**n/a (not offered)**

What dollar amount are you prepared to put at risk for failure to meet your GDR guarantee?

Not applicable; BCBSAZ is not offering a guaranteed generic dispensing rate.

Specialty Pharmacy Program Pricing

2. Please provide your organization's definition and qualification criteria of a "specialty drug product."

   Please see **Section 9G** for a copy of our specialty self-injectable drug list through our exclusive Specialty Pharmacy provider, BriovaRx.

   Specialty drug products are medications generally prescribed for people with complex or ongoing medical conditions to reduce morbidity or mortality (e.g. multiple sclerosis, hemophilia, hepatitis, immunologic disorders, enzyme deficiencies, cancer, HIV, pulmonary arterial hypertension, growth hormone deficiency, organ transplant, severe kidney disease, etc.). These medications also typically have one or more of the following characteristics: injected or infused or implanted, but some may be taken by mouth or inhaled; unique storage or shipment requirements; additional education and support required from a nurse or pharmacist health care professional; moderate to severe side effects which need additional support or education; significant or serious health consequence if not taken as prescribed; reduced intended outcome if not taken as prescribed or managed sufficiently with other medical conditions or medications, and may not be readily stocked at retail pharmacies or may have limited distribution by the manufacturer.

3. Provide an AWP-based pricing list of all specialty pharmaceuticals that your company dispenses and distributes to providers and patients. Your pricing must include adequate supplies of ancillaries such as needles, swabs, syringes, and containers. The following items must be included in your list:

   a. Product Name

   b. Therapeutic Group/Therapeutic Category

   c. Guaranteed Minimum AWP Discount for all specialty pharmacy program prescriptions for both Open and Exclusive specialty arrangements

   Specialty Pharmacy Program claims: Specialty drug specific discounts are available in **Section 9G** and only apply when the drug is dispensed by BCBSAZ exclusive Specialty Pharmacy provider, BriovaRx.

Complete the following tables:

Open Specialty Pharmacy Program	1/1/2016-12/31/2016		1/1/2017-12/31/2017		1/1/2018-12/31/2018	
Dispensing Fee	$ **n/a**	per Rx	$ **n/a**	per Rx	$ **n/a**	per Rx
Administrative Fee	$ **n/a**	per Rx	$ **n/a**	per Rx	$ **n/a**	per Rx
Minimum Rebate Guaranteed*	$ **n/a**	per employ	$ **n/a**	per employ	$ **n/a**	per employ

*100% of rebates must be passed through on a per employee per month basis, as a credit to the Medical administrative fee.		ee per month		ee per month		ee per month

Note: BCBSAZ does not offer an open Specialty Pharmacy Program.

Exclusive Specialty Pharmacy Program	1/1/2016-12/31/2016		1/1/2017-12/31/2017		1/1/2018-12/31/2018	
Dispensing Fee	**$0.00**	per Rx	**$0.00**	per Rx	$ **n/a**	per Rx
Administrative Fee	**$0.00**	per Rx	**$0.00**	per Rx	$ **n/a**	per Rx
Minimum Rebate Guaranteed* *100% of rebates must be passed through on a per employee per month basis, as a credit to the Medical administrative fee.	$ **n/a**	per employ ee per month	$ **n/a**	per employ ee per month	$ **n/a**	per employ ee per month

AWP discounts in **Section 9G** are offered as pricing guarantees provided the medication is dispensed at a BriovaRx pharmacy.

Per the City's request, BCBSAZ will provide a per employee per month administrative fee credit in lieu of BCBSAZ remitting any rebates attributable to drug utilization by the City'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 the City. BCBSAZ shall not remit any rebate payments to the City. Please refer to the self-funded rates and assumptions in **Section 7**.

4. Please provide the open and exclusive guaranteed default specialty discount guarantees.

   An open program is not offered. The discounts in the Specialty Drug Pricing document in **Section 9G** are offered at a drug level, provided the medications are dispensed at BCBSAZ's exclusive specialty pharmacy, BriovaRx.

5. Please provide the open and exclusive minimum overall specialty guaranteed discount.

   An open program is not offered. The discounts in the Specialty Drug Pricing document in **Section 9G** are offered at a drug level, provided the medications are dispensed at BCBSAZ's exclusive specialty pharmacy, BriovaRx.

6. Please provide the open and exclusive mode specialty discount guarantees.

   An open program is not offered. The discounts in the Specialty Drug Pricing document in **Section 9G** are offered at a drug level, provided the medications are dispensed at BCBSAZ's exclusive specialty pharmacy, BriovaRx.

7. Please provide the open and exclusive average specialty discount guarantees.

An open program is not offered. The discounts in the Specialty Drug Pricing document in **Section 9G** are offered at a drug level, provided the medications are dispensed at BCBSAZ's exclusive specialty pharmacy, BriovaRx.

8. Are your proposed guarantees for your retail/mail program contingent upon the City's purchase of your specialty drug program?

   Yes.

9. Based on the City's attached prescription drug claims information for September 2013 through August 2014, indicate the percent retail and mail specialty prescriptions and specialty AWP on the following table:

Specialty Rxs at Retail as a Percent of all Retail Rx's	**0%**
Specialty AWP at Retail as a Percent of all Retail AWP	**0%**
Specialty Rxs at Mail as a Percent of all Mail Rx's	**0%**
Specialty AWP at Mail as a Percent of all Mail AWP	**0%**

   Note: BCBSAZ's Specialty Pharmacy Program requires these medications be dispensed from a BriovaRx Pharmacy. Retail and Mail Order Pharmacies will not be able to dispense.

10. Based on the City's attached prescription drug claims information through August, 2014 for prescriptions **that were dispensed at retail**, and your specialty pharmacy program pricing list provided in response to question 1 in the Specialty Pharmacy Program Pricing, what is the weighted average AWP discount for specialty prescriptions on the list?

    Not applicable. Medications covered under BCBSAZ's Specialty Pharmacy Benefit are only available at BriovaRx.

11. Based on the City's attached prescription drug claims information for November 2013 through October , 2014 for prescriptions **that were dispensed at mail**, and your specialty pharmacy program pricing list provided in response to question 1 in the Specialty Pharmacy Program Pricing, what is the weighted average AWP discount for specialty prescriptions on the list?

    Not applicable. Medications covered under BCBSAZ's Specialty Pharmacy Benefit are only available at BriovaRx.

12. **Provide an overall percentage discount off of Medispan AWP-based, NDC level pricing for specialty. Confirm this guarantee be reconciled annually and is a stand-alone guarantee.**

    Not applicable. An open program is not offered. The discounts in the Specialty Drug Pricing document in **Section 9G** are offered at a drug level, provided the medications are dispensed at BCBSAZ's exclusive specialty pharmacy, BriovaRx.

Formulary Management/Disruption

1. **Based on the utilization data provided, list all products that will change tier under your proposed formulary or become non covered or non-preferred. Fill in the table below:**

Current Tier	Proposed Tier	Type of Change	Rxs	% of Total Rxs
1	1	No Change	**0**	**0%**
2	2	No Change	**0**	**0%**
1	2	Negative(Tier 1 to Tier 2)	**0**	**0%**
2	1	Positive (Tier 2 to Tier 1)	**0**	**0%**
3	3	No Change	**all**	**100%**
		Total		100.0%

Note: This is not applicable. As BCBSAZ is the incumbent carrier, there will not be member impact or disruption for the current multi-tier benefit design or pharmacy network.

2. **Please list which formulary you are proposing in this bid and include a brief description.**

Instead of requiring members to adhere to a strict formulary program, BCBSAZ offers a multi-level copay benefit design providing coverage for all drugs (with the exception of plan exclusions) at varying levels. As a result, this benefit design creates an incentive for physicians and members to make the most cost effective choice about prescription drugs for each individual member through copay differentials. Typically, generic drugs are covered at Level 1—the lowest copayment whereas, levels 2, 3 and 4 (if applicable) include most brand products. The lists may be found in **Section 10P.**

The BCBSAZ P&T Committee determines preferred brand drugs by taking into account the drug's efficacy based on the FDA-approved indication and cost.

Additionally, BCBSAZ's rebate program works in tandem with preferred brand drugs to determine the lowest total cost rather than selecting preferred brand drugs based on a manufacturer's rebate offering—as this may result in higher total costs for our clients and their members.

3. **Will you guarantee that any proposed changes to the formulary, in future contract years will NOT impact the amount of the credit to the medical administrative fee (City retains right to approve or disapprove of all proposed formulary changes with no financial impact)?**

Please Confirm.

No. BCBSAZ does not agree to obtain the City's approval prior to making drug tier changes to our program. Program design and drug tier changes are determined by BCBAZ's P&T Committee. BCBSAZ is offering our multi-tiered benefit program which applies to all of our at-risk business in addition to ASC groups. Because a single program is used for all business, BCBSAZ is able to

negotiate better rebate arrangements with pharmaceutical manufacturers while keeping our goal of lowest net cost in sight.

Changes requiring member notification must be made in compliance with Department of Labor requirements, which we adhere to. Any changes that would be of a negative impact would result in notification direct to affected members prior to any changes being put in place.

Clinical Programs and Utilization Management

1. Please confirm that you will administer the current clinical edits at no additional charge.

   BCBSAZ confirms.

2. Based on the utilization data provided, list your Clinical Program recommendations along with pricing. In addition, provide savings and disruption projections for the City.

   Not applicable, as BCBSAZ is the incumbent carrier.

Performance Guarantees

The City will require specific performance guarantees. All guarantees shall be set and measured annually, and must have the ability to measure performance separately based on its experiences with the chosen PBM. Measurement of performance guarantees may be based on internal self-reporting, subject to independent audit.

Performance guarantees offered below are for the first contract year. For each subsequent year, BCBSAZ will verify the performance guarantees and amounts at-risk as part of the renewal process. Generally, we can offer initial guarantees for the entire multi-year duration of a client's contract. However, our current contract with our PBM, Catamaran, ends 12/31/17 and certain guarantees are passed directly through this contract. Should any modifications be required, BCBSAZ will work with the City to offer mutually-agreeable standards.

BCBSAZ is submitting a bundled quote including medical and pharmacy administration. As such, many of our performance guarantees are based on overall performance (including medical and pharmacy).

Measurement of performance guarantees is based on internal self-reporting. BCBSAZ does not offer independent audit of reporting results at this time. BCBSAZ wishes to note that, while we are unable to offer independent auditing for performance guarantees, we offer clients robust audit rights in other areas, as detailed within the Audit Rights section of the sample contract in Section 10A.

1. The City is looking for flat dollar ($) performance guarantee amounts. Indicate the amount you are willing to place at risk for each item listed in the table below. In addition, you may provide other guarantees designed to differentiate your program.

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
Implementation				
Clean Implementation	No systems errors, ID card delays, and the City online access to all tools prior to effective date	Not proposed separately. BCBSAZ agrees as part of overall implementation, provided clean pharmacy benefits and eligibility are received by the BCBSAZ	Please see Medical performance guarantees. BCBSAZ is not placing a separate amount at-risk for PBM.	n/a

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		Pharmacy department at least 45 days prior to the effective date. BCBSAZ will discuss and mutually agree upon tools for online access.		
Implementation Timeline	Implementation team will be assigned and introduced to the City at least 3 months in advance of effective date	Not proposed separately. BCBSAZ agrees as part of overall implementation. After award, Client Implementation Managers Scott Salisbury and Trisha Honaker will meet with the City to develop a mutually agreed upon implementation plan.	Please see Medical performance guarantees. BCBSAZ is not placing a separate amount at-risk for PBM.	n/a
Implementation Team	Implementation team members will not change and will be responsible for the accurate installation of all administrative, clinical and financial parameters for the City's program	Not proposed separately. Client Implementation Managers Scott Salisbury and Trisha Posser will oversee implementation.	Please see Medical performance guarantees. BCBSAZ is not placing a separate amount at-risk	n/a

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
			for PBM.	
Implementation Satisfaction Scorecard	Assigned Account Executive will work with the City prior to the start of implementation to agree on terms of a satisfaction scorecard to be issued to the City after effective date for completion	Not proposed separately.	Please see Medical performance guarantees. BCBSAZ is not placing a separate amount at-risk for PBM.	n/a
Payment Accuracy & System Performance				
Protected Health Information	PBM guarantees no incidents in violation of HIPAA Security Rules which results in a transmission of electronic PHI for the City's covered members	Not proposed. We have standards and monitoring in place to comply with government rules and regulations.	n/a	n/a
Plan Administration Accuracy	Implementation of all plan design changes will be 100% accurate	Not proposed.	n/a	n/a
Pricing Change Accuracy	Implementation of all pricing changes will be 100% accurate	Not proposed.	n/a	n/a
Financial accuracy (electronic and paper claims)	Percentage of claim payments made without error relative to the total dollars paid will be at least 99%	Not proposed. Pricing guaranteed are offered instead, as documented in PBM RFP response.	n/a	n/a

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
Mail Service Non-Financial Accuracy	The mail service pharmacy shall guarantee dispensing accuracy of at least 99.995% (correct participant name, correct participant address, correct drug, correct dosage form, and correct strength)	**Book of Business** **Modification offered:** At least 99.95% prescription dispensing accuracy.	**$500 per quarter**	**Measured quarterly** **Paid annually**
System Downtime	At least 99.5% access to its systems by all the retail pharmacies in PBM's network 24 hours a day, 7 days a week, 365 days a year	**Book of Business** **Modification offered:** Average of at least 98% availability (excluding scheduled downtimes).	**$500 per quarter**	**Measured quarterly** **Paid annually**
Invoicing Errors	All invoicing errors will be credits back to the City by next billing cycle or PBM will pay interest	Not proposed.	n/a	n/a
Claims Eligibility Data	Eligibility loads not to exceed 24-hours after receipt	**Book of Business**	**$500 per quarter**	**Measured quarterly** **Paid annually**
Eligibility Data Error Reporting	Eligibility file error reporting on all eligibility file updates will be provided to the City within 2 business days	**City-specific**	**$2,000 per year**	**Measured annually** **Paid annually**
Eligibility Error Rate Audits	Error rate identified through quarterly audits shall not exceed, on an average basis, 2%	Not proposed.	n/a	n/a
Retail Pharmacy Audit	PBM will perform an on-site audit of 3% or more of their retail pharmacies which dispense greater than 500 claims a year	**City-specific** Results will be provided within 90 days of the	**$500 per year**	**Measured annually** **Paid annually**

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		close of the calendar year.		
Retail Pharmacy Turnover	Less than 5% of retail pharmacies will leave the retail network	Not proposed.	n/a	n/a
Claims Detail File	All claims detail files sent to external vendors will be provided within 8 days of request or scheduled delivery date	Not applicable. Our pharmacy benefit management program is only offered when medical administration is selected.	n/a	n/a
Account Management				
City Approval of Member Communications	100% of all member communications will be approved by the City – exceptions for drug recalls and urgent patient safety communications	Not proposed.	n/a	n/a
Delivery of Standard Reports	Within 30 days of end of reporting quarter	**City-specific** Our clients can obtain pharmacy reporting through BlueInsight℠. BlueInsight, our online reporting tool, is available 24 hours a day, seven days a week. It is updated on the 20th of each month.	**$2,000 per year**	**Measured annually** **Paid annually**

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
Accuracy of Standard Reports	All standard reports provided will be 100% accurate	**City-specific** Our clients can obtain pharmacy reporting through BlueInsight℠. BlueInsight is an integrated reporting tool, with information aggregated directly from our claims and eligibility system.	**$2,000 per year**	**Measured annually** **Paid annually**
Pharmacy Audit Resolution	48 hours after receipt of findings	Not proposed.	n/a	n/a
PBM Account Team's Performance	The City may assess a penalty after the first Contract Year and each successive Contract Year, the City's benefits staff do not rate PBM account team's performance for such Contract Year an average of 3 or better on a scale of 1 to 5 (5 being the best based on a range of performance criteria agreed to between the City and PBM at the beginning of such Contract Year)	**City-specific** Overall score of 3 (satisfied) or better on the annual BCBSAZ medical Account Management Score Card (annual Group Benefit Administrator survey). Categories include: effective support for open enrollment events, timely client notification of issues impacting members,	**$5,000 per year**	**Measured annually** **Paid annually**

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		response to client issues and questions in timely, comprehensive manner, effective coordination to resolve open issues, accessibility, and delivery of agreed-upon reports on time. BCBSAZ Account Management Score Card (annual) – see attached.		
Account Management Turnover	Account team members will remain constant for at least the first 18 months of the contract period, unless a change in account management staff is requested by the City	Not proposed. BCBSAZ will make every effort to comply and will advise the City of any unforeseen circumstances relating to Account Management team.	n/a	n/a
Member Services				
Mail Turnaround – Prescriptions not requiring intervention	95% of prescriptions dispensed within average of 2 business days and 100% within average of 3 business days	**Book of Business** **Modification offered:** Average of 90% of prescriptions not	**$500 per quarter**	**Measured quarterly** **Paid annually**

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		subject to intervention will be dispensed within two (2) business days and prescription subject to intervention within two business days after resolution of intervention.		
Mail Turnaround – Prescriptions requiring intervention	95% of prescriptions dispensed within average of 4 business days and 100% within average of 5 business days	Not proposed separately; see guarantee above.	n/a	n/a
Paper Claims Turnaround	95% of prescriptions reimbursed within average of 10 business days and 100% within average of 14 business days	**Book of Business** **Modification offered:** Average of 95% within an average of ten (10) business days after receipt by Catamaran.	**$500 per quarter**	**Measured quarterly** **Paid annually**
ID Cards Mailing	98% of all ID cards are sent within 5 business days of receipt of eligibility. 100% mailed within 10 business days.	**City-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	**$5,000 per year**	**Measured annually** **Paid annually**

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
		information in a format agreed upon between the City and BCBSAZ.		
Mailing Member Materials	All applicable member materials (for example, mail order forms) will be mailed at least 10 days prior to the effective date and will be 100% accurate (provided that eligibility file was received at least 30 days prior to the effective date).	Not proposed.	n/a	n/a
Phone Average Speed of Answer	100% of calls to the City-specific toll free line shall be answered within 20 seconds (excluding IVR)	**Book of Business** **Modification offered:** Average of 30 seconds or less.	**$500 per quarter**	**Measured quarterly** **Paid annually**
Phone Abandonment Rate	100% of calls to the City-specific toll free line shall be answered with an abandonment rate of 3% of less	**Book of Business** **Modification offered:** Equal to or less than 3% after 30 seconds.	**$500 per quarter**	**Measured quarterly** **Paid annually**
Written Inquiry Answer Time	95% of inquiries responded to in 5 business days – 100% in 20 business days	Not proposed.	n/a	n/a
Member Satisfaction Survey	The PBM agrees to conduct a Member Satisfaction Survey for each contract year and that the Satisfaction Rate will be 90% or greater. A penalty may be assessed against the PBM for failure to meet this standard. "Member Satisfaction Rate" means (i) the number of Eligible Persons responding to PBM annual standard Patient Satisfaction Survey as being	Not proposed separately. BCBSAZ's pharmacy benefits administration (PBM) quote is contingent upon selection of BCBSAZ	Please see Medical performance guarantees. BCBSAZ is not placing a separate	n/a

	Standard	Measurement Criteria (BOB or City specific)	Penalty Dollars at Risk	Timing of Payments
	satisfied with the overall performance under the Integrated Program divided by (ii) the number of Eligible Persons responding to such annual Patient Satisfaction Survey; the City must provide timely approvals and responses, and a minimum of 20% of surveys must be returned for the Performance standard to be applicable.	medical coverage. This performance guarantee is addressed within the medical performance guarantees.	amount at-risk for PBM.	
Issue Resolution: Verbal Inquiries	PBM will resolve 99% of all telephone issues at the first point of contact (the number of telephone inquiries completely resolved at the time of initial contact divided by the total number of calls)	**Book of Business** **Modification offered:** First call resolution: 93% or greater of calls related to pharmacy matters will be resolved on first call.	**$500 per quarter**	**Measured quarterly** **Paid annually**
Issue Resolution: Written Inquiries	PBM will resolve 98% of all written inquiries within 10 business days of receipt of inquiry	Not proposed.	n/a	n/a
Issue Resolution: the City Staff Involvement / Escalation	When the City contacts you with an elevated claim issue via phone, email or through their Consultant, you will respond within 24 hours and provide progress reports every 48 hours until the issue is resolved.	Not proposed separately. Responsiveness measure will be included in annual medical Account Management Scorecard, as proposed in the "PBM Account Team's Performance" guarantee, above.	n/a	n/a

QUESTIONNAIRE

Complete the following tables in regards to your PBM services only:

Contact Information

Organization Name:	Blue Cross® Blue Shield® of Arizona (BCBSAZ)
Date Founded	1939
Contact Person's Name	Ken Muth
Title	Strategic Relationship Executive
Address	8220 N. 23rd Ave., Bldg. #2
City/State	Phoenix, AZ 85021
Phone Number	602-336-7520
E-mail Address	ken.muth@azblue.com
Fax Number	602-864-5899

References

CURRENT REFERENCES				
Name	**Contact Name**	**Phone Number and Client Location**	**Number of Members**	**Contract Start Date**
Tempe Elementary School District	Christine Busch	(480) 730-7132 Tempe, AZ	2,010	7/1/2005 to present
City of Glendale	Jim Brown	(623) 930-2277 Glendale, AZ	4,527	5/1/93 to present
Phoenix Union High School District	Cyndy Nelke	(602) 764-1105 Phoenix, AZ	3,145	7/1/03 to present
City of Peoria	Christine Nickel	(623) 773-7101 Peoria, AZ	2,893	11/1/89 to 7/1/99, 7/1/2001 to present
RECENTLY TERMINATED CLIENT REFERENCES				
Name	**Contact Name**	**Phone Number**	**Termination Reason**	**Termination Date**
Phoenix Elementary School District #1	Larry Weeks	(602) 257-3790	funding change/rates	7/1/2012
John C. Lincoln Health Network	David Lamparter	(623) 434-6229	rates	1/1/2012
Scottsdale Unified School District	Jeff Thomas	(480) 484-6297	joined VSEBT	7/1/2010

Ken Muth

Authorized Signature

ORGANIZATIONAL STABILITY & EXPERIENCE	RESPONSE
1. Provide the latest annual report, financial statement, SAS 70 type II, and other financial reports that indicate the financial position of your organization. Including:	BCBSAZ will complete our first SSAE 16 SOC in 2016. Previously, we did not seek or obtain SAS 70 or SSAE 16 reports. We are a URAC-accredited health plan and are required to have rigorous internal and external controls, as well as reporting, for privacy and security. In addition, the Blue Cross and Blue Shield (BCBS) Association has strict standards required of all Blue Plans that ensure adequate quality and accuracy measures are in place. As such, we perform claims accuracy audits, as required by the BCBS Association.
a. Current ratio	See above.
b. Days cash on hand	See above.
c. Debt to equity ratio	See above.
2. Complete the following table:	
a. Parent Company	Not applicable. BCBSAZ is an independent licensee of the Blue Cross and Blue Shield Association. BCBSAZ is independently operated, with its own board and management, and is regulated by the laws of the State of Arizona. BCBSAZ is a not-for-profit organization. Blue Cross Blue Shield of Arizona (BCBSAZ) subcontracts for certain PBM services with Catamaran.
b. Year PBM Established	BCBSAZ PBM Services: 1998
c. Membership count (total covered lives)	See below.
Current (2014)	323,616
1 year prior (2013)	282,000
2 years prior (2012)	269,559
% of total potential lives from the City (current)	Less than 1 percent
% from MCO/HMO plans (current)	5.6 percent
d. Number of Group Plans In Force (current)	See below.

ORGANIZATIONAL STABILITY & EXPERIENCE	RESPONSE
Total	3,656
Under 10,000 lives	3,654
Over 100,000 lives	0
Number of Health Plans	99 percent
e. AWP dollars processed (calendar year 2013)	See below.
Retail	*Proprietary, Confidential and/or Trade Secret* BCBSAZ Book of Business* Retail: $154,104,559.89
Mail Order	*Proprietary, Confidential and/or Trade Secret* BCBSAZ Book of Business Mail Order: $15,410,806.10
3. Have you relocated staff, changed computer or telephone systems in the last 12 months?	No significant staffing relocations or changes in computer/telephone systems have occurred during the past 12 months.
4. Do you anticipate any major changes to your organization or structure in the next 12-24 months? If so, elaborate.	No, we do not anticipate and material changes that would have an effect on the City at this time.
5. Indicate the number of any outstanding legal actions pending against your organization and/or owners.	**BCBSAZ:** BCBSAZ has been and is involved in certain litigation regarding benefits and violations of law. While it is not possible to predict the outcomes of litigation, based on the status of the existing lawsuits, we do not believe the current lawsuits have merit or that they will have a material adverse effect on the company. **Catamaran:** As a public company in a highly regulated industry, we are occasionally subject to claims or litigation, none of which has had or will not have adverse effect. Any material litigation is disclose in the annual report, Form 10K.There are no current actions that will disrupt service to the City.
Explain the nature and status of the action(s).	See immediately above.
Can you assure the City these actions will	See immediately above.

ORGANIZATIONAL STABILITY & EXPERIENCE	RESPONSE
not disrupt business operations?	
6. What general and professional liability coverage do you currently have in place for the entity that is proposing to protect the City from losses or negligence?	Managed Care Errors & Omissions Liability: $10,000,000 Limit Managed Care Errors & Omissions Liability Excess: $10,000,000 Limit Managed Care Errors & Omissions Liability Excess: $10,000,000 Limit Fiduciary Liability: $10,000,000 Limit Employee Fidelity & Electronic Crime Program: $5,000,000/Occurrence, $10,000,000/Aggregate General Liability: $1,000,000/Occurrence, $2,000,000/Aggregate Cyber Liability: $10,000,000/Aggregate
7. Provide a disclosure of all potential conflicts of interest (e.g. brand manufacturer payments, programs that shift prescriptions to drugs that are more expensive, etc.)	BCBSAZ is identifying Pharmaceutical manufacturer rebates as a program we believe is NOT a conflict of interest because BCBSAZ passes rebate revenue back to our clients either as 100% of rebate check payments, or as an offset to administrative fees in lieu of actual earned rebates (the City has elected a per employee per month offset to the administrative fee in lieu of actual earned rebates). We do not believe there are any other potential conflicts of interest, to our knowledge.

OUTSIDE SERVICE ORGANIZATIONS PROVIDING PBM FUNCTIONS	YES	NO	NAME AND ADDRESS OF THE SERVICE PROVIDER
Complete the following indicating the provider of each PBM service.			
a. Formulary Management (appeals, utilization management)		**No**	(performed in-house)
b. Any outsourced clinical programs (prior-authorizations, etc.)		**No**	(all performed in-house)
c. Any outsourced administrative functions (including but not limited to all administrative functions listed in the fees section above)	**Yes**		**Claims adjudication:** Catamaran (headquarters) 1600 McConnor Parkway, Schaumburg, IL 60173-6801
d. Formulary Pharmacy and Therapeutics Committee		**No**	(managed in-house)

e. Drug Manufacturer rebate contracting		**No**	(managed in-house)
f. Retail Pharmacy Network contracting	**Yes**		Catamaran (headquarters) 1600 McConnor Parkway, Schaumburg, IL 60173-6801
g. Customer Service functions	**Yes**		Catamaran (headquarters) 1600 McConnor Parkway, Schaumburg, IL 60173-6801
h. Member Service functions (800 lines, internet, etc.)	**Yes**	**No**	Catamaran (headquarters) 1600 McConnor Parkway, Schaumburg, IL 60173-6801 Member services for the Client will be handled at Catamaran's Phoenix call center located at: Catamaran 4805 E. Thistle Landing Suite 100D, Phoenix, AZ 85044 For web services, BCBSAZ provides through BlueNet.
i. Mail Order drug purchasing and dispensing	**Yes**		Walgreens, 8350 S. River Parkway, Tempe, Arizona 85284
j. Electronic Claim Payment System	**Yes**		Catamaran (headquarters) 1600 McConnor Parkway, Schaumburg, IL 60173-6801
k. City management reporting tools and standard report production		**No**	(BlueInsight managed in-house)
l. Specialty Pharmacy	**Yes**		BriovaRx 6330 South Sandhill Road, Suite 12, Las Vegas, NV 89120
m. City invoicing / accounting		**No**	(performed in-house)
n. Other (Describe)	**Yes**		**Pharmacy Audit functions:** Catamaran (headquarters) 1600 McConnor Parkway, Schaumburg, IL 60173-6801
Describe what portion of the City's business with your organization will be serviced by a subcontractor or through leased services / networks	All subcontractors applicable to our pharmacy benefit management services are described above. Please note, 100% of the Pharmacy network and customer service call center is managed by Catamaran		

ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES	RESPONSE
1. Which office would handle the general member servicing of the City?	Member services for the Client will be handled at Catamaran's Phoenix call center located at: Catamaran 4805 E. Thistle Landing Suite 100D Phoenix, AZ 85044
What are the standard office hours for the sales and service office?	Services are available 24 hours a day, 7 days a week, 365 days a year.
2. Will you agree to monthly conference calls and one annual face-to-face meeting with the City to discuss plan performance, present financial results, etc.?	Yes. The City's current BCBSAZ account management team will continue to oversee the account. The team is comprised of Chris Hogan, R. Ph., VP Pharmacy Benefits Management; Ken Muth, Strategic Relationship Executive; and Colette Severns, CSM. The team will meet with the City on a quarterly basis, or more frequently if needed, in addition to an annual benchmark presentation.
What information would be shared at these meetings?	Quarterly meetings will review utilization patterns, updates relating to drug tier changes, quantity limits, prior authorizations and pharmacy network. The annual benchmark meeting, which occurs prior to release of renewal, will propose benefit design recommendations and alternative incentive strategies.
3. Will dedicated customer service representatives be assigned to this account?	No. The City's members will be serviced by the BCBSAZ team at Catamaran.
4. Do customer service reps have online access to real time claim processing information?	Yes.
5. For the customer service center proposed for the City provide the following for 2013:	
a. Percent of calls abandoned	Catamaran: 0.825 percent
b. Percent of calls handled by live representative	*Proprietary, Confidential and/or Trade Secret* Catamaran: 90 percent of calls are handled by a live member services representative.
c. Number of seconds to reach a live customer service representative	9 seconds
d. Inquiries made	Not available/not tracked in this manner
6. Will you record 100% of customer service calls? If not, what percentage of	Yes, Catamaran records 100% of customer service calls.

ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES	RESPONSE
customer service calls will be recorded?	
Do you offer the City online access to information and services via the Internet or through CRT interface? Are there quantity access limits? If yes, what information is accessible and at what additional cost, if any.	No, the City will not have access to the vendor adjudication system. Information for the member is available through the BlueNet Member portal including drug and tier information.
7. Will the City be able to produce ID cards and/or temporary proof of benefit letters in "real time"?	Yes. Once enrolled, members can print temporary ID cards on their effective date from the member portal on azblue.com.
8. Can your organization send recovery letters to members who continue to use their drug card after their termination? If yes, at what cost?	No. Member eligibility is communicated to both retail and mail order vendors.
9. Will you survey the City members:	
a. Annually regarding program administration satisfaction?	Yes, BCBSAZ will conduct an annual satisfaction survey for the City's members. Please note that BCBSAZ's PBM proposal is contingent upon selection of our medical coverage. As the City's incumbent carrier, our 2014 survey of the City's members indicated that over 91% were satisfied with the service from BCBSAZ.
b. If yes, provide an example.	BCBSAZ will provide the survey detail upon award of the contract.
10. Will one toll-free number handle coverage for the retail, mail order, and specialty program?	No; basic customer service is provided through a single toll-free number; however, because the mail order and specialty pharmacies are providers as well, specific prescription inquiries may need to be directed to the mail and specialty providers, who each have a unique toll-free number.
11. What hours will the telephone lines be staffed?	The City's members will be serviced by the BCBSAZ team at Catamaran. Services are available 24 hours a day, 7 days a week, 365 days a year.
12. Are automated services available 24/7?	Yes, via telephone and online access.
13. How do you service members traveling internationally? What if international stay is for an extended period (visiting semester, etc.)?	Customer service is available 24 hours a day, 7 days a week, 365 days a year. Members may receive their medications via the mail order benefit prior to departing the USA.
14. Can you provide early refills for traveling members?	No; this is a general plan exclusion. BCBSAZ encourages members to utilize their mail order benefit for extended trips.

ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES	RESPONSE
15. List the top five member complaints related to retail, mail order, and the specialty pharmacy program.	General information indicates that the top five reasons for complaints are: 1. mail order - back ordered medications 2. mail order - turn around time/delivery 3. customer service - turn around time 4. specialty pharmacy - turn around time/delivery 5. general customer service experience
16. Do you provide member support services for selecting and/or locating network pharmacies and formulary look-ups?	Yes. Members who have a BlueNet account can log in and use the pharmacy locator tool and cost share calculator tools. Drug Tier lists are also available on our public website azblue.com.
17. How are members notified of the following events? (Indicate for each below: Phone, Written Document, or Other (specify)).	
a. Plan Change	Written Document
b. New Drug Additions/Formulary Changes	Other (see below) BCBSAZ updates the appropriate tier list(s) at azblue.com. Specific scenarios regarding formulary change are as follows: At the time a preferred brand drug (lower copay tier) has a generic equivalent enter the market, the preferred brand drug will generally move to non-preferred status (higher copay tier). Pharmacies are in the practice of moving members to a generic equivalent once the generic is available; no direct member notices are sent. If a drug is moved off of the preferred brand drug list (Level 2) for reasons other than a generic equivalent becoming available, then it is our policy to notify utilizing members 60 days prior to the drug moving to a higher tier. If a non-preferred brand drug (higher copay tier) moves to preferred brand (lower copay tier) status - no member notices are sent.
c. Change in Pharmacy Network Panel	Other (no notification). Members can use the Pharmacy locater in the member portal on BlueNet.
d. Ineligible, Banned, or Recalled Drug	Written Document (based on BCBSAZ evaluation)

ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES	RESPONSE
e. Generic Substitution	Other (pharmacy providers typically inform members of generic availability). The "What's My Cost-Share" tool, available online through BlueNet, also provides information on eligible generics.
f. Change in medical/clinical management rules	Written Document
18. How many sub-group levels can be captured in your claims and billing systems?	BCBSAZ's system has the ability to accommodate numerous sub-group levels. Upon further clarification, specific needs can be addressed.
19. Do you administer medical necessity appeals? Please describe the process in detail for your self-insured ERISA plans and the City.	Yes; BCBSAZ appeals process complies with state and federal laws and accreditation standards. BCBSAZ's Medical Appeal and Grievance Department handles healthcare appeals upon receipt. Appeals are imaged and tracked using an automated workflow system to ensure all timeliness requirements are met. An acknowledgement letter is mailed to the member and treating provider within five days of receipt of the level one request. Final determinations are communicated via written correspondence to both the member and the treating physician. The Appeals Process applies to denials of requests for services not yet provided and denials of claims for services already provided. Members have either one (1) or two (2) internal levels of appeal depending on product and one (1) external level of appeal performed by the Arizona Department of Insurance (DOI) or an Independent Review Organization (IRO). The timeframes and process may vary pre-service and post-service appeals depending on the type of plan. Internal levels of appeal 1. Expedited Level 1 (pre-certification appeals): the standard time frame is one day (72 hours for non-grandfathered self-funded plans) or 72 hours if holiday weekend 2. Expedited Level 2 (pre-certification appeals): the standard time frame is three business days 3. Standard Level 1 appeals: the standard time frame is 30 days 4. Standard Level 1 grievances: the standard

ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES	RESPONSE
	time frame is 60 days 5. Standard Level 2 pre-certification: appeals the standard time frame is 30 days 6. Standard Level 2 grievances: the standard time frame is 60 days – this date can be extended if additional time is needed to gather information, etc. Please see **Section 10G** for a copy of our explanation of benefits, which includes instructions on appeals.
20. How are out-of-network claims processed?	This is dependent on many factors, including benefit plan design. For instance, in these scenarios, the member would pay cash and submit the claim to BCBSAZ for reimbursement. BCBSAZ can then either apply the allowed amount and reduce by the appropriate cost share, or we could customize a cost share for out-of-network claims.
21. Describe any reports either clinical or financial in nature that would be provided to the City in order to help manage benefit costs.	Our clients can obtain pharmacy utilization reporting through BlueInsight℠. Please see the BlueInsight material in **Section 10E**. BCBSAZ will make numerous pharmacy reports available to the City, both online and in a non-electronic format. There are standard, pre-set formats as well as dynamic reporting functions to allow for ad hoc customization. These additional reports are available at the summary level, as well as at the claimant or detail level. BCBSAZ updates the reports on a monthly basis (20th of each month) to allow for trending on an ongoing basis.
22. How many days does the City have to pay once an invoice is received? What methods of payment are available (e.g., ACH, Direct Deposit, SurePay, Checks)? What exceptions are there to the standard payment terms?	BCBSAZ does not require a separate bank account to pay the group's claims. Bank reconciliations are not required. You will be provided with claims detail in order to "reconcile" the claims reimbursement invoice to the detailed listing of paid claims. However, the level to which reconciliation is completed and the requirements of that reconciliation are strictly at your discretion. By eliminating the need for a separate banking arrangement, additional bank account reconciliation time is not required. BCBSAZ generates claim invoices on approximately the 15th of every month, with payment due by the end of that month. Payment may be made via mailing a check to our Cash Control Department or

ADMINISTRATIVE, MEMBER & CLAIM PAYING SERVICES	RESPONSE
	via ACH draft through the employer portal on azblue.com.
23. Please confirm your organization can provide comprehensive plan sponsor benefit description set-up documents upon request or on an ongoing basis to the City. Please provide the guaranteed turn-around time for providing such requested documents.	Not applicable, as BCBSAZ is unable to offer stand-alone pharmacy benefit management. As pharmacy benefit management, if selected, would be handled as part of the medical administration, set-up would be handled as part of the standard process. BCBSAZ prepares Summaries of Benefits and Coverage (SBCs) and member benefit-plan booklets including any riders or amendments in accordance with applicable state and federal laws. BCBSAZ does not produce a Summary Plan Description (SPD) but can provide language that the City can incorporate into their plan document.

PRESCRIPTION REIMBURSEMENT ISSUES	RESPONSE
1. What is your proposed source for AWP data?	
First DataBank	n/a
Medi-Span	BCBSAZ uses Medi-Span.
Redbook	n/a
2. How often are AWP prices updated in your adjudication system?	
Monthly	
Quarterly	n/a
Semi-annually	n/a
Annually	n/a
Other	Daily: BCBSAZ's vendor receives daily updates from Medispan. Price changes are made as reported to Medispan by the pharmaceutical manufacturers/wholesalers.
3. What percent of your network pharmacy contracts include the "lesser of retail price, MAC price, or discounted price" provision?	
0 – 20%,	n/a

PRESCRIPTION REIMBURSEMENT ISSUES	RESPONSE
21 - 40%,	n/a
41 - 60%,	n/a
61 – 80%,	n/a
81 – 100%	100% of retail pharmacies
4. How do you guarantee that members always receive this lowest price? What procedures are established to ensure that the pharmacy is in compliance with this provision?	The pharmacy claims processing system is programmed to calculate this amount. Should the pharmacy attempt to charge an amount greater than the copay, we would receive complaints from members. For claims that are less than the copay, we rely on pharmacy network audits to identify outliers.
5. Will you guarantee on a dollar-for-dollar basis that the average, realized AWP discounts for brand and generic drugs and quoted dispensing fees will be no less than those quoted at Retail and Mail Order for the life of the contract?	No. Pricing guarantees are offered, with stated exceptions, based on BCBSAZ's book of business. We are offering pricing guarantees for year 1 and year 2 only at this time.
6. Explain in detail how network pharmacies' U&C prices are captured and reported.	Pharmacies include their claimed U&C when the pharmacy claim is submitted for adjudication. The claims are then processed looking at the various pricing components (discounted AWP, MAC (if applicable), submitted Usual & Customary Cost and submitted ingredient cost).
7. Describe the retail network pharmacy reimbursement process in detail.	Catamaran invoices clients for claim costs and dispensing fees on a weekly or semi-monthly basis. This corresponds with our pharmacy funding cycles which have cutoffs on the 15th and last day of each month. Catamaran utilizes paper checks or electronic funds transfer (EFT) for pharmacy reimbursement.
8. a. Are there financial incentives to network pharmacies, physicians and other providers that are tied to utilization rates, compliance goals, quality of care outcomes, or other performance results?	Yes, for physicians only.
b. If so, explain and include any incentive-based dispensing fees, bonuses, withholds, retroactive capitations, etc.	Physicians included in BCBSAZ's Patient Centered Medical Home program receive financial incentive for meeting generic dispensing goals. BCBSAZ pays these incentives.
9. Describe any financial or other incentives you are willing to offer the City based on	As BCBSAZ contracts for this service based on our book of business, we realize a significant discount

PRESCRIPTION REIMBURSEMENT ISSUES	RESPONSE
increased Internet utilization for mail order claim submission in recognition of the inherent cost savings.	based on volume. We are not able to offer any additional incentive based on internet utilization for mail order claim submission.
10. Do your MAC price lists vary contractually between network pharmacies? If yes, why?	BCBSAZ contracts with Catamaran for Pharmacy Network services; MAC pricing arrangements are between Catamaran and their contracted providers.
11. Will the retailers provide the lower of the discounted plan cost plus dispensing fee, member cost, U&C, or retail price for plan adjudication?	Pharmacies will submit the dispensing fee, ingredient cost and U&C for plan adjudication. The Rx claims processing system calculates the discounted plan cost and calculates the 'lower of' and returns that information to the pharmacy. The pharmacy is contractually obligated to collect this amount from the member.
12. Explain in detail the process you propose regarding the City verification of drug manufacturer revenue transparency.	BCBSAZ receives payment from pharmaceutical manufacturers for prescription claims utilization only. This amount is passed on to the City. The City may review these billing and payment documents specific to the City.

FORMULARY MANAGEMENT & REBATES	RESPONSE
1. a. If you require a formulary management fee, indicate amount or percentage proposed.	BCBSAZ does not charge any fees for our programs.
b. Other than these fees, do you guarantee that 100% of all rebates collected will be passed through to the City in the form of a per employee per month credit to the medical administrative fee?	Based on the City choosing a rebate eligible plan design, BCBSAZ will provide a PEPM credit to the administrative fee in lieu of remitting actual earned rebates.
2. Describe how your preferred drug list is established. Include how specific drugs are selected and how often your P&T Committee meets	Pharmacy management uses a dynamic evaluation process with consideration of numerous factors for the consideration of tier (level) placement of prescription medications. These considerations include, but are not limited to: • Advisement of the Pharmacy and Therapeutics committee and other community resources (examples: physician specialists in psychiatry, etc.) • Availability of alternative brand medications with similar indications from multiple manufacturers • Availability of components sold separately for combination medications • Generic availability, with consideration for

FORMULARY MANAGEMENT & REBATES	RESPONSE
	competitive generic pricing • Dosage forms available (capsules, tablets, liquid, sustained release, sol-tab, etc.) • Salt forms available • Relative use of medication considering other steps in care (lifestyle modification, OTC alternatives, etc.) • Direct to consumer marketing and effectiveness on consumers ability to "drive market share" verses consideration for cost effective medication selection • FDA warning letters to the manufacturer • National Legislation Issues • Patent Expiration consideration; litigation, pediatric indication extension, etc. • Plan and National Utilization-Average prescription cost based on dosing, frequency of use, physician specialty, indication of use. • Consideration for special population • Dosage price leveling (i.e. all dosage strengths are equal, therefore increases in dosing will not impact cost projections) • Off label uses (especially those that would affect dosing, population treated, etc.) • Medication specific pharmacoeconomic publications • AMCP (Academy of Managed Care Pharmacy) Dossier at the time of review • FDA safety notification and labeling changes for medication or class of medications • Rebates from pharmaceutical manufacturers after the most cost-effective medications have been selected for lower co-pay tier placement.
3. a. Are any P&T Committee members employed by or under contract with any drug manufacturers?	No, according to the most recent submitted disclosure statement(s).
b. Are any P&T members directly employed by your organization?	BCBSAZ's P&T Committee is comprised of three BCBSAZ employees , two community physicians , three pharmacists and three alternates.
4. Can you support custom changes to the preferred drug list at the request of the City?	No. BCBSAZ is not offering customization support at this time.

FORMULARY MANAGEMENT & REBATES	RESPONSE
5. Describe your process for defining "preventive drugs" for PPACA and High Deductible Plan purposes? How would you handle disputes between the City's preventive drugs lists and your standards? How will you support the associated cost share tiers?	Not applicable; as the City's incumbent carrier, our PPACA preventive drug list is currently used. Please see **Section 10P** for a copy of the PPACA Preventive Drug List.
6. Will you guarantee that any preferred drug lists switches which are not economically advantageous to the City on an ingredient cost basis will be reported and reimbursed to the City on a dollar-for-dollar basis using the least expensive, therapeutically equivalent alternative drug as the basis for reimbursement?	No. BCBSAZ drug lists are designed for all business, including self-funded and fully insured, for which BCBSAZ bears the risk. As such, switches that are not economically advantageous are not made.
7. Can the City be given the ability to authorize non-formulary overrides directly?	BCBSAZ is offering a multi-tier benefit design, not a formulary. BCBSAZ will provide self-funded/ASC groups this level of authority. Any deviations from the standard tier system may result in impacts to rebates. Since the City is receiving a PEPM credit in lieu of earned rebates, it may impact the PEPM credit. The City would additionally assume risk for customer service inquiries, appeals, grievances, etc.
8. What percent of all available brand drugs are excluded from your formulary or preferred drug listing (based on total number of Rx dispensed for plans with an open formulary)?	BCBSAZ allows coverage for all drugs on our multi-tiered benefit design. The only exception would be plan exclusions.
9. Please provide the percentage of non-formulary brand drugs that have a generic equivalent.	BCBSAZ does not track this information.
10. What percent of all available brand drugs are non-preferred (not on your preferred drug list)?	BCBSAZ does not track this information.
11. Do you have a Formulary Grievance Process in place to address member concerns regarding preferred drug list alternatives? If yes, explain this process in detail.	No. Members can grievance their cost share but drug tier placement is not appealable.

FORMULARY MANAGEMENT & REBATES	RESPONSE
12. Do you have the capabilities to have a specified cost-share for Multi-Source Brand drugs regardless of formulary status? (e.g., 75% co-insurance for all multi-source brands). Specify if there are system limitations where formulary coding supersedes any specific cost share coding specified for multi-source brands.	Not applicable. BCBSAZ is offering to continue the City's current multi-tier benefit design, which not a formulary. The multi-tier benefit design provides coverage for all drugs in varying tiers. The cost for multi-source brand drugs would be based on the applicable tier cost share.

Mail Order Program

MAIL ORDER PROGRAM	RESPONSE
1. Complete the following for your proposed mail order facility.	
a. Where will the mail-order facility location for the City be?	Through Catamaran, we contract with Walgreens located at 8350 S. River Parkway, Tempe, Arizona 85284 for mail order. A back-up/overflow facility is located in Orlando, FL.
b. What are the days and hours of operation for this facility?	Standard hours of operation are 6:30 a.m. to midnight Monday through Friday and 7 a.m. to 3 p.m. Saturday, local time. Live customer service representatives became available to mail pharmacy patients 24/7.
c. What was the total number of prescriptions filled in calendar year 2013 for this facility?	Approximately 11.9 million prescriptions were filled at the Tempe facility in 2013.
d. Which organizations are used for delivery services?	Walgreens primarily ships through the United States Postal Service (USPS), and uses UPS Mail Innovations to introduce shipments from the mail pharmacy to the USPS work stream. Within the mail pharmacy, logic-based shipping software analyzes medication type, weight, and destination zip code to select the best delivery method or service available. Walgreens may use FedEx or other major/regional carriers when expedited shipping is required, or when one carrier has proven unreliable for a specific member or in a certain geographical area.
2. a. Does your organization own the mail service facility?	No.
b. If this is a subcontractor, whom do you contract with?	Through Catamaran, we contract with Walgreens located at 8350 S. River Parkway, Tempe, Arizona 85284 for mail order. A back-up/overflow facility is

MAIL ORDER PROGRAM	RESPONSE
	located in Orlando, FL.
3. How far in advance may participants order a refill on a 90-day supply prescription?	All claims are refillable after the initial claim has been utilized by 75%.
a. 90 days in advance	see above
b. 60-89 days in advance	see above
c. 30-59 days in advance	see above
d. less than 30 days in advance	see above
e. Other	see above
4. a. Will you agree that all mail order discount guarantees will be based on lowest listed NDC-level AWP cost?	No.
b. If not, state your suggested pricing basis.	Our mail order discount guarantees are based on the actual NDC for the AWP based on fill date as provided by Medispan.
5. Will mail order pricing apply to all Rxs dispensed through mail order facilities?	Yes.
6. Explain the proration of copayments at mail service. (e.g., if a member gets a 60 day supply instead of 90, then would they only pay 2/3rds of the mail service copay?)	BCBSAZ can adjust the benefit design based on the City's needs. Current benefit design shows the cost for 90-day supply is 2 copays at mail order pharmacy.
7. How many calendar days advanced notice must a member provide in order to guarantee that their supply is received before the existing supply is depleted?	
a. Less than 7 days	n/a
b. 7-9 days	n/a
c. 10-14 days	n/a
d. Greater than 14 days	Generally, Walgreens recommends that patients have a 14-day supply of medication on hand prior to ordering.
8. What is the average time in calendar days between receipt of claim and delivery to patient (include delivery time)?	Walgreens estimates approximately one calendar week will pass from receipt of a claim at their facility until delivery of the member's prescription(s). Walgreens recommends and promotes that patients have at least a 14-day supply of medication on hand prior to re-ordering. To that end, we implemented a refill reminder

MAIL ORDER PROGRAM	RESPONSE
	service that can prevent delays and improve compliance; members will receive an automated call when a 14-day supply of medication remains. For reporting purposes, Walgreens defines and measures turnaround time as the time from receipt of a prescription to time of manifesting and shipping. Turnaround time is tracked in business days for both "clean" (no follow-up required) and "exception" claims. For the calendar year-to-date (January through October 2014): 1. "Clean" claims turnaround averaged 0.69 business days 2. "Exception" claims turnaround averaged 1.39 business days
9. What will you set the threshold at for the uncollected member cost share at mailorder?	In cases where a customer's balance exceeds a set threshold and he/she sends in a refill request, Walgreens will contact the customer to obtain payment. Currently, notices are sent to members who have an account balance of more than $125; Walgreens notifies the patient of outstanding account balances when an order ships, and via letter after 30 and 60 days. After 90 days without payment or response Walgreens may refer the client to an outside agency.
10. Does your organization, or your associated facilities, repackage drug products for use in filling mail order prescriptions? If yes, does the AWP for repackaged drugs match the AWP of the same package size of the source labeler? If not, describe how you establish the AWP for your repackaged NDCs	No, Walgreens does not repackage or re-label products.
11. Describe your policy on too-early refills and emergency supplies. Outline your process for prescriptions which are ordered prior to the first available refill date.	Not applicable. BCBSAZ does not cover early refills. Members can submit a request for consideration at which time BCBSAZ will make an administrative decision.
12. Explain the process for providing members with a short-term retail prescription supply in the case of delayed delivery of their mail order prescription.	If Walgreens cannot fulfill the prescription within the pharmacy's internal guidelines (generally seven business days) as a result of something within the mail pharmacy's control, Walgreens will contact the member and coordinate the provision of a short-term supply at no charge to the customer. The member may choose to pick up the short-

MAIL ORDER PROGRAM	RESPONSE
	term supply at a Walgreens retail pharmacy at no charge. Alternatively, Walgreens could work with a local non-Walgreens retail pharmacy and reimburse the member for any incremental out-of-pocket cost. The member would send us the receipt for Walgreens to process this request.
13. How are members notified when a mail order prescription is delayed due to the following circumstances?	
a. A prescription requiring clarification from the physician or physician's agent (e.g., missing quantity, illegible drug name).	Walgreens will call the prescriber (and the member, if necessary) about a problem with the prescription to resolve the issue. Walgreens may also communicate delays via email, if the member provides us with a correct email address. If Walgreens can quickly resolve the issue, Walgreens would not notify the member. If the issue takes more time to resolve, Walgreens would contact the members via phone or email.
b. A clean prescription where the delay is due to operational, capacity, or drug supply issues.	Should a delay occur as a result of operational capacity or drug- supply issues, Walgreens' phone center would contact the member to explain the situation and offer solutions. If Walgreens cannot fulfill the mail prescription within the pharmacy's internal guidelines (generally seven business days) as a result of the issues within the mail pharmacy's control, Walgreens will contact the member and coordinate the provision of a short-term supply at no charge to the customer.
c. A clean prescription where the delay is a result of a therapeutic switch intervention.	Walgreens typically does not hold prescriptions that are eligible for therapeutic intervention longer than 48 hours, so as not to interfere with the timely delivery of medication to the member. Walgreens will send up to three faxes to the prescriber office. In the unlikely event that a delay does occur, the phone center would contact the member to explain the situation and offer solutions; email notifications are also sent.
d. Other	Walgreens may communicate, via phone or email, any delay outside normal operational guidelines.
14. a. Describe your quality controls to ensure accurate dispensing of prescriptions.	Quality controls are built into Walgreens pharmacy processes at our mail service facilities. Images of all prescription order materials are created, so pharmacists and staff are able to

MAIL ORDER PROGRAM	RESPONSE
	review the internal order as well as the original prescription. Pharmacist verification is completed before the order is filled. Walgreens has an information and data management system that provides immediate analysis of any potential non-conformity identified within our processes. In addition, we have a Quality Assurance team that monitors our processes for compliance and continuous quality improvement opportunities using Lean and Six Sigma methods and tools. **Quality Assurance Program** Quality assurance procedures are followed in every phase of our mail service pharmacy. We operate under the four basics of all Total Quality Management (TQM) Programs: 1. Measurement of Key Performance Indicators 2. Feedback on both a Team and Individual level 3. Empowered Employees 4. Focus on Continuous Improvement These four key components of our business are measured and reported on a daily basis: Turnaround Time, Customer Service Levels, Quality and Cost. **Measurement** Each morning, the leaders of the key functional areas meet with the General Manager to review key indicators for yesterday's performance, discuss any variations from plan and set goals for the coming day. At this time adjustments are made. Results, as well as the day's goals, are posted around the facility for everyone's review. **Feedback** Within each team, departmental performance is charted on a monthly basis, and frequency distributions ("bell curves") on quality and quantity are done. This allows for a visual representation of each individual's performance and is used as a coaching tool. Other tools, such as random call recording, allow Customer Service Representatives to hear their interaction with members and develop (or be recognized for) the desired quality in assisting our members.

MAIL ORDER PROGRAM	RESPONSE
	Larger departments have a Performance Coach, who is responsible for initial training, follow up coaching, and departmental quality reporting. In addition, our human resources staff handles Leadership training and coordination of company initiatives (e.g., Imaging technology) and works with the departmental Performance Coaches to ensure that training objectives are met. **Empowerment** Our facilities are relatively flat in hierarchy. We are organized into teams, with a Team Lead responsible for the activities of ten to fifteen individuals. Jobs are designed along functional lines, with as much cross training and rotational aspects as possible. In addition to the departmental focus, we have several cross-functional work teams who look to improve procedures, communication and workflow between departments. Some of these are standing teams that meet periodically and rotate membership annually. Others are put together with specific tasks in mind. **Continuous Improvement** Management and certain team leads spend time each week listening to member calls, to ensure management's understanding of members' needs and expectations. Audits are also critical to maintaining optimal levels of performance. At the internal level, facility management reviews production, delivery, customer service and other quality indicators on a continual basis. This review covers the previous period's performance and includes a discussion of such topics as customer service level, the dispensing process, prescription order turnaround time, new or unusual issues and general facility input. Through a combination of technology, commitment and people, we continue to provide best-in-industry products and services.
b. How many levels of review take place and who conducts the reviews?	A pharmacist performs front-end verification. A technician utilizes multiple-scan technology during the dispensing process to ensure accuracy. Final product review is performed by a pharmacist as required by law.
15. Describe online integration, if any, with retail pharmacies to ensure non-	BCBSAZ uses a single claim adjudication system (Catamaran's RxClaim). All claims, retail, mail

MAIL ORDER PROGRAM	RESPONSE
duplication and to identify potential adverse interaction.	order and specialty, are adjudicated on the same system. System edits are in place to prevent duplicate fills, early refills between retail pharmacies or between retail and mail order pharmacies.
16. What are your contingency plans and procedures for providing backup service in the event of strike, natural disaster, or backlog?	All Walgreens sites have detailed emergency plans to ensure support for patients. **Customer Care** The disaster recovery plans for our mail service facilities includes call re-routing procedures in place with our phone carriers. Alternate facilities will take calls until our hot backup site is enabled. Walgreens has a contract to provide full backup for the operations of our call center, order entry department and all other office functions. Should a period of extended downtime occur at the mail pharmacy, all prescriptions would be immediately routed to an alternate site. Any "overflow" beyond a facility's capabilities would be sent to an appropriate Walgreens facility (central dispensing or retail). Retail locations are fully-integrated. With over 8,200 pharmacies nationwide and a staff of more than 27,000 registered pharmacists, Walgreens offers a comprehensive health and wellness presence. **Data Recovery** Walgreens has contracts currently in place to support database and application process recoveries. The recovery facilities themselves include separate power sources, Uninterruptible Power Source (UPS) capability, automated power switching, alternate diesel generators with two-day capacity before refueling, computer controlled access, and fire suppression. In the event of a disaster within our data center, tapes would be shipped to a contractor's facility. Recovery instructions to support environmental and application recoveries are stored in the Walgreens disaster recovery plan, and would be used to execute a recovery should our main data center be lost. **Testing/Updates** Walgreens plans yearly disaster recovery testing on its systems and contracts with multiple third party providers that have sites with hardware to meet our needs in case a disaster is declared. A

MAIL ORDER PROGRAM	RESPONSE
	typical test will consist of bringing key component servers online, network (LAN\WAN) workstation recovery, re-routing 800 lines and end-to-end system testing. The mail pharmacies tested in March 2014 with success. The data center in Illinois tests various systems throughout the year.
17. How often do you switch generic manufacturers for particular products?	Changes in generic manufacturers are not tracked, but are generally minimal. Walgreens dispenses only A-rated generics
How are participants notified of the switch?	To illustrate the switch, Walgreens includes changes in physical descriptions of the drug on every vial label, indicating the size, shape, and color of the medication dispensed. This information includes not only the physical characteristics of the drug, but also possible side effects and prescription-specific auxiliary labels. All prescription orders are shipped with leaflets containing information/instruction intended to educate the patient on how best to take the medication. This leaflet includes a description of the physical product.
18. a. Are on-site audits performed at your mail service pharmacies?	Yes. Walgreens Mail Service is audited by State Boards of Pharmacy(s), National Association or Boards of Pharmacy (NABP), the Drug Enforcement Agency (DEA) and independent auditors to ensure all operations are within applicable standards. The Arizona State Board of Pharmacy inspected our Tempe, Arizona mail pharmacy in January 2014. The mail pharmacy passed inspection with no violations.
b. Describe the frequency and types of audits performed and by whom.	Walgreens Mail Service is audited by State Boards or Pharmacy(s), National Association of Boards of Pharmacy (NABP), the DEA and independent auditors to ensure all operations are within applicable standards. The Arizona State Board of Pharmacy inspected our Tempe, Arizona mail pharmacy in January 2014. The mail pharmacy passed inspection with no violations.
19. Describe the process for notifying members of prescriptions not on the formulary.	BCBSAZ is offering a multi-tier benefit design, not a formulary. Walgreens adheres to the formulary messaging of the claims processor.
20. When do you bill the patient?	Walgreens generally requests payment be

MAIL ORDER PROGRAM	RESPONSE
	submitted at the time of order. Members are billed for prescriptions after the order is verified.
a. before the prescription is filled	see above
b. after the prescription is filled	see above
21. How do you provide notification of a product recall (such as Vioxx) to the City and members?	The Food and Drug Administration (FDA) ranks the drug recalls by recall class and market level. Not all requests to remove products are recalls and the drug may not fall into the recall classes. Recalls are classified by a drug's danger to public health. When a recall is a consumer level recall, Walgreens sends letters to contact the member about the recall, with instructions on how to return the medication. When we receive notice of a product recall we immediately check for affected inventory lots. Affected lot numbers are pulled from the shelves and quarantined in the facility returns department. Affected product is held in this area until return information is acquired from the manufacturer or from our headquarters.
22. How do you handle the following situations?	
a. No co-pay included in envelope	Walgreens requests payment at the time of order in nearly all cases. If the copayment is not included with the member's order and a credit card is not authorized, the copay amount will be included in the patient's account balance and the order will proceed to the dispensing process. If the balance is under $125, outstanding balance notices are sent to the patient to resolve the issue. For balances over $125 we will contact the patient directly to resolve the issue.
b. Bounced check from patient	Generally we are notified of insufficient funds/rejected checks after dispensing has occurred. In these situations we may place an Account Balance Hold exception on the patient's account, then work the member to resolve the issue. Notices are sent to members who have an account balance of more than $125. We notify patients of outstanding account balances when an order ships, and via letter after 30 and 60 days. After 90 days without payment or response we may refer the client to an outside agency.
c. Terminated/not authorized credit card	Walgreens will first try to re-submit the card

MAIL ORDER PROGRAM	RESPONSE
	information for payment. If the card is invalid, we issue a letter to the patient explaining the situation and debit the patient account for the amount owed. If the account balance is over a set threshold, we put an Account Balance Hold exception on the patient's account and work with the patient to resolve the issue.
23. Does your organization have the ability to administer a 90 day prescription at retail should the City wish to include such a provision?	Yes.

Specialty Pharmacy Program

SPECIALTY PHARMACY PROGRAM	RESPONSE
1. Explain any programs offered by your organization designed to encourage appropriate utilization of specialty drug products.	Catamaran's specialty pharmacy, BriovaRx, acts as a safety net for patients in managing their conditions and as the trusted advisor who gives our clients the insights to make informed decisions. We will proactively identify and discuss cost savings opportunities with the City to help manage specialty cost without comprising care. In order to manage the growing costs of specialty pharmaceuticals, BriovaRx recognizes the importance of having a variety of utilization management strategies for specialty products, such as implementing online automated step edits and quantity limits, selecting preferred products, and developing coverage criteria that may be enforced through the prior authorization process. We offer the following utilization management opportunities for consideration: 1. Dose Optimization 2. Quantity Limits 3. Step Therapy 4. Preferred Products 5. Adherence Management 6. Waste Management 7. Exclusive Specialty Pharmacy Network For additional information and details, please see the lengthy question responses for the Specialty Pharmacy Program found in **Section 9G**.
2. What are your cost saving guarantees on your specialty drug programs?	Not applicable. BCBSAZ is guaranteeing the reimbursement rates for those medications

SPECIALTY PHARMACY PROGRAM	RESPONSE
	dispensed by a BriovaRx Pharmacy in **Section 9G.**
3. a. Will a member incur any additional costs for the delivery of specialty drugs?	No. Delivery cost is included.
b. If so, outline all billing/payment methods and all associated costs.	Not applicable; delivery cost is included.
4. Confirm that members will continue to be able to receive specialty prescriptions dispensed at retail pharmacies, and that these prescriptions are included under the retail guarantees.	No. Specialty drugs must be dispensed by BCBSAZ's exclusive specialty pharmacy, BriovaRx.
5. Please describe your organization's ability to limit specialty medication utilization to 30 days' supply per month.	BCBSAZ's benefit limits all specialty medications to a 30 day supply.
6. What differentiates your company and capabilities from other specialty drug vendors in a very competitive industry?	Briova Rx has numerous differentiators compared to other specialty pharmacies. Primarily, our specialty pharmacy service model focuses on doing what is right for members. Through our three core pillars – Service Excellence, Clinical Excellence and Connecting Communities – we deliver personalized healthcare experiences, second to none. It is about more than providing the right drug, at the right time, at the right cost. It is about being a "safety net" for patients, so that they know someone is always looking out for them and is proactive in supporting their care. Patients report high levels of satisfaction with our high-tech, yet highly personal patient support approach. For additional information and details, please see the lengthy question responses for the Specialty Pharmacy Program found in **Section 9G**. For example, to improve patient understanding and management of specialty therapies, BriovaRx launched an industry-first innovation this year, the Briova Live Video Consultation Service, which connects newly-diagnosed patients with a specialty pharmacist, giving them advanced support and enhanced patient education and creating a highly personalized experience. We are currently the only specialty pharmacy offering video consultations. Most pharmacies offer either a consultation at the retail counter, over the phone, through written communication, or a home health nurse. Our approach personalizes through video, creating a direct

SPECIALTY PHARMACY PROGRAM	RESPONSE
	connection between the pharmacist and patient without the patient feeling overwhelmed by having someone physically in their home. As evidence of this successful approach, more than 97% of patients who participated in a Briova Live video consultation agree that this service is an improvement over traditional medication counseling performed by a pharmacist over the telephone.
7. Do you agree to renegotiate specialty product pricing terms on an annual basis with the City?	No.
8. Do you agree to include a contract provision enabling the City to "carve-out" specialty drug services annually without impact to non-specialty contractual provisions, terms, and pricing?	No. Specialty may not be carved out.
9. Explain in detail each point at which you make patient contact in the specialty drug dispensing and management process.	Upon receipt of the first prescription fill, an introductory call with the patient is scheduled with a clinical nurse or pharmacist, depending on the therapy. Together, they review the overall treatment protocol, dosing, potential side effects of the medication, financial support and any injection/infusion needs. This patient-centric comprehensive approach is an essential step to the patients' understanding of their therapy. The clinical nurses and pharmacists are also available 24/7 to discuss any questions or issues the patient may be experiencing with their medication. After the first prescription fill, the patients will also receive monthly ongoing assessments with an outbound call five to seven business days prior to the calculated exhaust date. The clinical nurses or pharmacists have access to the patient's medication history and treatment regimen and will identify any changes that can impact the patient's course of therapy. The focus of the monthly outreach is to: 1. Determine any benefit changes 2. Conduct re-assessment to determine disease progression, new side effects, adverse events, or therapy challenges 3. Document on-hand drug supply at home to determine adherence to treatment regimen and reasons for non-adherence 4. Provide re-education on importance of adherence, if necessary

SPECIALTY PHARMACY PROGRAM	RESPONSE
	5. Conduct clinical interventions including consultation with prescriber, if necessary 6. Provide educational materials, if necessary 7. Deliver medication based on need-by date 8. Manage billing through electronic claims submission or paper claims BriovaRx provides various services based on the disease state being treated. Ultimately, the focus of our core services is to improve patient outcomes and manage costs. As each disease state has unique needs, the pharmacy team is well educated on various disease states and associated therapies and is equipped to manage all aspects of a patient's care plan.
10. Provide the customer and member service operation hours of your specialty pharmacy program.	BriovaRx's standard hours of operation are 8:30 a.m. to 5:00 p.m. local time Monday through Friday. The Jeffersonville, Indiana location also has extended hours until 10:00 p.m. location time Monday through Friday. In addition, four locations (Alabama, Indiana, Maine, and Nevada) are open on Saturdays from 9:00 a.m. to 2:00 p.m. local time. Outside of standard operating hours, we maintain an after-hours answering service that is equipped to take calls and triage them as necessary to an on-call pharmacist. Pharmacists are available 24/7 to answer calls and provide assistance to patients. Additional services beyond our standard patient care management services include: 1. Re-direct shipping to a business or US vacation location at the request of the patient 2. Free access to educational websites with various descriptions of diseases, supporting educational materials and training, and links to advocacy groups and manufacturers 3. BriovaRx mobile application for information when patients are on the go 4. BriovaRx Connect an online web portal for physicians to access patient information; referral status, care coordination updates and communications 5. Support to gain access to Patient Assistance Programs 6. Briova Live video counseling is available for patients with select disease states

SPECIALTY PHARMACY PROGRAM	RESPONSE
	7. Nurse supported selected disease management programs 8. Side-effect management programs for select therapies
11. Please describe any additional service or value benefits provided by your specialty drug pharmacies (e.g. sharps disposal units at no cost upon request for injectable drug users, research of financial assistance options that may be available for members who request it, etc.)	Briova Rx has numerous value-added benefits compared to other specialty pharmacies. For additional information and details, please see the lengthy question responses for the Specialty Pharmacy Program found in **Section 9G**. As an example, to improve patient understanding and management of specialty therapies, BriovaRx launched an industry-first innovation this year, the Briova Live Video Consultation Service, which connects newly-diagnosed patients with a specialty pharmacist, giving them advanced support and enhanced patient education and creating a highly personalized experience. We are currently the only specialty pharmacy offering video consultations. Most pharmacies offer either a consultation at the retail counter, over the phone, through written communication, or a home health nurse. Our approach personalizes through video, creating a direct connection between the pharmacist and patient without the patient feeling overwhelmed by having someone physically in their home. As evidence of this successful approach, more than 97% of patients who participated in a Briova Live video consultation agree that this service is an improvement over traditional medication counseling performed by a pharmacist over the telephone.

Exhibit 2 to Attachment A to Administrative Service Agreement - Services Provided by BCBSAZ
BCBSAZ Exceptions to RFP

If and to the extent that any "exception" identified herein has been articulated/incorporated in a term of this agreement, the Parties agree it is no longer an "exception".

City of Chandler Solicitation No. HR5-948-3502
Exceptions to RFP

INFORMATION AND INSTRUCTIONS TO OFFERORS

1. GENERAL INFORMATION

1.23 Public Record. All Offers submitted in response to this Solicitation and all evaluation related records shall become property of City and shall become a matter of public record for review, subsequent to publication by the City of the proposed award in the agenda for the City Council Meeting or award by the appropriate approving authority or as otherwise required by law.

A request for nondisclosure of data such as trade secrets or other proprietary information must be submitted with the Offer and must contain the basis for the request. The affected information shall be clearly identified. A blanket statement of confidentiality will not be considered.

The City will not ensure confidentiality of any portion of the information submitted in the event that a public record request is made.

The City will endeavor provide 48-hours notice before releasing materials identified by the Offer as confidential or proprietary in order for the Offeror to apply for a court order blocking the release of the information.

Please refer to **Section 9A** for our request for nondisclosure of data and the basis of the request.

1.31. DEFINITIONS

1.31.4. For purposes of this solicitation and the resulting contract, the following definitions shall apply:

- *"Subcontract"* means any Contract, express or implied, between Contractor and another party or between a subcontractor and another party delegating or assigning, in whole or in part, the making or furnishing of any material or any service required for the performance of the Contract. A subcontract does not include any contract between Contractor and any health care provider or any contract between Contractor and any third party administrator reimbursement entity or any specially contracted health care provider arrangement. An example of a third party administrator reimbursement entity is a vendor that provides mental health services to Contractor's customers. In addition, the term "Subcontract" shall not include any normal service arrangements with information systems providers such as Microsoft, EDS and the drug claims processor.

3. SPECIFIC TERMS AND CONDITIONS

3.1 ~~INDEMNIFICATION: To the fullest extent permitted by law, Contractor, its successors, assigns and guarantors, shall defend, indemnify and hold harmless City and any of its elected or appointed officials, officers, directors, commissioners, board members, agents or employees from and against any and all allegations, demands, claims, proceedings, suits, actions, damages, including, without limitation, property damage, environmental damages, personal injury and wrongful death claims, losses, expenses (including claim adjusting and handling expenses), penalties and fines (including, but not limited to,~~

~~attorney fees, court costs, and the cost of appellate proceedings), judgments or obligations, which may be imposed upon or incurred by or asserted against the City by reason of this Agreement or the services performed or permissions granted under it, or related to, arising from or out of, or resulting from any negligent or intentional actions, acts, errors, mistakes Contractor caused in whole or part by Contractor, or any of its subcontractors, or anyone directly or indirectly employed by any of them or anyone for whose acts any of them may be liable, relating to the discharge of any duties or the exercise of any rights or privileges arising from or incidental to this Agreement, including but not limited to, any injury or damages claimed by any of Contractor's and subcontractor's employees.~~

~~The amount and type of insurance coverage requirements set forth in the Agreement will in no way be construed as limiting the scope of indemnity in this paragraph.~~

Indemnification By Contractor - Contractor shall indemnify, defend, save and hold harmless the City and its officers, officials, agents, and employees (hereinafter referred to as "Indemnity") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any federal, state or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnity shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnity, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, Contractor agrees to waive all rights of subrogation against the Contractor, its officers, officials, agents and employees for losses arising from the work performed by Contractor for the City.

Indemnification By the City - The City shall indemnify, hold harmless, and defend Contractor, its directors, officers, employees or agents from and against any and all actions, causes of action, suits, claims, judgments, settlements, liabilities, damages, penalties, losses and/or expenses, and costs, including, without limitation, attorneys' fees, punitive and exemplary damages, resulting from or arising solely out of or in connection with negligent or willful acts or omissions of the City, its directors, officers, employees or agents including but not limited to breach of this Agreement. This indemnification obligation shall survive the termination or expiration of this Contract.

3.2 INSURANCE:

1. General.

F. ~~Use of SubContractors: If any work is subcontracted in any way, the Contractor shall execute a written agreement with Subcontractor containing the same Indemnification Clause and Insurance Requirements as the City requires of the Contractor in this Agreement. The Contractor is responsible for executing the Agreement with the Subcontractor and obtaining Certificates of Insurance and verifying the insurance requirements.~~

EXHIBIT A – PROPOSAL REQUIREMENTS

1. MINIMUM REQUIREMENTS:

G. Comply with all term requirements in standard and special terms and conditions.

Please refer to our exceptions provided in the Information and Instructions to Offerors section above.

2. SPECIFIC REQUIREMENTS:

B. Medical Benefit Requirements:

(8) Contractors must conduct a full dependent audit at the request of the City and at **no additional charge to the City.**

The City can use the proposed allotment funds to conduct a dependent audit. BCBSAZ can provide a full list of dependents to the City for the audit.

3. STOP LOSS (EXCESS INSURANCE) REQUIREMENTS

C. Should a member be covered under the plan, however be subsequently deemed ineligible for any reason, the stop loss coverage will apply.

D. The stop loss carrier will be required to attempt to recover any monies paid on behalf of the City for an ineligible member, but will not attempt to collect the re-imbursement from the City.

Stop loss coverage applies only to eligible members covered under the benefit plan.

9. BOOKLETS:

A. Contractor shall be responsible for drafting of the summary plan descriptions (booklets), and for printing the booklets. Cover artwork and paper stock should match that used by "City brochures." City shall provide camera-ready artwork for covers. All such materials shall be subject to review and modification by City.

BCBSAZ prepares Summaries of Benefits and Coverage (SBC) and member benefit plan booklets, including any riders or amendments, in accordance with applicable state and federal laws. We do not produce a Summary Plan Description (SPD) but will provide the benefit plan booklet, which the City can wrap into its SPD.

BCBSAZ can provide the City's artwork on the benefit books and will provide an electronic version in color but print hard copies in black and white.

10. IDENTIFICATION CARDS:

A. Contractor shall prepare and print identification cards for distribution to members. It is preferred that employee identification numbers issued by City be used as the identification number if possible. Contractor shall mail identification cards within seven (7) to ten (10) days after City transmits the eligibility list or enrollment forms. For employees with family coverage, Contractor shall distribute a minimum of two identification cards. Identification cards must be mailed a minimum of ten (10) days prior to the effective date.

BCBSAZ's system cannot accommodate client-assigned employee identification numbers on the ID card. The open enrollment file must be received at least 20 days prior to the effective date to meet the requested identification card mail date.

12. CITY CONTRIBUTIONS:

A. City reserves the right to establish and modify, in its complete discretion, the percentage of premium contributed by employees.

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.

EXHIBIT A, PART A – PERFORMANCE GUARANTEES

	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	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 greater satisfied on a 4-point scale in year one and subsequent years Data based on survey with a 4-point scale.	Annually	$20,000

BCBSAZ Notes:
• Total of all risk measures cannot exceed $100,000.
• The above stated performance guarantees will be effective for the contract period 1/1/2016-12/31/2016.
• The Performance Guarantee payout does not include stop loss premiums, claims reimbursement amounts, vendor interface fees, capitated claim payments, etc.
• 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 would be payable annually on the 15th of the month following the 90-day period. BCBSAZ will not be required to pay a penalty for Performance Guarantees if the group is in default of its contract with BCBSAZ and/or has not paid all claims and premiums by the date due.

EXHIBIT B – SCOPE OF SERVICES

1. GENERAL:

C. Contractor shall agree to sign the City's Business Associate Agreement as written and provided prior to award.

We will sign the agreement as modified in Exhibit E and provided in **Section 5**.

E. Contractor shall provide with their "submission" any sample contract that requires signatures with their proposal. This sample contract should contain the following language: To the extent there is an inconsistency between the contract and the RFP, the "Solicitation" shall govern.

If we are awarded the contract, we will include the following language in the contract: To the extent there is an inconsistency between the contract and the Request for Proposal (RFP) between the parties, the RFP will govern. The City will be required to sign BCBSAZ's contract, and a sample has been provided in **Section 10A**.

2. DATA AND REPORTING:

A. Contractor shall agree that all data shall be available to the City and shall provide such data in regular reporting intervals, as well as on an ad hoc basis, as requested by the City at no additional cost to the City.

BCBSAZ agrees to run up to 15 ad-hoc reports for the first year for the City at no additional cost. After the first year, customized reports per the City's specifications may or may not require additional fees. The number of hours and required resources will determine the amount of the fee, if any. Due to our extensive reporting package, the need for ad hoc reporting should be minimized. BCBSAZ agrees to provide the requested data, provided that claim data is the property of the City to the extent the data does not contain confidential, trade secret and/or information considered proprietary by BCBSAZ.

D. Contractor shall provide prescription drug utilization and cost information as outlined in item C above. Should additional reporting be required, Contractor shall provide within 30 days of the request at no additional cost to the City any and all data associated with claims payments, medical management, eligibility, and Incurred but not reported Lag reports as permitted via a valid Business Associate agreement held between the City and their respective vendors. No data shall be withheld as long as there is a "need to know" for purposes of plan management or rate setting.

We will provide reports as agreed to in our response to the Reporting Section of Exhibit A, Part A. We agree to run up to 15 ad-hoc reports for the first year for the client at no additional cost. After the first year, customized reports per the group's specifications may or may not require additional fees.

3. ADMINISTRATION:

A. Contractor shall provide all required services to all eligible members as determined by the City. This includes the ability for a member to change options (Red, White and Blue) outside of open enrollment for any reason that is adopted by the City as a permitted basis for the change. Participation is voluntary and Contractor shall not invoke any minimum participation requirements.

The City will continue to determine member eligibility. However, 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.

E. Contractor shall provide staffing, as appropriate, to perform administrative work as determined by the City.

BCBSAZ will provide staffing for administrative purposes on a time and materials basis.

G. Contractor shall absorb all programming costs associated with data file transfers in current data file compliant formats.

A fee for this service will not be charged as long as file formats follow 834 HIPAA format or BCBSAZ's preferred format.

4. IMPLEMENTATION:

B. Contractor shall provide a draft ID card sample to the City for approval on or before August 1, 2015. Contractor shall mail finalized approved ID cards to members 10 days before the

beginning of each Plan year, and 15 days after notice for new hire and life event changes. The ID cards will be laminate, black and white without the City's logo. The cards must be mailed and shipping included in the cost of your proposed administrative fees.

The open enrollment file must be received at least 20 days prior to the effective date to meet the requested identification card mail date. The ID card stock is comprised of a heavy paper stock with a thin plastic overlay.

6. CLAIMS ADMINISTRATION:

D. Contractor shall send any initial request for information within 5 working days after receipt of the claim, and shall send any second request for information within 21 calendar days thereafter. If quality standards, statues or regulations would be impacted by this requirement, Contractor shall specify and provide detail for approval to change this requirement in the Deviation section of the RFP response.

If the claim is not a clean claim and requires additional information to adjudicate the claim, contractor shall send a written request for additional information within 30 calendar days after receipt of the claim. The claim will be processed within 30 calendar days after receiving additional information. ARS § 20-3102(B)

7. SURVEYS:

B. The survey documents and processes shall be subject to prior approval by the City.

BCBSAZ conducts annual member and provider satisfaction surveys to assess satisfaction with plan services. BCBSAZ agrees to provide survey documents and methodology for review prior to annual survey launch.

10. AUDIT:

A. The City shall be granted access to all detailed claims history for no less than the three (3) completed plan years at no cost to the City. Older years must be archived for up to seven years and can be subject to fees.

B. Contractor shall permit no less than one audit per year by a third party auditor selected by the City.

C. 100% of all records will be provided to the auditor at no cost to the City.

D. The City reserves the right to audit results for up to the three last complete plan years either for full claims or for a target selection/sample of records to validate plan provisions and financial accuracy.

E. Contractor shall allow for on-site follow up audits for a statistically valid sample number of claims.

F. The right to audit shall continue for up to 24 months after the termination of the contract.

G. Contractor shall have the right to inspect and review our audit methodology and findings. All methods and findings are proprietary and confidential and cannot be shared with any third party other than by court order or prior written approval given by the City's Consultant (Segal).

J. These rights shall survive any transition of claim paying processing duties to any third party or sub-contractor.

K. Contractor shall provide full disclosure of its records and those of its subcontractors upon notice from the City and/or the City's selected auditor. Contractor shall cooperate with the auditors and waive any fees associated with obtaining access to the City's data and/or records.

L. Contractor shall agree to allow the audit of Contractor's records and those of its respective subcontractors including, but not limited to: access to provider data/records; provider contracts; all types of provider fee schedules; customer service departments; claims departments; records to support network adequacy; appeals/grievances/disputes both from providers and/or members; quality assurance programs; systems data; reporting data; Medicare reclamation; rebate revenues and calculations; overpayments and underpayments; fraud hotline complaints; investigations and closing actions; shared cost savings, if the concept continues; COBRA and FSA billing and other records; abandoned collections and recoveries; eligibility records; fraud detection and preventative activities; performance guarantees; and reporting.

Upon reasonable prior written notice to BCBSAZ and as mutually agreed upon during BCBSAZ's normal working hours, the Plan may audit the records of payments made to Providers and other data specifically related to BCBSAZ's performance under this Agreement. BCBSAZ agrees to provide reasonable assistance and information to the Plan's auditors without charge. Plan shall bear the costs of the audit provided that if the Plan reveals a breach of this Agreement, BCBSAZ will bear the costs of the audit. Any audit for any plan year must be both commenced and finalized within twelve (12) months of the last day of the plan year being audited. BCBSAZ shall have no liability to pay the Employer or Plan any amounts as a result of any audit unless demand for payment based on such audit is received by BCBSAZ within twelve (12) months of the date the claim was paid or denies. "Paid" includes both payment and/or application of benefits.

11. ELIGIBILITY:

B. The City shall provide Contractor with a weekly eligibility file in an electric format containing sufficient information for Contractor to validate eligibility. Contractor shall accept eligibility in the format as submitted to Contractor by the City.

BCBSAZ will accept a mutually agreed upon electronic file format.

C. Contractor shall load and reconcile weekly and monthly eligibility files within 24 hours of receipt.

Eligibility updates provided in an 834 file are performed on a daily basis and are generally completed within five days of receipt. All other mutually agreed upon file formats will be loaded within seven days of receipt. Our average load time is two days.

F. City shall self-bill monthly fees/premiums based on the City's monthly eligibility data, and shall remit the amount due to Contractor (payment made via check). The City shall remit any monthly fees/premiums and claims in arrears to Contractor 30 days from the date the bill is received with no interest charge. Contractor shall agree to the most preferred method of billing as determined during implementation of this contract and approved by the City.

BCBSAZ pays claims from its bank account throughout the month on behalf of the group. The group is invoiced, generally within 10 to 15 days after the close of the month, and payment is due from the group within 15 days of the invoice date. Payment must be received in the office of BCBSAZ by the last day of the month following the period for which the claims were paid. For example, the January claims invoice for all claims paid in January is due by February 28.

Billing statements are generated approximately two weeks prior to the due date, for example the January to February billing statement is mailed mid-December. Enrollment processing occurs daily. If applications are processed after generation of billing, all premiums owed will be reflected on the next billing statement that is generated. Premiums are due on the first day of the billing period and considered delinquent if not paid by the end of the grace period indicated in the Group Master Contract.

G. Discrepancies of claims or fees other than those based upon eligibility file transfer resulting in variances of less than five percent (5%) shall be accepted by Contractor without dispute.

Failure to provide written notice of a disputed discrepancy within the specified timeframe shall be considered Contractor's acceptance of the City's calculations, records, and payments.

All claims invoices should be paid as billed. Changes as a result of an eligibility file transfer should be adjusted and paid or refunded.

H. The City reserves the right to offset any premiums, fees or other remittances due to Contractor in order to collect performance penalties, overpayments resulting from incorrect calculations, eligibility adjustments, incorrectly paid claims, or other errors or adjustments identified by audit, analysis or other means. If no premiums, fees or other remittances are due the City, Contractor shall remit to the City any performance penalties assessed, any overpayments resulting from incorrect calculation, eligibility adjustment, incorrectly paid claim, or other errors or adjustments within 30 days after identification and communication of such claim to Contractor.

The City should pay as billed on any invoice it receives from BCBSAZ. Any amounts due for damages, non-performance or other expenses will be reviewed in accordance with the terms of the contract and will be refunded, if appropriate, in a separate payment to the group.

I. The Contractor shall provide, at no cost to the City, collection of coordination of benefits (COB) information no less than twice per year. Contractor shall verify COB status based on the guidelines and frequency as stipulated by the City during implementation and for the full term(s) of this contract.

BCBSAZ follows National Association of Insurance Commissioners (NAIC) guidelines to coordinate benefits for medical claims and determine which carrier is primary and which is secondary. During enrollment, we require members to complete an application and provide Coordination of Benefits (COB) information, if applicable. If BCBSAZ is primary, the claim is adjudicated immediately; if secondary, a copy of the primary carrier's explanation of benefits (EOB) is requested from the member to determine payment.

If no COB is indicated, we process claims in accordance with standard procedures and pay as primary. If COB is later identified, BCBSAZ pursues COB retrospectively. Our corporate policy is to "pay and pursue." We will send a query letter to the member and an inquiry to the other carrier. If we determine that the other carrier should have paid as primary payer, we will seek reimbursement of overpayment. We do not coordinate benefits for prescription claims processed at retail pharmacies.

K. Contractor shall agree to communicate through HIPAA-compliant electronic sites to exchange data between themselves and any other required vendor as requested by the City.

BCBSAZ will consider working with the City's vendors at no additional cost if we already have established connectivity with the vendor. There will be fees associated with establishing connectivity with a vendor we have not worked with.

12. MEDICAL NETWORK:

B. Contractor shall update the online provider directory every 96 hours for any changes reported by a provider.

We update the online provider directory every 24 hours. The time it takes to process provider changes varies, depending on the extent of the changes and whether clarification is needed.

G. Contractor shall provide a network that includes a provider profiling program.

BCBSAZ is willing to collaborate with the City to see what information would be requested to satisfy this requirement. Our patient-centered medical home (PCMH) model places the patient and

primary care practice at the center of care and creates a healthcare setting that is a collaborative partnership between the patient and his personal physician. All physicians who participate in our Patient-Centered Medical Home (PCMH) must be contracted providers with BCBSAZ. In addition, BCBSAZ contracts with these PCMH physicians through an additional PCMH-contract that provides payment incentives based on the achievement of specific clinical outcomes and care.

13. PLAN MEMBER COMMUNICATION MATERIALS, ADVERTISEMENTS AND MARKETING MATERIALS:

A. Contractor shall submit all copies of member materials, web portal member communications and promotional materials for written approval by the City as well as submit those enrollment materials to the Department of Insurance (DOI), as required, for approval and their subsequent use in promoting the Plan to eligible enrollees. Materials include notification letters, error/correction letters, form letters for additions or changes to network newsletters, or any other written communication distributed in any fashion to 50 or more members.

BCBSAZ agrees to submit copies of materials created specifically for the City's eligible enrollees. We will submit all City plan information and enrollment information to the DOI as required.

Exhibit 3 to Attachment A to Administrative Service Agreement
BlueCard – PPO Plans

I. Out-of-Area Services

A. BlueCard® Program

Under the BlueCard® Program, when Participants access covered healthcare services within the geographic area served by a Host Blue, BCBSAZ will remain responsible to the City for fulfilling BCBSAZ contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Participant liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to BCBSAZ by the Host Blue.

The calculation of the City liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSAZ by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to BCBSAZ by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such 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). However, the amount paid by the Participant and the City is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to BCBSAZ is a

final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that the City pay(s) in a variance account, pending settlement with its participating healthcare 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 the City. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. Some Host Blues may retain interest earned, if any, on funds held in variance accounts.

A small number of states require Host Blues either (i) to use a basis for determining Participant liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge.

Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, BCBSAZ would then calculate Participant liability and the City liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

BlueCard Program Fees and Compensation

The City understand(s) and agree(s) to reimburse BCBSAZ for certain fees and compensation which we are obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any employer. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with the City's benefit period under this Agreement.
Some of these fees and compensation are charged each time a claim is processed through the BlueCard Program and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency fees, and ITS transaction fees. An access fee may be passed on to the City as an additional claim liability. If one is charged, it will be a percentage of the discount/differential BCBSAZ receive(s) from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. Other Program-related fees that BCBSAZ may charge include, but are not limited to, a toll-free number fee, and a fee for providing PPO healthcare provider directories.

All BlueCard Program-related fees, including any access fees paid to Host Blues are, for new groups, provided with the Agreement and, for renewing groups, provided with your proposal at time of renewal.

B. **Negotiated National Account Arrangements**

As an alternative to the BlueCard Program, your Participant claims for covered healthcare services may be processed through a Negotiated National Account arrangement. In these instances, BCBSAZ and a Host Blue may have negotiated custom fees and compensation in connection with this Agreement.

In negotiating such arrangement(s), BCBSAZ is not acting on behalf of or as an agent for the City, the City's employee welfare/group health/medical plan or the City's Participants.

Participant Liability Calculation

Participant liability for covered healthcare services will be based on the lower of either billed covered charges or negotiated price, refer to the description of negotiated price under the BlueCard Program, Paragraph A above, made available to BCBSAZ by the Host Blue for covered healthcare services outside of BCBSAZ service area.

The calculation of the City liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSAZ by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services.

Fees and Compensation

The City understand(s) and agree(s) to reimburse BCBSAZ for certain fees and compensation which we are obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the Programs' standard procedures for revising such fees and compensation, which do not provide for prior approval by any employer. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations.

These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with The City 's benefit period under this Agreement.

In addition, the participation agreements with the Host Blue may provide that BCBSAZ must pay an administrative and/or network access fee to the Host Blue, and The City further agrees to reimburse BCBSAZ for any such applicable administrative and/or network access fees.

C. **Non-Contracted Healthcare Providers Outside BCBSAZ's Service Area Participant Liability Calculation**

1. **In General**

When covered healthcare services are provided outside of BCBSAZ service area by non-contracted (i.e., non-participating) healthcare providers, the amount(s) a Participant pays for such services will be based on the lesser of the non-contracted providers billed charges or the applicable BCBSAZ Fee Schedule with adjustment for certain claim editing procedures. In these situations, the Participant may be responsible for the difference between the amount that the non-contracted healthcare provider bills and the payment BCBSAZ will make for the covered services as set forth in this paragraph, in addition to any applicable deductible, copayment or coinsurance.

2. **Exceptions**

In some exception cases, BCBSAZ may pay claims from non-contracted healthcare providers outside of BCBSAZ service area based on the provider's billed charge, such as in situations where a Participant did not have reasonable

access to a participating provider, as determined by BCBSAZ in our sole and absolute discretion or by applicable state law. In addition, when emergency care services are received from non-contracted providers outside of the BCBSAZ service area, BCBSAZ would then pay the Participant the BCBSAZ Allowed Amount for such services. In this situation, the amount(s) a Participant pays for such services will be based on the non-contracted healthcare provider's billed charges.

3. **Fees and Compensation**

The City understand(s) and agree(s) to reimburse BCBSAZ for certain fees and compensation which we are obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by the City. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with the City's benefit period under this Agreement.

In addition, BCBSAZ must pay an administrative fee to the Host Blue, and the City further agree(s) to reimburse BCBSAZ for any such administrative fee.

A. Out-of-Area Services

BCBSAZ covers only limited healthcare services received outside of BCBSAZ's service area. As used in this Subsection, the term, "Out-of-Area Covered Healthcare Services," refers to services for emergency care, urgent care and authorized follow-up care obtained outside the BCBSAZ geographic service area. Any other services will not be covered, and the Participant will be responsible for the payment of such services.

1. BlueCard® Program

Under the BlueCard® Program, when Participants access Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, BCBSAZ will remain responsible to the City for fulfilling BCBSAZ's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers.

The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Participant's liability on claims for Out-of-Area Covered Healthcare Services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to BCBSAZ by the Host Blue.

The calculation of the City's liability on claims for Out-of-Area Covered Healthcare Services processed through the BlueCard Program will be based on the negotiated price made available to BCBSAZ by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to BCBSAZ by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with

Inter-Plan Programs policies, prospectively increase or reduce such 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). However, the amount paid by the Participant is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to BCBSAZ is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that the City pay(s) in a variance account, pending settlement with its participating healthcare 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 The City . Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. *Some* Host Blues may retain interest earned, if any, on funds held in variance accounts.

A small number of states require a Host Blue either (i) to use a basis for determining Participant liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, BCBSAZ would then calculate Participant liability and the City's liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

BlueCard Fees and Compensation

The City understand(s) and agree(s) to reimburse BCBSAZ for certain fees and compensation which we are obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any employer. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with the City benefit period under this Agreement.

Some of these fees and compensation are charged each time a claim is processed through the BlueCard Program and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. An access fee may be passed on to the City as an additional claim liability. If one is charged, it will be a percentage of the discount/differential BCBSAZ receive(s) from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. Other Program-related fees that BCBSAZ may charge include, but are not limited to a toll-free number fee, and a fee for providing healthcare provider directories.

B. **Non-Contracted Healthcare Providers Outside BCBSAZ Service Area**

When Out-of-Area Covered Healthcare Services are received from non-contracted healthcare providers (i.e., non-participating providers), the amount(s) a Participant pays for such services will be based on the non-contracted healthcare provider's billed charges. When emergency care or urgent care services are received from non-contracted providers outside of the BCBSAZ service area, BCBSAZ would then pay the Participant the BCBSAZ allowed amount for such services.

MAXIMUM AGGREGATE AND SPECIFIC LIABILITY AGREEMENT
GROUP CONTRACT NUMBER 28399
(CLAIMS **INCURRED** DURING TERM OF AGREEMENT)

PARTIES:

The Parties to this Agreement are Blue Cross and Blue Shield of Arizona, Inc. ("BCBSAZ"), an Arizona non-profit corporation and an independent licensee of the Blue Cross and Blue Shield Association, and City of Chandler (the "Employer"), an Arizona municipal corporation.

EFFECTIVE DATE:

The Effective Date of this Maximum Aggregate and Specific Liability Agreement (the "Agreement") is January 1, 2016.

SCOPE AND APPLICABILITY:

Medical Only: X
Dental Only □
Medical and Dental □

RECITALS:

1. Pursuant to A.R.S. § 11-981, the Employer has established a self-funded, employee welfare benefit plan (the "Plan"), which provides certain hospital, medical and/or dental benefits to certain employees of the Employer and to certain dependents of such employees (collectively the "Participants"), on such terms and conditions as are more fully described in the Employer's Benefit Plan Booklet attached hereto as described in Paragraph 6.a.ii. and by this reference made a part of this Agreement.

2. The Employer has retained BCBSAZ to provide stop loss coverage in connection with the Employer's Administrative Service Agreement under which BCBSAZ provides ministerial claims processing and related administrative services and utilization management services in conjunction with the Employer's group health plan.

3. The Employer desires to accept liability for payments incurred for Covered Service (as those terms are defined in Section 1. below) subject to certain maximum liability limits (the "Maximum Liabilities") as described in Subsection 3.a.;

4. BCBSAZ is a hospital, medical, dental service corporation within the meaning of A.R.S. Section 20-821 et seq.;

5. Pursuant to its activities as a hospital, medical, dental service corporation, BCBSAZ has developed considerable expertise in assessing, minimizing and underwriting risks and costs associated with the provision of hospital, medical and dental services and supplies;

6. The Parties desire that BCBSAZ shall reimburse the Employer, or its agent the Benefit Administrator, for payments incurred for Covered Services to the extent that such payments exceed the Maximum Aggregate Claims Liabilities, on such terms and conditions as described below.

NOW, THEREFORE, the Parties agree as follows:

AGREEMENT:

1. Definitions.

   For the purposes of this Agreement, the following terms shall have the meanings provided below:

   a. **Administrative Service Agreement** – The contract between BCBSAZ and Employer under which BCBSAZ provides ministerial claims processing and related administrative services and utilization management services in conjunction with the Employer's group health plan and for which this Agreement provides stop loss coverage

b. **Contract Month** - shall coincide with a calendar month within the Contract Year; the first Contract Month shall commence with the effective date of this Agreement and the last Contract Month shall terminate upon the termination of this Agreement.

c. **Contract Year** - a twelve- (12) month period during the term of this Agreement.

d. **Covered Services** - health care services and supplies rendered or delivered to Participants for which benefits are available under the Plan.

e. **Eligible Participants or Participants** - Collectively Employees and Dependents as defined in the Plan(s).

f. **Enrollment Units and Enrollment Categories** - "Enrollment Unit" shall mean each employee or retiree, with or without dependents, enrolled for coverage under the respective Plan(s). Enrollment Units are categorized for rating purposes into "Enrollment Categories." Enrollment Categories are based upon whether the employee or retiree only or the employee or retiree and dependents are enrolled. In addition, Enrollment Categories may distinguish which dependents are enrolled along with the employee or retiree. For example: employee and spouse; employee and child(ren); employee and dependent(s) (spouse and/or child[ren]). Premiums and/or other cost factors are based on Enrollment Categories.

g. **Plan(s)** - shall mean only that portion of the employee welfare benefit plan that provides for hospital, medical and/or dental benefits, as expressly set forth in the Summary Plan Descriptions, schedules of coverage and any amendments and endorsements attached thereto on the effective date of this Agreement or as may be added thereafter and approved as provided in Section 24. below.

h. **Providers/Provider Network(s)** - health care providers with whom BCBSAZ has entered into a participation agreement and who comprise the Provider Network(s) to which the Employer and Participants have access.

2. Term of Agreement.

a. On or before two hundred ten (210) days prior to the end of this Agreement, BCBSAZ will forward to the Employer a Maximum Aggregate and Specific Liability Agreement Amendment which is BCBSAZ's offer to renew this Agreement for one (1) year period at the rates specified on the Maximum Aggregate and Specific Liability Agreement Amendment.

If BCBSAZ receives a signed Maximum Aggregate and Specific Liability Agreement Amendment on or before the last day of the current contract period, this Agreement will renew for a one (1) year period at the rates specified in the Maximum Aggregate and Specific Maximum Liability Agreement Amendment with the coverage the Employer has designated on the Amendment.

If BCBSAZ has not received the signed Maximum Aggregate and Specific Liability Agreement Amendment on or before the last day of the current contract period, BCBSAZ will consider the Employer's failure to forward the Amendment as the Employer's rejection of BCBSAZ's offer to renew and this Agreement will terminate as of the last day of the current contract period.

After this Agreement has been in effect for twelve (12) months, either Party may terminate this Agreement at any time, without cause, as of the last day of any calendar month by giving sixty (60) days' prior written notice to the other.

b. Termination. Except as provided in Subsection 2.a. of this section this Agreement may be terminated only as provided below:

i. Either Party may terminate this Agreement at any time in the event of a material breach of this Agreement by the other, but only if said breach is not cured within thirty (30) days after written notice to the breaching Party.

ii. BCBSAZ may terminate this Agreement upon the occurrence of any of the following:

1. Failure by the Employer to timely pay when due: (1) premiums and/or other charges ("Premiums and Charges") referred in Exhibit A of this (1) premiums and/or other charges ("Premiums and Charges") referred in Exhibit A of this Agreement; (2) funds sufficient to satisfy payments made by BCBSAZ for Covered Services under the Administrative Service Agreement; and (3) Administrative Fees due under the Administrative Service Agreement.

2. The sale, exchange or transfer of (i) all or substantially all of the assets of Employer to a third party, (ii) more than twenty-five percent (25%) of the outstanding stock in Employer or (iii) controlling interest in Employer, whichever is less.

3. Insolvency, appointment of a receiver or a trustee for Employer, assignment for the benefit of creditors by Employer, or the commencement of any proceedings under bankruptcy or insolvency laws by or against Employer that continues for sixty (60) days, or the attachment, levy or other seizure by legal process of any substantial part of the assets of Employer, and such attachment, levy or seizure is not quashed, stayed or released within sixty (60) days of its occurrence.

4. Default by Employer under any other agreement with BCBSAZ.

5. Fraud or misrepresentation by the Employer.

iii. This Agreement will terminate automatically upon the occurrence of any of the following:

1. Termination of the Plan in its entirety.

2. The enactment of any law or the promulgation of any regulation or rule that makes it illegal to continue this Agreement or for BCBSAZ to perform any of the services required under this Agreement.

3. The termination of the Employer's Administrative Service Agreement.

iv. After this Agreement has been in effect for twelve (12) months, either Party may terminate this Agreement at any time, without cause, as of the last day of any calendar month by giving sixty (60) days' prior written notice to the other.

c. Effect of Termination. Upon termination of this Agreement, the Parties shall have only those continuing duties of performance as provided herein; provided, however, upon completion of its performance under this Agreement, BCBSAZ shall cause the orderly transfer of records, if any, from BCBSAZ to the Employer or its designee in a time frame mutually agreed upon, but not to exceed six (6) months from the date of termination.

The Employer agrees to reimburse BCBSAZ for any and all amounts BCBSAZ is required to pay pursuant to an applicable grievance and/or appeals process regardless of whether BCBSAZ is still administering claims for the Employer at the time the appeal is conducted. The Employer also agrees to reimburse BCBSAZ for any and all amounts which The Centers for Medicare & Medicaid Services (CMS), previously known as the Health Care Financing Administration) or any other government agency requires BCBSAZ to pay because Medicare was not required to pay as primary, regardless of whether BCBSAZ is administering claims for the Employer at the time CMS makes such determination.

3. The Employer's Obligations

a. Maximum Liabilities. The Employer shall be liable for, and agrees, to provide funds sufficient to satisfy all payments made for Covered Services subject to a maximum aggregate claims liability applicable to the Contract Year (the "Maximum Aggregate Claims Liability"), and the cumulative claims incurred and reimbursed by BCBSAZ on behalf of any Participant for the Contract Year (the "Specific Claims Liability") as determined below:

i. Except as otherwise specifically provided in Subsection 3.b. below, the Maximum Aggregate Claims Liability for the Contract Year is the sum of the monthly claims liability limits (Claims Liability Limit[s]) for that Contract Year.

ii. The Claims Liability Limit for any Contract Month shall be the greater of the minimum monthly attachment level (as set forth in Exhibit A) or the sum of the products of the applicable monthly claims liability factor for each Enrollment Category times the number of Enrollment Units in that Enrollment Category enrolled in the respective Plan(s), as described in the Employer's Summary Plan Description, for that Contract Month. The applicable monthly claims liability factors shall be as set forth in Exhibit A and the number of applicable Enrollment Units shall be determined by BCBSAZ based on enrollment information provided to BCBSAZ by the Employer, and reported in accordance with Paragraph 3.a.vi., below.

iii. The Employer's Maximum Aggregate Claims Liability for the Contract Year shall be equal to the sum of the Monthly Claims Liability Limits, as set for in Paragraph 3.a.ii., above for each month in the Contract Year. Payments for Covered Services incurred within a Contract Year and paid within that Contract Year or within twelve (12) months following the close of that Contract Year shall be considered to be incurred during that Contract Year. Payments for Covered Services incurred during the Contract Year but paid more than twelve (12) months after the close of that Contract Year shall be considered to be incurred in the subsequent Contract Year. If there is no subsequent Contract Year, then payments for Covered Services incurred within the final Contract Year and paid within twenty-four (24) months after the close of the final Contract Year shall be considered to be incurred during the final Contract Year. Any payments for Covered Services incurred in excess of the Maximum Aggregate Claims Liability under this Agreement for the Contract Year shall be the claims liability of BCBSAZ.

iv. In no event shall the Employer be liable for payments for Covered Services incurred during the Contract Year with respect to any individual Eligible Participant in excess of the Maximum Specific Claims Liability set forth on Exhibit A. Payments for Covered Services incurred during the Contract Year and paid during that Contract Year or within twelve (12) months following the close of that Contract Year shall be considered to be incurred in that Contract Year. Payments for Covered Services incurred during the Contract Year but paid more than twelve (12) months after the close of that Contract Year shall be considered to be incurred in the subsequent Contract Year. If there is no subsequent Contract Year, then payments for Covered Services incurred during the final Contract Year and paid within twenty-four (24) months after the close of the final Contract Year shall be considered to be incurred during the final Contract Year. Any payments made for Covered Services incurred in excess of the Maximum Specific Claims Liability under this Agreement for the Contract Year with respect to an individual Eligible Participant shall be the claims liability of BCBSAZ.

v. Unless otherwise noted in Exhibit A, this Agreement has a twenty-four (24) month claims run-out period from the date of termination of this Agreement. For purposes of calculating the Maximum Claims Liabilities under this Agreement, claims for Covered Services incurred during a Contract Year and paid during the Contract Year and the claims run-out period immediately following will be attributed to the Contract Year in which the claims are incurred.

vi. Monthly enrollment units may be retroactively adjusted (up to 12 months after the reporting month) to reflect the appropriate enrollment within each enrollment category. Retroactive adjustments include, but are not limited to, additions and terminations reported to BCBSAZ subsequent to any reporting month.

vii. Fees associated with BlueCard ("Blue Card fees"), including but not limited to, Access Fees and Administrative Expenses fee schedule (AEA), will be charged as pass through group claim expenses. BlueCard fees will accumulate toward the Employer's specific and aggregate stoploss as described in Paragraphs i., ii. iii., iv. and v. of Subsection 3.a. and in Exhibit A. These fees are subject to change without prior notice as directed by the Blue Cross Blue Shield Association.

b. Employer's Liability Upon Termination.

i. Following termination of this Agreement, the Employer shall be liable for all payments incurred while this Agreement was in force. The Employer's obligations under this Paragraph 3.b.i. shall survive the termination of this Agreement and shall remain in effect for twenty-four (24) months following the termination of this Agreement with respect to payments so incurred are outstanding and payable.

ii. Where any payment is approved in relation to a contested claim, BCBSAZ shall determine, on the basis of the date on which payment is actually made, whether such payment or any portion of it is an obligation of the Employer or an obligation of BCBSAZ under the terms of this Agreement. Payments made in accordance with the terms of any judgment or settlement shall be considered payments made to Eligible Participants under the Plan, as described in the Employer's Summary Plan Description, during the period in which such judgment or settlement is satisfied, whether paid during the term of this Agreement or following the termination of this Agreement.

iii. Upon termination of this Agreement, the Employer's maximum liability for Covered Services incurred during the term of this Agreement, whether such Covered Services are paid prior or subsequent to termination, shall be equal to the Employer's Maximum Aggregate claims Liability for the final Contract Year; less the amount of Covered Services actually charged against the Maximum Aggregate Claims liability for the final Contract Year (as calculated pursuant to Paragraph 3.a.i.) on the date of termination.

iv. If the term of this Agreement is less than twelve (12) months, the Employer's Maximum Aggregate Claims Liability will be annualized to reflect a complete twelve (12) month contract year.

4. Payments Applicable to the Employer's Maximum Claims Liabilities.

a. Satisfaction of Maximum Claims Liabilities. Only the following payments may be applied to satisfy the Employer's Maximum Liabilities, as defined in Section 3., under the terms of this Agreement:

i. Except as otherwise specifically provided in this Paragraph 4.a.i., only payments made by the Employer, or the Benefit Administrator, in accordance with the terms and conditions of the respective Plan(s), as described in the Employer's Summary Plan Description, and incurred during the term of this Agreement by those Eligible Participants who are designated by class and coverage on Exhibit A. and who are otherwise eligible for Covered Services under the terms and conditions of the respective Plan(s), as described in the Employer's Summary Plan Description, (at the time that the relevant Covered Services are rendered or delivered) may be applied to satisfy the Employer's Maximum Liabilities, as defined in Section 3., for the applicable Contract Year under this Agreement.

ii. Notwithstanding anything in this Agreement to the contrary, payments made by the Employer, or the Benefit Administrator, relating to payments incurred during the term of this Agreement for which there has been or will be reimbursement by another insurance company, reinsurance company or any other third party or payments incurred after the termination of this Agreement or for which BCBSAZ has otherwise reimbursed the Employer, or the Benefit Administrator, may not be applied to satisfy the Maximum Liabilities, as defined in Section 3., under this Agreement. In the event that the Employer, or the Benefit Administrator, receives any reimbursement from any third party as provided above, BCBSAZ shall be entitled to recover such amounts to the extent that BCBSAZ has reimbursed the Employer, or the Benefit Administrator, for those amounts. BCBSAZ shall be entitled to recover such amounts regardless of whether or not such reimbursement is received during the year in which the respective payments are incurred and whether or not such reimbursement is received during the term of this Agreement or after the termination of this Agreement. Moreover, to the extent that BCBSAZ has reimbursed the Employer, or the Benefit Administrator, for such amounts, BCBSAZ shall have the right to recover from the Employer, or the Benefit Administrator, any amounts recovered. Further, the Employer, and the Benefit Administrator, if applicable, shall cooperate to assure BCBSAZ's right to recover pursuant to this Paragraph 4.a.ii. Any payments that have been reimbursed under this Agreement as payments in excess of the Maximum Specific Liability, as defined in Section 3., for

the Contract Year with respect to specific Eligible Participants, may not be applied to satisfy the Maximum Aggregate Claims Liability, as defined in Section 3., for such Contract Year.

iii. For purposes of this Agreement, only payments made pursuant to the terms of this Agreement and the respective Plan(s), as described in the Employer's Summary Plan Description, may be applied to satisfy the Employer's Maximum Liabilities, as defined in Section 3., for the Contract Year. Such payments shall be based upon Eligible Expenses as defined in Exhibit A. Such determination shall be in the sole discretion of BCBSAZ or its designated agent.

b. Application of Payments. Any payments made by the Employer or the Benefit Administrator shall be applied to the contract period during which the payments are actually made.

5. Payment of Benefits

BCBSAZ, whether acting in its capacity as administrator under the Administrative Service Agreement or under this Agreement, shall:

i. Make a final determination of the amount of Covered Services, if any, to which a Participant may be entitled under the Plan and this Agreement and for which BCBSAZ is liable, pursuant to Paragraph 3.a.iii. and iv.

ii. Make payment of all benefits payable under the Plan and this Agreement by BCBSAZ, pursuant to Paragraph 3.a.iii. and iv. Any and all payments made by BCBSAZ to any provider or participant are made on behalf of the Employer;

iii. Undertake the defense of any action brought in connection with any claim for benefits payable under the Plan and this Agreement by BCBSAZ, pursuant to Paragraph 3.a.iii. and iv., and make such disposition of such action as BCBSAZ deems appropriate.

6. BCBSAZ's Obligations.

a. Reimbursement. BCBSAZ agrees to reimburse the Employer, or the Benefit Administrator, for payments made under the respective Plan(s), as described in the Employer's Summary Plan Description, by the Employer, or the Benefit Administrator, incurred during the term of this Agreement and paid to or on behalf of all Eligible Participants, to the extent that such payments are in excess of the Maximum Aggregate Claims Liability, as defined in Section 3., for the applicable Contract Year and to or on behalf of specific Eligible Participants, to the extent that such payments are in excess of the Maximum Specific Liability, as defined in Section 3., for the applicable Contract Year with respect to such specific Eligible Participants, subject to certain limitations as described more fully below:

i. BCBSAZ's liability under this Agreement is limited to reimbursement to the Employer, or its agent the Benefit Administrator, for payments for Covered Services to or on behalf of Eligible Participants under the terms of this Agreement and the terms and conditions of the respective Plan(s), as described in the Employer's Summary Plan Description.

ii. Except as otherwise specifically provided in this Agreement, BCBSAZ's obligations under this Agreement will apply only to payments made by the Employer, or the Benefit Administrator, in accordance with the terms and conditions of the respective Plan(s), as described in the Employer's Benefit Plan Book, incurred during the term of this Agreement by those Eligible Participants who are designated by class and coverage in Exhibit A and are otherwise eligible to receive such payments (at the time that the relevant Covered Services are rendered or delivered) under the terms of this Agreement and the terms and conditions of the respective Plan(s), as described in the Employer's Benefit Plan Booklets attached hereto as Exhibit B and incorporated herein by this reference. Following the termination of this Agreement, BCBSAZ's obligations under this Agreement will apply only to those payments incurred during the term of this Agreement, whether such payments are made prior or subsequent to the termination of this Agreement and otherwise meet the requirements of the preceding sentence.

iii. Where any payment is approved in relation to a contested claim, BCBSAZ shall determine, on the basis of the date on which payment is actually made, whether such payment or any portion of it is

an obligation of the Employer or an obligation of BCBSAZ under the terms of this Agreement. Benefit payments made in accordance with the terms of any judgment or settlement shall be considered benefits paid to Eligible Participants under the Plan during the period in which such judgment or settlement is satisfied, whether paid during the term of this Agreement or following the termination of this Agreement.

7. Contribution and Participation Requirements

a. The Employer agrees to contribute at least seventy-five percent (75%) of the cost for all Eligible Participants or fifty percent (50%) of the total cost for all Eligible Participants.

b. If the Employer contributes one hundred percent (100%) of the cost for Eligible Participants, all employees eligible for coverage under the Plan and this Agreement must be enrolled. If the Employer contributes less than one hundred percent (100%) of the cost for Eligible Participants, at least seventy-five percent (75%) of all employees eligible for coverage under the Plan and this Agreement must be enrolled; those employees eligible for coverage under the Plan and this Agreement who are covered under their spouse's group health plan, Medicare, AHCCCS, CHAMPUS or Indian Health Services shall not be considered for purposes of determining whether the Employer has satisfied this seventy-five percent (75%) requirement. In any event, at least one hundred (100) Eligible Participants must be enrolled on the effective date of this Agreement. If the Employer fails to meet the contribution or participation requirements as determined by BCBSAZ, BCBSAZ reserves the right to terminate this Agreement and any other applicable Agreements in effect between the Employer and BCBSAZ.

c. The Employer agrees to comply with such other contribution and participation requirements as shall be mutually agreed upon by the Parties from time to time. Such requirements shall become effective no sooner than sixty (60) days after BCBSAZ has given written notice to the Employer.

8. Compensation.

a. Premium Payments For the services provided by BCBSAZ under this Agreement, the Employer agrees to pay BCBSAZ such stop loss premiums and/or other charges ("Premiums and Charges") as set forth in Exhibit A and/or as otherwise authorized in this Agreement, as amended from time to time by the Parties. BCBSAZ will invoice the Employer for such Premiums and Charges which are due and payable on the first (1st) day of each calendar month or as otherwise stated in the BCBSAZ invoice. Any amounts not timely paid within the applicable time period shall accrue interest at the rate of one percent (1%) per month until paid in full.

b. Adjustments to Cost Factors. BCBSAZ reserves the right to adjust the premium rates set out in Exhibit A retroactive to the first day of any billing month in which the Employer's contribution (percentage or dollar amount) changes or enrollment of Employees varies by more than ten percent (10%) from that set out in Exhibit A.

c. Grace Period. This Agreement has a grace period of thirty-one (31) days. This means that if a premium is not paid on or before the date it is due it may be paid during the grace period. During the grace period, the Agreement shall remain in force; however, the Employer shall be liable for any premiums that are or become due.

If, by the last day of the applicable grace period, the Employer fails to pay the premiums which are due, the Agreement may be terminated, at the option of BCBSAZ, retroactive to the date on which the premiums first became due. In such case, the Employer shall be liable for all Covered Services rendered to Eligible Participants during the grace period, and the Employer agrees to hold BCBSAZ harmless from all costs therefor. In any event, the Employer agrees to hold BCBSAZ harmless from all costs for Covered Services rendered to Eligible Participants after the expiration of the grace period.

d. Adjustments Upon Changes in Applicable Law. Premium payments required under this Agreement are comprised of various components and cost factors. Premium tax is an example of one component that is required by state law. If federal or state law affecting premium payments, benefits, administrative procedures, etc., are amended during the term of this Agreement, BCBSAZ reserves the right to adjust, retroactively or prospectively, the premiums, premium rate restrictions/maximums then in effect accordingly. Further, BCBSAZ specifically reserves the right to recover from the Employer any premium

tax deficiencies, which may be assessed against BCBSAZ with respect to prior periods of coverage under this Agreement, whether such deficiencies are assessed during the term of this Agreement or following its termination.

e. Notice of Rate Changes: Except as stated in Subsection 8.b. and d. and Section 24., BCBSAZ reserves the right to change the premiums due under this Section 8., and will provide the Employer in writing notice of any changes at least one hundred eighty (180) days prior to the effective date of the changes. For purposes of this Subsection 8.e., notice to the Broker/Consultant designated in the Employer's Administrative Service Agreement, as it may be amended or restated by the Parties from time to time, shall constitute notice to the Employer.

9. Records and Review.

The Employer agrees to furnish to BCBSAZ all information that BCBSAZ may from time to time require in order to determine when the Employer's Maximum Liabilities, as defined in Section 3., for the Contract Year have been satisfied. The Employer shall notify BCBSAZ immediately as to any modification of the Plan(s), as described in the Employer's Summary Plan Description, or the termination thereof. BCBSAZ shall not be responsible for any delay or non-performance of its obligations under this Agreement that are caused or contributed to, in whole or in part, by the failure of the Employer to timely furnish any required information.

10. Limitation of Liability and Indemnification.

a. Limitation of Liability and Indemnification Regarding Certain Liabilities. For purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") (or any other comparable federal or state law applicable to the Employer in the event that ERISA is not applicable) and the Consolidated Omnibus Reconciliation Act of 1985, as amended ("COBRA"), BCBSAZ shall not be considered to be the Plan administrator of this Agreement, nor shall BCBSAZ be liable with respect to any liabilities, damages, penalties, losses, costs, and/or expenses, resulting from or arising out of the Employer's obligations with respect to its governmental reporting requirements and/or governmental regulation compliance, including, but not limited to, notification, reporting and disclosure requirements under ERISA and COBRA. Further, the Employer agrees to be liable to the extent permitted by applicable state and/or federal law and agrees to indemnify, hold harmless and defend BCBSAZ and its directors, officers, employees, or agents, from and against any and all actions, causes of action, suits, claims, judgments, settlements, liabilities, damages, penalties, losses, costs, and/or expenses, including, without limitation, extra contract damages, court costs, attorneys' fees, and punitive and exemplary damages, resulting from or arising out of or in connection with, any acts, omissions, or negligence of the Employer, its directors, officers, employees, or agents with respect to the Employer's governmental reporting requirements and/or governmental regulation compliance, including, but not limited to, notification, reporting and disclosure requirements under ERISA and COBRA. To the extent permitted by applicable state and/or federal law, the Employer further agrees to indemnify, hold harmless and defend BCBSAZ, its directors, officers, employees and agents from and against any liability with respect to taxes, assessments and penalties incurred by or which may be levied upon BCBSAZ by reason of payments made or services performed under this Agreement, together with any interest thereon.

b. Mutual Indemnifications. Except as otherwise specifically provided in Subsection 10.a. above, the Employer and BCBSAZ agree that each respective Party shall only be responsible for claims, losses, damages, liabilities, penalties, costs, expenses, and obligations, including attorneys' fees, arising out of or resulting from its own breach of the terms of this Agreement. To the extent permitted by applicable state and/or federal law, each Party shall indemnify, hold harmless and defend the other Party, its directors, officers, elected officials, employees, or agents from and against any and all actions, causes of action, suits, judgments, settlements, claims, losses, damages, liabilities, penalties, costs, and/or expenses arising out of or resulting from its own breach of this Agreement or negligent acts or omissions with respect to its obligations under the terms of this Agreement.

c. BCBSAZ's Liability. BCBSAZ agrees to make payments to Eligible Participants and providers on behalf of the Employer and does not assume liability for any claims brought against BCBSAZ due to any payment made in accordance to the Plan(s) or as required by the Employer.

11. Claims for Reimbursement.

a. Timeliness. This paragraph applies only when an entity other than BCBSAZ is acting as the Benefit Administrator as defined in this paragraph. If the Employer, or the Benefit Administrator, submits a claim for reimbursement (the "Claim") to BCBSAZ under this Agreement, it must do so in writing to BCBSAZ's address as set forth in Section 21. below, or such other address of which the Employer receives notice under this Agreement, by the earlier of: (a) ninety (90) days of the date of service; or (b) thirty (30) days of the date the health care provider submits the claim to BCBSAZ, provided, however, that BCBSAZ shall have no liability to pay or reimburse for any claim or Claim submitted later than one (1) year after the effective date of termination of this Agreement. The Employer, or the Benefit Administrator, as the case may be, must provide BCBSAZ with such information as BCBSAZ shall reasonably request to support such Claim, including proof of payment and satisfaction of the applicable Maximum Liabilities, as defined in Section 3. The term "Benefit Administrator" means the entity that processes the underlying benefit claims.

b. Determination. BCBSAZ shall make a determination as to the validity of a claim for reimbursement under this Agreement within thirty (30) days of receipt of such claim.

c. Reconsideration. Upon written request, BCBSAZ shall reconsider its original determination. A written request for reconsideration must be filed with BCBSAZ within sixty (60) days following the date the first disallowance or payment notice is mailed. Additional documentation in support thereof must accompany the request, if appropriate. Failure to timely request reconsideration shall waive the Employer's right to reconsideration under this Agreement. BCBSAZ shall review the request for reconsideration and shall notify the Employer, or the Benefit Administrator, as the case may be, of its decision in writing within sixty (60) days following receipt of the request for reconsideration.

12. Legal Action.

The Employer agrees that it shall not file suit or request arbitration until sixty (60) days after the date upon which the Employer, or the Benefit Administrator, submits proof of claim and satisfaction of applicable Maximum Liabilities, as defined in Section 3., as required under this Agreement.

13. Legal Fees.

In the event an action is brought to enforce or interpret any of the terms, covenants or obligations of this Agreement, the prevailing Party shall be entitled to recover all court costs and reasonable attorneys' fees actually incurred in any such action and fees incurred in enforcing any judgment obtained following entry of such judgment.

14. Confidentiality.

The Employer shall ensure that the Employer, its principals and agents, including, but not limited to, the Benefit Administrator, shall maintain the confidentiality of any and all proprietary information with respect to BCBSAZ acquired during the term of this Agreement. Such proprietary information shall not be divulged, disclosed or otherwise made available to anyone not a Party to this Agreement without BCBSAZ's prior written consent, nor shall such proprietary information be used to the detriment of BCBSAZ. The obligations of the Employer, its principals and agents under this Section 14. shall survive the termination of this Agreement.

15. Applicable Law and Venue.

This Agreement shall be governed by and construed according to the laws of the State of Arizona and applicable federal law. The Parties consent to the jurisdiction of and to venue for any dispute involving this Agreement in the state courts of the State of Arizona or the United States District Court for the District of Arizona.

16. Audit Rights.

Upon reasonable prior written notice to BCBSAZ and as mutually agreed upon during BCBSAZ's normal working hours, the City may audit the records of payments made to provider and other data specifically related to BCBSAZ's performance under this Agreement. BCBSAZ agrees to provide reasonable assistance

and information to the City's auditors without charge the City shall bear the costs of the audit provided that; however, if the City reveals a breach of this Agreement, BCBSAZ will bear the costs of the audit. Any audit for any plan year must be both commenced and finalized within 12 months of the last day of the plan year being audited. BCBSAZ shall have no liability to pay the City any amounts as a result of any audit unless demand for payment based on such audit is received by BCBSAZ within 12 months of the date the claim was paid or denied. "Paid" includes both payment and/or application of benefits.

BCBSAZ audit requirements include:

1. BCBSAZ must receive a 30-day written notification of an audit for a maximum of 200 claims.

2. BCBSAZ reserves the right to designate the specific dates of availability for audit upon notification. In no event shall the audit period extend more than one year immediately preceding the commencement date of the particular audit. Both parties agree to follow any pertinent State and Federal laws.

3. No later than thirty days prior to audit commencement, client must supply BCBSAZ in a mutually-agreed format with a written audit scope outline and list of documents needed for audit.

4. BCBSAZ requires confidentiality statements to be signed by auditors and client representatives prior audit.

5. Access to BCBSAZ's specific information may be available only with the assistance of a BCBSAZ representative, and hard copy documentation will be provided upon mutual agreement.

Above criteria must be met to proceed with audit.

6. If either BCBSAZ or client desires to utilize an outside audit firm to perform the audit, both BCBSAZ and client must agree on the selection of the outside auditing firm. BCBSAZ will only approve auditors that are independent and objective and will not approve auditors paid on a contingency fee or other similar basis. The party requesting the audit will be responsible for the audit fees charged by the auditing firm. BCBSAZ agrees to support audit activity without charging the client for the time supporting the audit activity.

7. BCBSAZ shall be given the opportunity to respond in writing, to all audit findings, prior to the issuance of the final report.

8. Adjustments will be initiated on claim mispayments identified no more than one year from the paid date. Recoupments will be initiated on claims with an overpayment of greater than $35 and no more than one year from the paid date.

17. Changes in Plan(s).

No changes in the respective Plan(s), as described in the Employer's Summary Plan Description, shall be covered by this Agreement, nor shall any amounts paid by the Employer as payments resulting from any such changes in the respective Plan(s), as described in the Employer's Summary Plan Description, be applied toward the satisfaction of the Employer's Maximum Liabilities, as defined in Section 3., in the absence of prior written acceptance of such changes by BCBSAZ.

18. Prevailing Terms.

During the term of this Agreement, in the event that the terms of this Agreement are inconsistent with the terms of the respective Plan(s), as described in the Employer's Summary Plan Description, the terms of this Agreement shall prevail.

19. Waiver.

No waiver of any term, provision or condition of this Agreement will be valid unless in writing and signed by both Parties.

20. Paragraph Headings.

The headings of paragraphs contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

21. Notices:

All notices or demands required to be given pursuant to the terms of this Agreement shall be given to the other party in writing, delivered by hand, overnight delivery, registered or certified mail, at the addresses set forth below, or to such other address as the parties may substitute by written notice given in the manner prescribed in this paragraph.

In the case of the CITY		In the case of BCBSAZ	
Contract Administrator:	Debra Stapleton	Firm Name:	BCBSAZ
Contact:	Director Human Resources	Contact:	Vice President - Sales
Mailing Address:	M.S. 703, P.O. Box 4008	Address:	8220 N. 23rd Avenue
Physical Address:	175 S. Arizona Ave., Second Floor	City, State, Zip	Phoenix, Az 85021
City, State, Zip	Chandler, AZ 85225	Phone:	(602) 864-4570
Phone:	480-782-2351	FAX:	
FAX:	480-782-2366		

Notices shall be deemed received on date delivered, if delivered by hand, and on the delivery date indicated on receipt if delivered by certified or registered mail. Notice to the Employer's designated Broker/Consultant shall constitute notice to the Plan.

22. Severability.

If any provision of this Agreement is held to be illegal, invalid or unenforceable under present or future laws effective during the term of this Agreement, such provision shall be fully severable; this Agreement shall be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part of it; and the remaining provisions shall remain in full force and effect and shall not be affected by such illegal, invalid or unenforceable provision or by its severance.

23. Use of Tradename.

Each Party expressly agrees not to use the corporate name or any tradename, trademark or service mark of the other Party in any advertising, publications, press releases, brochures or other public communications without the prior written consent of the other Party.

24. Amendment.

Except as otherwise specifically provided under this Agreement, this Agreement may be altered, amended or modified only in writing upon the mutual written consent of the Parties. BCBSAZ, however, specifically reserves the right to alter, amend or modify this Agreement and/or its performance under this Agreement as may be required by applicable state and/or federal law and/or as may be necessitated by the terms and conditions of various participation agreements with Providers into which BCBSAZ shall enter from time to time during the term of this Agreement.

25. Assignment.

Neither Party may assign or transfer any right, benefit, obligation or duty under the terms of this Agreement without the advance written consent of the other; except BCBSAZ may transfer and assign this Agreement to a subsidiary or parent or an entity or person acquiring control of BCBSAZ or its assets or acquiring a division of BCBSAZ providing administration services under this Agreement.

26. BCBSAZ's Relationship to the Blue Cross and Blue Shield Association.

Employer, on behalf of itself and its Participants, expressly acknowledges and agrees that:

(i) This Agreement is a contract solely between Employer 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 Blue Shield Service Marks in the State of Arizona;

(ii) BCBSAZ is not contracting as the agent of the Association;

(iii) Employer has not entered into this Agreement based on any representations by the Association, or any Blue Cross or Blue Shield plan other than BCBSAZ; and

(iv) Employer shall not seek to hold the Association or any other Blue Cross or Blue Shield plan accountable or liable to Employer for any of BCBSAZ's obligations to the Employer or Participants created under this Agreement.

This Paragraph shall not create any additional obligations whatsoever on the part of BCBSAZ other than those obligations created under other provisions of this Agreement.

27. Entire Agreement.

This Agreement, including all Exhibits attached hereto, constitutes the entire understanding of the parties with respect to the stop loss coverage herein and supersedes all previous representations, written or oral with regard to stop loss coverage. This Agreement may not be modified or amended except by a written document, signed by authorized representatives of each party.

Intending to be legally bound, the Parties have executed this Agreement as of its Effective Date.

BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC., an Arizona nonprofit corporation

By: _____
(signature)
Jeff Stelnik
(printed)

Title: SVP, Strategy, Sales + Marketing

FOR THE CITY OF CHANDLER

_____

Attest: _____
City Clerk

APPROVED AS TO FORM:

_____
City Attorney

APPROVED AS TO FORM
BCBSAZ Legal Division
By _____
Attorney
Date 9/11/13

Exhibit A To Maximum Aggregate and Specific Liability Agreement

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Effective Date:	1/1/2016-12/31/2016	Date:	8/27/2015
Group / Bid ID:	28399	Bid/Renewal:	Bid
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:	Segal Company/Amy Girado	UW Code:	JO
Commission:	0.0%	Pooling / Specific Stop Loss:	$300,000
Commission (% of Billed Rate):	0.0%	Aggregate Stop Loss:	110%
Total Enrollment:	1,582		

Definitions

1. **OOP Max - out-of-pocket maximum**
2. **OV -office visit**
3. **Spec - specialist**
4. **UC - urgent care**
5. **ded & coins - deductible & coinsurance**
6. **Admin - administration**
7. **SSL - specific stop loss**
8. **ASL - aggregate stop loss**
9. **PEPM - per employee per month**
10. **Fixed Expenses - the amount BCBSAZ bills the City of Chandler each month for administration, specific stop loss, aggregate stop loss and broker commissions.**

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%	$3,000/$6,000	@ded & coins	@ded & coins	@ded & coins	@ded & coins	$10/$20/$40, 2x MOD
OON:	$4,500/$9,000	70%	$8,000/$16,000					

Sold Rates for Stop Loss Agreement

Red Medical Option	Enrollment	SSL	ASL	Commissions	Other	Total Stop Loss	ICAP	Expected Claims
Employee	213	$17.71	$3.18	$0.00	$0.00	$61.05	$711.17	$646.52
Employee + Spouse	172	$29.57	$5.49	$0.00	$0.00	$75.22	$1,226.49	$1,114.99
Employee + Child(ren)	119	$26.20	$4.83	$0.00	$0.00	$71.19	$1,080.36	$982.15
Employee + Family	283	$43.03	$8.02	$0.00	$0.00	$91.21	$1,796.11	$1,632.83
Total	787							

HCR Suite: N = Non-Grandfathered

Blue Medical Option	Enrollment	SSL	ASL	Commissions	Other	Total Stop Loss	ICAP	Expected Claims
Employee	31	$17.71	$3.10	$0.00	$0.00	$60.97	$693.13	$630.12
Employee + Spouse	29	$29.57	$5.34	$0.00	$0.00	$75.08	$1,195.38	$1,086.71
Employee + Child(ren)	19	$26.20	$4.70	$0.00	$0.00	$71.06	$1,052.96	$957.24
Employee + Family	17	$43.03	$7.83	$0.00	$0.00	$91.02	$1,750.56	$1,591.42
Total	96							

HCR Suite: N = Non-Grandfathered

White Medical Option	Enrollment	SSL	ASL	Commissions	Other	Total Stop Loss	ICAP	Expected Claims
Employee	212	$17.71	$2.80	$0.00	$0.00	$60.67	$534.99	$486.35
Employee + Spouse	71	$29.57	$4.82	$0.00	$0.00	$74.55	$922.65	$838.77
Employee + Child(ren)	87	$26.20	$4.24	$0.00	$0.00	$70.60	$812.72	$738.84
Employee + Family	329	$43.03	$7.07	$0.00	$0.00	$90.25	$1,351.15	$1,228.32
Total	699							

HCR Suite: N = Non-Grandfathered

Premium tax is included in the specific and aggregate charges.

Minimum Monthly Attachment Level: $1,619,441 based on 100% enrolled

Is Mayo Provider included in network? No

BCBSAZ reserves the right to adjust these premium rates retroactive to the first day of any billing month in which enrollment varies by more than ten percent (+/-15%) from that listed above.

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.

* BCBSAZ may adjust rates if the following requirements are not met:

  Where the employer contributes 100% of the employee cost, BCBSAZ requires 100% participation of all eligible employees, excluding those with other qualifying medical coverage.
  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.

* 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. 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. Cost for services provided by the BSA, 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 BSA. The BCBSAZ allowance (the difference between the PMPM rate BCBSAZ charges the Employer and the capitated fee BCBSAZ pays the BSA) in effect as of the Employer's contract effective date may change over the course of the Employer's contract year if BCBSAZ negotiates a different rate with the provider during the Employer's contract year. The PMPM rate BCBSAZ charges the employer is subject to change by BCBSAZ upon 60 days prior written notice. The PMPM rate(s) the Employer pays BCBSAZ and the PMPM capitated fee(s) BCBSAZ pays BSA are only applicable to Arizona enrollment.

  The PMPM rate(s) the Employer pays BCBSAZ is/are:
  1. Red Medical Option $2.13 PMPM
  2. Blue Medical Option $2.13 PMPM

  The PMPM capitated fee(s) BCBSAZ pays the BSA is/are:
  1. Red Medical Option $1.94 PMPM
  2. Blue Medical Option $1.94 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

* 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 Pass Through model effective 1/1/2016.

  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 pay run out claims (i.e., claims incurred but not paid during the term of the contract) as follows:
  - Month 1 through month 24 following the effective date of termination with stop loss.

* **VALUE BASED SERVICES**

  1. LOCAL

  BCBSAZ pays some of its contracted medical providers an amount to manage the medical care of members diagnosed with certain medical conditions if the provider demonstrates to BCBSAZ it has satisfied BCBSAZ's criteria for effectively managing the care ("Value Based Services").

  With respect to a BCBSAZ group members residing and receiving Value Based Services in Arizona under a BCBSAZ value based program, BCBSAZ will estimate at the beginning of the contract year the amount BCBSAZ projects it will pay BCBSAZ's contracted providers for members who receive Value Based Services throughout the upcoming year in the form of a PMPM or PEPM charge ("PMPM Charge"). BCBSAZ will charge BCBSAZ's ASC Groups via the Group's Claims Invoice this PMPM Charge beginning January 1, 2016.

  On an aggregate basis for the entire Value Based Program, the amounts used to calculate PMPM charge are fixed amounts estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by BCBSAZ until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

  On an aggregate basis for the entire Value Based Program, , at the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, BCBSAZ will take one of the following actions:
  - Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
  - Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

  NOTE: If an ASC Group terminates its BCBSAZ contract, that Group will neither receive a refund nor a charge to reflect any variance between what BCBSAZ charged the Group in Value Based Charges and what BCBSAZ paid the providers for Value Based Services.

  2. NATIONAL

  Value Based Services will also apply to your members who reside in other states/geographical locations served by other Blue Cross Blue Shield Plans. A full description of these arrangements will be described in your contract.

Exhibit B to Maximum Aggregate and Specific Liability Agreement

THE EMPLOYER'S BENEFIT PLAN BOOKLETS WHICH ARE EXHIBIT B ARE THE PAGE(S) IMMEDIATELY FOLLOWING THIS PAGE

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.

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact 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) 864-4456	(602) 864-4823	(602) 864-4884
		(800) 232-2345, ext. 4456	(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)

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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
Behavioral Services Administrator (BSA)	(800) 224-2125
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 providing services in Arizona 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	

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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

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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 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.

"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 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.**

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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, access fee, coinsurance, pharmacy deductible, and precertification charges.

"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.**

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“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.

“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.

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“Summary of Benefits and Coverage” (SBC) means a federally required document in a specified template with information on applicable copays, access fees, 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.

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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.

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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.

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.

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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.

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Network Status

In-Network Providers (Contracted)

In-network providers are the following: (1) Except as noted in this benefit book, health care providers licensed in the United States who have a PPO contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ PPO members); and (2) Except as noted in this benefit book, out-of-state health care providers licensed in the United States who have a PPO contract with a Blue Cross and/or Blue Shield plan other than BCBSAZ.

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

- Independent Clinical Laboratory & Specialty Pharmacy: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the referring provider is located.

- Durable Medical Equipment/Medical Supplies: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the member resides.

- Air Ambulance: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state of the member pickup location.

In-network providers will file your claims with BCBSAZ or the applicable out-of-state Blue Cross and/or Blue Shield plan. 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.**

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); (3) Providers who are contracted with the BlueCard Worldwide program; and (4) Providers who do not have a PPO contract with the Blue Cross and/or Blue Shield plan to which the applicable claim is filed.

- **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, 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

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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, coinsurance, and access fees (except for emergency services), plus the balance bill.

Eligible Provider Status and Payment – Summary Table Subject to all terms and conditions noted in this section.				
Provider Contract Status	**Network Status and Applicable Cost-Share**	**Provider Required to File Claim on Member's Behalf**	**Accept 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.

***Except as noted in this benefit book**

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

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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 Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BCBSAZ serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside BCBSAZ's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; **or**
- The negotiated price that the Host Blue makes available to 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 also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSAZ has used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, BCBSAZ may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price made available to BCBSAZ by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than any related patient cost sharing under this contract.

Special Cases: Value-Based Programs

BlueCard® Program

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

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Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If BCBSAZ has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on your behalf, BCBSAZ will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

Nonparticipating Providers Outside BCBSAZ's Service Area

1. **Liability Calculation**

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

2. **Exceptions**

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

BlueCard Worldwide® Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the 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, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

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

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

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- **Submitting a BlueCard Worldwide Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should 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.

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.

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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. If it is required, your provider must obtain it on your behalf before rendering services.

BCBSAZ may change the services that require precertification at any time without providing notice. Go to www.azblue.com for a current 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, as follows:

- 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.

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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.

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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.

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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

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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.

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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.com or 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, duplicate procedures, application of Correct Coding Initiative (CCI) guidelines, member's age and sex edits, services inappropriately billed with office visit (evaluation and management) codes, modifier validation, pre and post-operative service validation, multiple surgical procedure pricing guidelines and other types of claim edits as determined by BCBSAZ. 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.

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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.

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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

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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

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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.

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MEMBER COST-SHARING & OTHER PAYMENTS

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.

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 plus 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.

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 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.

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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 access fees and 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. 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

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

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

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:

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

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- 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: Not required.

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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. 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. Intensive ourtpatient services, ECT and partial hospitalization services are not available through the BSA.

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 (See the "Neuropsychological and Cognitive Testing" section)
- 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

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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 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-Specific 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 or eyeglasses 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-Specific 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

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- 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, 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 - 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.

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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

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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: 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.

H.1 Durable Medical Equipment (DME)

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

- Be designed for appropriate 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:

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- 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:

- Cochlear implants
- 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, 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

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I. EDUCATION AND TRAINING

Precertification: Not required.

Your Cost-Share: See descriptions under subheadings.

I.1 Diabetes and Asthma Education and Training

Your Cost-Share: Waived.

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

- An in-network provider delivers the education and training;
- Education and training are provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Training is conducted in person; **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.

I.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
- Eating Disorders
- Heart Failure
- High Cholesterol
- Hypertension
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

I.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.

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Emergency Room: You pay one emergency room 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 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 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.

"Formula" is amino-acid based formula.

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.

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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 "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.

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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. The cost-share amount will depend on the provider's network status. 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.

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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 facility services are received from in-network hospitals.

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

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- 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 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 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 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: 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.

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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 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

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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

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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: 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 facility services are received from in-network hospitals.

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.

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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: 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. The list of medications that require precertification is subject to change at any time without prior notice. 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.

Other than as noted in this section, no exceptions will be made concerning the cost-share you will pay, regardless of the medical reasons requiring use of a particular medication, even when there is no equivalent medication on a lower Level or if you are unable to take a medication on the lower Level for any reason.

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:

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- 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.

"Specialty Self-Injectable Medications" are medications that treat chronic or complex conditions. BCBSAZ and/or the PBM determine which medications are Specialty Self-Injectable Medications.

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

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 most prescription medications from retail pharmacies or the in-network mail order pharmacy. Compounded medications must be obtained from retail pharmacies that have been credentialed by BCBSAZ (or BCBSAZ's vendor) to dispense compound medications. Please contact BCBSAZ Customer Service at the number listed in your benefit plan materials for a list of pharmacies credentialed to dispense compound medications.

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

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

If a medication is not processing at the pharmacy, you or your physician/provider may request an exception by calling the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception. Reasons for requesting an exception include but are not limited to the following: quantity, age, gender, dosage and/or frequency of refill limitations, requests for a Formulary Exception and requests for waiver of cost-share for brand name medications or devices taken or used for a preventive purpose.

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If you are currently obtaining a Specialty Self-Injectable Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book. BCBSAZ will decide whether you are eligible to receive the Specialty Self-Injectable medication from a retail pharmacy instead of a Specialty Pharmacy.

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, the medication is excluded from coverage under this Pharmacy Benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

Benefit-Specific Exclusions:

- Abortifacient 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

N. 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.

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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 PT, OT, and ST services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration and home independence
- All services in excess of the sixty (60) visit limit
- Any care 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
- 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
- Work re-entry therapy, services or programs

Z. 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.

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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 (including follow-up care) of FDA-approved contraceptive devices in female members
- FDA-approved implanted contraceptive devices for female members
- Abortifacient medications for the abortions covered under this plan, including oral medications as described in the BCBSAZ Medical Coverage Guidelines.

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.

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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 abortifacient 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, 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 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.

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Your Cost-Share:

In-Network:

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 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.

For certain covered preventive medications and items obtained from an in-network pharmacy, your cost-share is waived for the generic version of the medication or item and you pay applicable cost-share for the brand-name version of the medication or item. You may request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy. See the **"Benefit-Description"** section below for information about the exception process.

Please note: Your cost-share is waived 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.

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 procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.

Benefit-Specific 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. **If a preventive service has been denied due to a gender edit and you are undergoing or have undergone transgender treatment, please contact BCBSAZ Customer Service at the number listed in the front of this benefit book for assistance.**

Benefits are available for the following services:

- 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

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- 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, HPV and syphilis screening
- prostate specific antigen (PSA) testing
- TB testing

- Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
- Aspirin for asymptomatic pregnant women who are at increased risk of preeclampsia and who have no prior adverse effects with or contraindications to low-dose aspirin (after 12 weeks of gestation)
- 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 and interventions for tobacco cessation and augmented pregnancy counseling and interventions 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 counseling for all sexually active adolescents and for adults at risk of sexually transmitted infections
- Intensive behavioral dietary counseling interventions for overweight or obese adults with hyperlipidemia who have other cardiovascular disease (CVD) risk factors such as hypertension, dyslipidemia, impaired fasting glucose, or metabolic syndrome to promote a healthful diet and physical activity for CVD prevention
- 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 medication 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 durable medical equipment (DME) providers. See the “Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics” benefit section.

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- 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, HPV and other cervical cancer screening tests
- 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 and referrals for individuals who screen positive
- Screening, counseling and behavioral intervention for obesity, including children age 6 and older
- Screening for chlamydia for sexually active women ages 24 and younger and all women who are at increased risk of infection
- Screening for gonorrhea for sexually active women ages 24 and younger and all women who are at increased risk of infection
- Screening for high blood pressure in adults age 18 and older
- Screening and testing for Pompe disease (glycogen storage disease)
- 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 and behavioral counseling interventions for alcohol and drug use/misuse 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 diabetes
- 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 in persons at high risk for infection, including asymptomatic, non-pregnant adolescents and adults who have not been vaccinated and other persons at high risk for HBV infection (including persons at high risk who were vaccinated before being screened for HBV infection)
- 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 obesity
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Screening sigmoidoscopy or colonoscopy, including related anesthesia services and prescription prep kits
- Screening, genetic counseling and BRCA testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer
- Screening, genetic counseling and BRCA testing for women with a history of non-BRCA cancer
- 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.

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In order to request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy, you or your physician/provider can call the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception.

Benefit-Specific Exclusions:

- Abortifacient 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 applicable deductible and coinsurance.

Benefit-Specific Maximum: You have a combined in- and out-of-network maximum of Two Hundred Forty (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.

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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 a Level A, B, C or D copay. Copays do not apply to deductibles. For Cancer Treatment Medications that are also classified as Specialty Self-Injectable Medications, you pay the Level 1 retail/mail order pharmacy copay. BCBSAZ determines which Cancer Treatment Medications are classified as Specialty Self-Injectable Medications. Copays do not apply to deductibles or out-of-pocket coinsurance maximums.

If you are currently obtaining a Specialty Self-Injectable Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book. BCBSAZ and/or the PBM will decide whether you are eligible to receive the Specialty Self-Injectable Medication from a retail pharmacy instead of a Specialty Pharmacy.

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. 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.

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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

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- 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-Specific 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, the donor 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 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 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

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- 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 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.com under "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 received from an in-network provider. You pay out-of-network deductible and coinsurance for services received from an out-of-network provider. 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 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)

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- 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

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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.

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

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

Inpatient or Outpatient Long Term Care

Laboratory Services Provided Without an Order from an Eligible Provider

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, except as stated in this plan

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

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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

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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

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

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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).

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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.

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- 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;

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- 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 Periods"* 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 Periods."*

- **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 Periods."*

Loss of Eligibility

Contractholder eligibility ends on the following days:

- The end of the month in which the Contractholder was entitled to receive compensation from the group, regardless of the date such compensation is actually paid and for which BCBSAZ has received payment from the Group.

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- The end of the month in which an approved leave of absence expires, if the Contractholder fails to return to active employment.

- The date on which the Contractholder's death occurs.

- 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 Contractholder, 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 child.

- The end of the month in which the disability or dependency ceases for a disabled 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 date the Contractholder's death occurs.

- 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

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- 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; **and**

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 sixty (60) days of the loss of other coverage:

- 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; **and**
- 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
- 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.

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- **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 amounts due.

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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.

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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.

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact 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) 864-4456	(602) 864-4823	(602) 864-4884
		(800) 232-2345, ext. 4456	(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)

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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
Behavioral Services Administrator (BSA)	(800) 224-2125
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 providing services in Arizona 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	

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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

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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 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.

"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 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.**

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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, access fee, coinsurance, pharmacy deductible, and precertification charges.

"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.**

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“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.

“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.

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“Summary of Benefits and Coverage” (SBC) means a federally required document in a specified template with information on applicable copays, access fees, 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.

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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.

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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.

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.

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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.

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Network Status

In-Network Providers (Contracted)

In-network providers are the following: (1) Except as noted in this benefit book, health care providers licensed in the United States who have a PPO contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ PPO members); and (2) Except as noted in this benefit book, out-of-state health care providers licensed in the United States who have a PPO contract with a Blue Cross and/or Blue Shield plan other than BCBSAZ.

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

- Independent Clinical Laboratory & Specialty Pharmacy: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the referring provider is located.

- Durable Medical Equipment/Medical Supplies: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the member resides.

- Air Ambulance: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state of the member pickup location.

In-network providers will file your claims with BCBSAZ or the applicable out-of-state Blue Cross and/or Blue Shield plan. 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.**

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); (3) Providers who are contracted with the BlueCard Worldwide program; and (4) Providers who do not have a PPO contract with the Blue Cross and/or Blue Shield plan to which the applicable claim is filed.

- **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, 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

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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, coinsurance, and access fees (except for emergency services), plus the balance bill.

Eligible Provider Status and Payment – Summary Table Subject to all terms and conditions noted in this section.				
Provider Contract Status	**Network Status and Applicable Cost-Share**	**Provider Required to File Claim on Member's Behalf**	**Accept 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.

***Except as noted in this benefit book**

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

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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 Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BCBSAZ serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside BCBSAZ's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; **or**
- The negotiated price that the Host Blue makes available to 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 also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSAZ has used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, BCBSAZ may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price made available to BCBSAZ by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than any related patient cost sharing under this contract.

Special Cases: Value-Based Programs

BlueCard® Program

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

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Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If BCBSAZ has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on your behalf, BCBSAZ will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

Nonparticipating Providers Outside BCBSAZ's Service Area

1. **Liability Calculation**

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

2. **Exceptions**

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

BlueCard Worldwide® Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the 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, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

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

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

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- **Submitting a BlueCard Worldwide Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should 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.

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.

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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. If it is required, your provider must obtain it on your behalf before rendering services.

BCBSAZ may change the services that require precertification at any time without providing notice. Go to www.azblue.com for a current 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, as follows:

- 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.

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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.

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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.

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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

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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.

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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.com or 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, duplicate procedures, application of Correct Coding Initiative (CCI) guidelines, member's age and sex edits, services inappropriately billed with office visit (evaluation and management) codes, modifier validation, pre and post-operative service validation, multiple surgical procedure pricing guidelines and other types of claim edits as determined by BCBSAZ. BCBSAZ periodically updates its computer system claim edits.

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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.

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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

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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.

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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.

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- **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.

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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.

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MEMBER COST-SHARING & OTHER PAYMENTS

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.

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 plus 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.

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 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.

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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 access fees and 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. 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

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

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

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:

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

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- 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: Not required.

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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, home, or walk-in clinic 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. 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. Intensive ourtpatient services, ECT and partial hospitalization services are not available through the BSA.

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, home, or walk-in clinic 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, member's home, or a walk-in clinic.

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. 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

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- Neurofeedback
- Neuropsychological and cognitive testing (See the "Neuropsychological and Cognitive Testing" section)
- 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 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, 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-Specific 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 or eyeglasses 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 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-Specific 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.

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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, 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 - 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.

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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

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- 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: 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.

H.1 Durable Medical Equipment (DME)

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

- Be designed for appropriate 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

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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:

- Cochlear implants
- 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, 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

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- 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.

I.1 Diabetes and Asthma Education and Training

Your Cost-Share: Waived.

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

- An in-network provider delivers the education and training;
- Education and training are provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Training is conducted in person; **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.

I.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
- Eating Disorders
- Heart Failure
- High Cholesterol
- Hypertension
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

I.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.**

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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 emergency room 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 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 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.

"Formula" is amino-acid based formula.

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.

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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 "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, 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 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

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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. The cost-share amount will depend on the provider's network status. 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.

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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 facility services are received from in-network hospitals.

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.

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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 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 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 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.

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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:

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 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.

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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).

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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, 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.

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

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 in-network 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: 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. The list of medications that require precertification is subject to change at any time without prior notice. 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.

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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.

Other than as noted in this section, no exceptions will be made concerning the cost-share you will pay, regardless of the medical reasons requiring use of a particular medication, even when there is no equivalent medication on a lower Level or if you are unable to take a medication on the lower Level for any reason.

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.

"Specialty Self-Injectable Medications" are medications that treat chronic or complex conditions. BCBSAZ and/or the PBM determine which medications are Specialty Self-Injectable Medications.

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

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.

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You may obtain most prescription medications from retail pharmacies or the in-network mail order pharmacy. Compounded medications must be obtained from retail pharmacies that have been credentialed by BCBSAZ (or BCBSAZ's vendor) to dispense compound medications. Please contact BCBSAZ Customer Service at the number listed in your benefit plan materials for a list of pharmacies credentialed to dispense compound medications.

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

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

If a medication is not processing at the pharmacy, you or your physician/provider may request an exception by calling the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception. Reasons for requesting an exception include but are not limited to the following: quantity, age, gender, dosage and/or frequency of refill limitations, requests for a Formulary Exception and requests for waiver of cost-share for brand name medications or devices taken or used for a preventive purpose.

If you are currently obtaining a Specialty Self-Injectable Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book. BCBSAZ will decide whether you are eligible to receive the Specialty Self-Injectable medication from a retail pharmacy instead of a Specialty Pharmacy.

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, the medication is excluded from coverage under this Pharmacy Benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

Benefit-Specific Exclusions:

- Abortifacient 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.

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- 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

N. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), AND SPEECH THERAPY (ST) SERVICES

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 PT, OT, and ST services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration and home independence
- All services in excess of the sixty (60) visit limit
- Any care 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
- 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
- Work re-entry therapy, services or programs

Z. 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:

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- 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 (including follow-up care) of FDA-approved contraceptive devices in female members
- FDA-approved implanted contraceptive devices for female members
- Abortifacient medications for the abortions covered under this plan, including oral medications as described in the BCBSAZ Medical Coverage Guidelines.

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.

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- 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, 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 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, 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 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.**

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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 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:

In-Network:

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 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.

For certain covered preventive medications and items obtained from an in-network pharmacy, your cost-share is waived for the generic version of the medication or item and you pay applicable cost-share for the brand-name version of the medication or item. You may request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy. See the **"Benefit-Description"** section below for information about the exception process.

Please note: Your cost-share is waived 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.

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.

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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-Specific 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. **If a preventive service has been denied due to a gender edit and you are undergoing or have undergone transgender treatment, please contact BCBSAZ Customer Service at the number listed in the front of this benefit book for assistance.**

Benefits are available for the following services:

- 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, HPV and syphilis screening
    - prostate specific antigen (PSA) testing
    - TB testing
- Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
- Aspirin for asymptomatic pregnant women who are at increased risk of preeclampsia and who have no prior adverse effects with or contraindications to low-dose aspirin (after 12 weeks of gestation)
- 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 and interventions for tobacco cessation and augmented pregnancy counseling and interventions for members who use tobacco
- Counseling on contraceptive methods for all women with reproductive capacity

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- 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 counseling for all sexually active adolescents and for adults at risk of sexually transmitted infections
- Intensive behavioral dietary counseling interventions for overweight or obese adults with hyperlipidemia who have other cardiovascular disease (CVD) risk factors such as hypertension, dyslipidemia, impaired fasting glucose, or metabolic syndrome to promote a healthful diet and physical activity for CVD prevention
- 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 medication 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 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, HPV and other cervical cancer screening tests
- 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 and referrals for individuals who screen positive
- Screening, counseling and behavioral intervention for obesity, including children age 6 and older
- Screening for chlamydia for sexually active women ages 24 and younger and all women who are at increased risk of infection
- Screening for gonorrhea for sexually active women ages 24 and younger and all women who are at increased risk of infection
- Screening for high blood pressure in adults age 18 and older
- Screening and testing for Pompe disease (glycogen storage disease)
- 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 and behavioral counseling interventions for alcohol and drug use/misuse 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 diabetes
- 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.

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- Screening for Hepatitis B (HBV) virus infection in persons at high risk for infection, including asymptomatic, non-pregnant adolescents and adults who have not been vaccinated and other persons at high risk for HBV infection (including persons at high risk who were vaccinated before being screened for HBV infection)
- 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 obesity
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Screening sigmoidoscopy or colonoscopy, including related anesthesia services and prescription prep kits
- Screening, genetic counseling and BRCA testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer
- Screening, genetic counseling and BRCA testing for women with a history of non-BRCA cancer
- 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.

In order to request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy, you or your physician/provider can call the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception.

Benefit-Specific Exclusions:

- Abortifacient 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.

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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 applicable deductible and coinsurance.

Benefit-Specific Maximum: You have a combined in- and out-of-network maximum of Two Hundred Forty (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 a Level A, B, C or D copay. Copays do not apply to deductibles. For Cancer Treatment Medications that are also classified as Specialty Self-Injectable Medications, you pay the Level 1 retail/mail order pharmacy copay. BCBSAZ determines which Cancer Treatment Medications are classified as Specialty Self-Injectable Medications. Copays do not apply to deductibles or out-of-pocket coinsurance maximums.

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If you are currently obtaining a Specialty Self-Injectable Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book. BCBSAZ and/or the PBM will decide whether you are eligible to receive the Specialty Self-Injectable Medication from a retail pharmacy instead of a Specialty Pharmacy.

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. 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, 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.

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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: Not applicable.

Benefit-Specific 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, the donor or the member's Caregiver;
- BCBSAZ has precertified the transplant procedure;

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- 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 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 which are not emergencies.

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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.com under "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 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 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

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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.

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

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

Inpatient or Outpatient Long Term Care

Laboratory Services Provided Without an Order from an Eligible Provider

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, except as stated in this plan

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

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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

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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

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

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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).

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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.

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- 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 Periods"* 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 Periods."*

- **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 Periods."*

Loss of Eligibility

Contractholder eligibility ends on the following days:

- The end of the month in which the Contractholder was entitled to receive compensation from the group, regardless of the date such compensation is actually paid and for which BCBSAZ has received payment from the Group.

- The end of the month in which an approved leave of absence expires, if the Contractholder fails to return to active employment.

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- The date on which the Contractholder's death occurs.

- 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 Contractholder, 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 child.

- The end of the month in which the disability or dependency ceases for a disabled 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 date the Contractholder's death occurs.

- 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 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)

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- 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; **and**

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 sixty (60) days of the loss of other coverage:

- 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; **and**
- 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
- 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

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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 amounts due.

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).

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- 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.

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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.

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact 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) 864-4456	(602) 864-4823	(602) 864-4884
		(800) 232-2345, ext. 4456	(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)

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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 providing services in Arizona 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	

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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

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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.

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“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, and precertification charges.

“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.

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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.

"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.

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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.

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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

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- 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.

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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.

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Network Status

In-Network Providers (Contracted)

In-network providers are the following: (1) Except as noted in this benefit book, health care providers licensed in the United States who have a PPO contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ PPO members); and (2) Except as noted in this benefit book, out-of-state health care providers licensed in the United States who have a PPO contract with a Blue Cross and/or Blue Shield plan other than BCBSAZ.

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

- Independent Clinical Laboratory & Specialty Pharmacy: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the referring provider is located.

- Durable Medical Equipment/Medical Supplies: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the member resides.

- Air Ambulance: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state of the member pickup location.

In-network providers will file your claims with BCBSAZ or the applicable out-of-state Blue Cross and/or Blue Shield plan. 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.**

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); (3) Providers who are contracted with the BlueCard Worldwide program; and (4) Providers who do not have a PPO contract with the Blue Cross and/or Blue Shield plan to which the applicable claim is filed.

- **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

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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.

Except as noted in this benefit book

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

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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 Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BCBSAZ serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside BCBSAZ's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; **or**
- The negotiated price that the Host Blue makes available to 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 also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSAZ has used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, BCBSAZ may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price made available to BCBSAZ by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than any related patient cost sharing under this contract.

Special Cases: Value-Based Programs

BlueCard® Program

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

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Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If BCBSAZ has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on your behalf, BCBSAZ will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

Nonparticipating Providers Outside BCBSAZ's Service Area

1. **Liability Calculation**

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

2. **Exceptions**

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

BlueCard Worldwide® Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the 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, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

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

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

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- **Submitting a BlueCard Worldwide Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should 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.

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.

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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. If it is required, your provider must obtain it on your behalf before rendering services.

BCBSAZ may change the services that require precertification at any time without providing notice. Go to www.azblue.com for a current 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, as follows:

- 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.

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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.

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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.

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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

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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.

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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.com or 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, duplicate procedures, application of Correct Coding Initiative (CCI) guidelines, member's age and sex edits, services inappropriately billed with office visit (evaluation and management) codes, modifier validation, pre and post-operative service validation, multiple surgical procedure pricing guidelines and other types of claim edits as determined by BCBSAZ. 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.

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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.

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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.

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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.

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- **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.

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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.

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MEMBER COST-SHARING & OTHER PAYMENTS

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.

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 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.

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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

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

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

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. 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:

- Diagnostic testing
- Intensive care units and other special care units
- Medications, biologicals and solutions
- Treatment and recovery rooms and equipment for covered services

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- 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. 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:

- 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: 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.

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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 (See the "Neuropsychological and Cognitive Testing" section)
- 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.

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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-Specific 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 or eyeglasses 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-Specific 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.

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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.

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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:

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- 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 applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status and the place you receive services. 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 appropriate 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.

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H.3 Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

- Cochlear implants
- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- 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, 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.

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**

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- 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
- Eating Disorders
- 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 your in-network cost-share for emergency services, even for services from out-of-network providers.

Emergency Room: You pay in-network deductible and coinsurance for services received in the emergency room. 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.

Admission to the Hospital from the Emergency Room: 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 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.

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"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 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.

"Formula" is amino-acid based formula.

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 "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.

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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

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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 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.

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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 facility services are received from in-network hospitals.

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 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 must be for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time.

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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 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: 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. 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.

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.

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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. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

For 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 facility services are received from in-network hospitals.

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: 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. The list of medications that require precertification is subject to change at any time without prior notice. 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 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.

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Other than as noted in this section, no exceptions will be made concerning the cost-share you will pay, regardless of the medical reasons requiring use of a particular medication, even when there is no equivalent medication on a lower Level or if you are unable to take a medication on the lower Level for any reason.

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.

"Specialty Self-Injectable Medications" are medications that treat chronic or complex conditions. BCBSAZ and/or the PBM determine which medications are Specialty Self-Injectable Medications.

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

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 most prescription medications from retail pharmacies or the in-network mail order pharmacy. Compounded medications must be obtained from retail pharmacies that have been credentialed by BCBSAZ (or BCBSAZ's vendor) to dispense compound medications. Please contact BCBSAZ Customer Service at the number listed in your benefit plan materials for a list of pharmacies credentialed to dispense compound medications.

Certain vaccines are covered when obtained from in-network retail pharmacies and administered by a certified, licensed pharmacist. The following medical devices are covered under this benefit: diabetic test strips, lancets, diabetic syringes/needles for insulin and spacer devices for asthma medications. **Covered medications are subject to limitations, including but not limited to, quantity, age, gender, dosage, and frequency of refills. BCBSAZ and/or the PBM determine which medications are subject to limitations. Medication limitations are subject to change at any time without prior notice.**

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If a medication is not processing at the pharmacy, you or your physician/provider may request an exception by calling the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception. Reasons for requesting an exception include but are not limited to the following:

quantity, age, gender, dosage and/or frequency of refill limitations, requests for a Formulary Exception and requests for waiver of cost-share for brand name medications or devices taken or used for a preventive purpose.

If you are currently obtaining a Specialty Self-Injectable Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book. BCBSAZ will decide whether you are eligible to receive the Specialty Self-Injectable Medication from a retail pharmacy instead of a Specialty Pharmacy.

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, the medication is excluded from coverage under this Pharmacy Benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

Benefit-Specific Exclusions:

- Abortifacient 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

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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-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 PT, OT, and ST services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration and home independence
- All services in excess of the sixty (60) visit limit
- Any care 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
- 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
- Work re-entry therapy, services or programs

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

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- 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
- Abortifacient medications for the abortions covered under this plan, including oral medications as described in the BCBSAZ Medical Coverage Guidelines.

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.

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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 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:

In-Network:

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 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.

For certain covered preventive medications and items obtained from an in-network pharmacy, your cost-share is waived for the generic version of the medication or item and you pay applicable cost-share for the brand-name version of the medication or item. You may request an exception for waiver

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of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy. See the **"Benefit-Description"** section below for information about the exception process.

Please note: Your cost-share is waived 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.

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 procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.

Benefit-Specific 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. **If a preventive service has been denied due to a gender edit and you are undergoing or have undergone transgender treatment, please contact BCBSAZ Customer Service at the number listed in the front of this benefit book for assistance.**

Benefits are available for the following services:

- 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, HPV and syphilis screening
    - prostate specific antigen (PSA) testing
    - TB testing

- Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
- Aspirin for asymptomatic pregnant women who are at increased risk of preeclampsia and who have no prior adverse effects with or contraindications to low-dose aspirin (after 12 weeks of gestation)

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- 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 and interventions for tobacco cessation and augmented pregnancy counseling and interventions 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 counseling for all sexually active adolescents and for adults at risk of sexually transmitted infections
- Intensive behavioral dietary counseling interventions for overweight or obese adults with hyperlipidemia who have other cardiovascular disease (CVD) risk factors such as hypertension, dyslipidemia, impaired fasting glucose, or metabolic syndrome to promote a healthful diet and physical activity for CVD prevention
- 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 medication 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 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, HPV and other cervical cancer screening tests
- 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 and referrals for individuals who screen positive
- Screening, counseling and behavioral intervention for obesity, including children age 6 and older
- Screening for chlamydia for sexually active women ages 24 and younger and all women who are at increased risk of infection
- Screening for gonorrhea for sexually active women ages 24 and younger and all women who are at increased risk of infection

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- Screening for high blood pressure in adults age 18 and older
- Screening and testing for Pompe disease (glycogen storage disease)
- 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 and behavioral counseling interventions for alcohol and drug use/misuse 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 diabetes
- 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 in persons at high risk for infection, including asymptomatic, non-pregnant adolescents and adults who have not been vaccinated and other persons at high risk for HBV infection (including persons at high risk who were vaccinated before being screened for HBV infection)
- 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 obesity
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Screening sigmoidoscopy or colonoscopy, including related anesthesia services and prescription prep kits
- Screening, genetic counseling and BRCA testing for women who have family members with breast, ovarian, tubal, or peritoneal cancer
- Screening, genetic counseling and BRCA testing for women with a history of non-BRCA cancer
- 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.

In order to request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy, you or your physician/provider can call the Pharmacy Benefit Customer Service number listed in the front of this benefit book twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception.

Benefit-Specific Exclusions:

- Abortifacient 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.

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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 applicable deductible and coinsurance.

Benefit-Specific Maximum: You have a combined in- and out-of-network maximum of Two Hundred Forty (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

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- 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:

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- 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-Specific 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, the donor 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 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;

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- 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, 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 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.com under “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.

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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

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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.

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

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

Inpatient or Outpatient Long Term Care

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Laboratory Services Provided Without an Order from an Eligible Provider

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

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

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

Massage Therapy – 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

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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

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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

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).

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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.

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- 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;

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- 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 Periods"* 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 Periods."*

- **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 Periods."*

Loss of Eligibility

Contractholder eligibility ends on the following days:

- The end of the month in which the Contractholder was entitled to receive compensation from the group, regardless of the date such compensation is actually paid and for which BCBSAZ has received payment from the Group.

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- The end of the month in which an approved leave of absence expires, if the Contractholder fails to return to active employment.

- The date on which the Contractholder's death occurs.

- 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 Contractholder, 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 child.

- The end of the month in which the disability or dependency ceases for a disabled 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 date the Contractholder's death occurs.

- 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 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; **and**

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 sixty (60) days of the loss of other coverage:

- 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; **and**
- 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
- 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.

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- **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 amounts due.

Benefit-Specific Eligibility

Under the following limited circumstances, a nonmember may be eligible to receive benefits under this plan:

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- 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.

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