Important Notice

**New Members:** Please read this book, which is part of your contract with Blue Cross Blue Shield of Arizona (BCBSAZ) and all accompanying documents when you receive them. If this benefit plan is unsatisfactory for any reason, you may cancel your policy by sending BCBSAZ written notice of cancellation within ten (10) days following receipt of this book. You may also contact BCBSAZ to discuss your options for obtaining coverage through another BCBSAZ plan. If you choose to cancel and you prepaid any premium, BCBSAZ will refund that premium and cancel the contract for your benefit plan as though it was never in effect.

**Renewing Members:** This provision does not apply if you are already a BCBSAZ member and are receiving this book other than at the time of original enrollment in this plan. If you are a current BCBSAZ member and want to cancel this plan, please follow the instructions in “Voluntary Termination of Coverage.”
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B. BEHAVIORAL AND MENTAL HEALTH SERVICES (including chemical dependency or substance abuse treatment)
C. CLINICAL TRIALS
D. CATARACT SURGERY AND KERATOCONUS
E. CHIROPRACTIC SERVICES
F. DENTAL SERVICES BENEFIT - MEDICAL
G. DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS
H. EDUCATION AND TRAINING
I. EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)
J. EOSINOPHILIC GASTROINTESTINAL DISORDER
K. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)
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O. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES
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Q. INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR) AND SKILLED NURSING FACILITY (SNF) SERVICES
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S. MATERNITY
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U. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING
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W. PHARMACY BENEFIT
X. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST), AND CARDIAC AND PULMONARY REHABILITATION SERVICES
Y. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST), COGNITIVE THERAPY (CT) AND CARDIAC AND PULMONARY HABILITATION SERVICES
Z. PHYSICIAN SERVICES
AA. POST-MASTECTOMY SERVICES
BB. PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER
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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).

<table>
<thead>
<tr>
<th></th>
<th>Customer Service:</th>
<th>Membership Services:</th>
<th>Hearing Impaired (TDD) (Claim Information)</th>
<th>Spanish-Language Phone Service (en Español – preguntas sobre su solicitud, beneficios, reclamos, o pagos)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maricopa County:</td>
<td>(855) 818-0242</td>
<td>(602) 864-4456</td>
<td>(602) 864-4823</td>
<td>(602) 864-4884</td>
</tr>
<tr>
<td>Pima County:</td>
<td>(520) 745-1883</td>
<td>(602) 864-4456</td>
<td>(602) 864-4823</td>
<td>(602) 864-4884</td>
</tr>
<tr>
<td>Statewide:</td>
<td>(800) 232-2345</td>
<td>(800) 232-2345 ext. 4456</td>
<td>(800) 232-2345, ext. 4823</td>
<td>(800) 232-2345 ext. 4884</td>
</tr>
<tr>
<td>Fax:</td>
<td>(602) 864-4041</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address:</td>
<td>All Correspondence Except as Noted Below: Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466</td>
<td>Attn: Membership Services, Mail Stop: A102, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Customer Walk-In Office Locations

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phoenix (main office)</td>
<td>2444 W. Las Palmaritas Drive, 85021-4883 (2 blocks north of Northern Avenue between the Black Canyon Freeway (I-17) and 23rd Avenue)</td>
</tr>
<tr>
<td>Tucson:</td>
<td>5285 E. Williams Circle, Suite 1000, 85711-7411 (East on Broadway Road, right on E. Williams Circle)</td>
</tr>
<tr>
<td>Flagstaff:</td>
<td>1500 E. Cedar Avenue, Suite 56, 86004-1643 (Intersection of Cedar Avenue and West Street)</td>
</tr>
<tr>
<td>Chandler:</td>
<td>2121 W. Chandler Blvd., Suite 115, 85224 (East of the 101 Freeway, West of Dobson Road)</td>
</tr>
</tbody>
</table>
**Provider Locator & Benefit Vendor Information**

<table>
<thead>
<tr>
<th><strong>BlueCard® Program</strong> (getting care outside of Arizona):</th>
<th>Blue Cross Blue Shield Association: (800) 810-2583 or web site at <a href="http://www.bcbs.com">www.bcbs.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Benefits Administrator (CBA):</td>
<td>(800) 678-9133</td>
</tr>
<tr>
<td>Pharmacy Benefit Customer Service:</td>
<td>(866) 325-1794</td>
</tr>
<tr>
<td>Alliance Provider Network Status:</td>
<td>Check the online provider directory at <a href="http://www.azblue.com">www.azblue.com</a> or call BCBSAZ customer service at the numbers listed above</td>
</tr>
<tr>
<td>Pediatric Eyewear Benefits Administrator:</td>
<td>(855) 855-4816</td>
</tr>
</tbody>
</table>

**Claim Submissions**

| **Mail New Claims to:** | Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix AZ 85062-2924 |
| **Mail claims for out-of-network services 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: A223, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466 |
| **Claims for Services Received on a Cruise Ship:** | Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466 |
| **Claims for Chiropractic Services:** | Claims Administration, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001 |

**Accessing Care**

| **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**

<table>
<thead>
<tr>
<th><strong>Medical Appeals and Grievances</strong> (except as noted below)</th>
<th><strong>Precertification Denial Appeals</strong> (you or your doctor may contact BCBSAZ)</th>
</tr>
</thead>
</table>
| **Maricopa County:** | (602) 544-4938  
(602) 544-5601 |
| **Statewide:** | (866) 595-5998  
(866) 595-5998 |
| **Fax:** | (602) 544-4938  
(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 |
| **For disputes over pediatric eyewear benefits:** | EyeMed Vision Care, ATTN: Quality Assurance Department, 4000 Luxottica Place, Mason, OH 45040 |
### Document and Form Requests

<table>
<thead>
<tr>
<th>Document/Request</th>
<th>Maricopa County</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Coverage Guidelines</strong> (request a copy of the Medical Coverage Guidelines):</td>
<td>(602) 864-4614</td>
<td>(800) 232-2345, ext. 4614</td>
</tr>
<tr>
<td></td>
<td>BlueNet members’ area of <a href="http://www.azblue.com">www.azblue.com</a> under Claims &amp; Benefits/Health Benefits/Medical Coverage Guidelines</td>
<td></td>
</tr>
<tr>
<td><strong>Requests for Transplant Travel and Lodging Claim Forms:</strong></td>
<td>(602) 864-4051</td>
<td>(800) 232-2345, ext. 4051</td>
</tr>
<tr>
<td><strong>Supply Line</strong> (provider directories, claim forms, BCBSAZ Appeal and Grievance Guidelines, ID cards, Rx mail order packet):</td>
<td>(602) 995-6960</td>
<td>(800) 232-2345, ext. 6960</td>
</tr>
</tbody>
</table>

### Social Media

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

"Advance Payment of the Premium Tax Credit" means payment of the tax credits specified in the Internal Revenue Code which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with applicable federal law.

"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. BCBSAZ uses the allowed amount to accumulate toward any out-of-pocket maximum that applies to the member’s benefit plan. 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.

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Type of Claim</th>
<th>Basis for Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers contracted with BCBSAZ as Alliance Network providers</td>
<td>Emergency and Non-emergency</td>
<td>Generally, the lesser of the provider’s billed charges or the applicable Alliance fee schedule, with adjustments for any negotiated contractual arrangements and certain claim editing procedures</td>
</tr>
<tr>
<td>Providers contracted with a vendor</td>
<td>Emergency and non-emergency</td>
<td>Generally, the lesser of the provider’s billed charges or the vendor’s fee schedule, with adjustments for any negotiated contractual arrangements</td>
</tr>
<tr>
<td>Providers contracted with another Blue Cross or Blue Shield Plan (&quot;Host Blue&quot;)</td>
<td>Emergency and non-emergency</td>
<td>Lesser of the provider’s billed charges or the price the Host Blue plan has negotiated with the provider</td>
</tr>
<tr>
<td>Noncontracted providers (in Arizona and out-of-state, including providers contracted with BCBSAZ as PPO or HMO Providers but not as Alliance Network providers)</td>
<td>Emergency</td>
<td>Billed charges</td>
</tr>
</tbody>
</table>

"Annual open enrollment period" means the period each year during which a qualified individual may enroll or change coverage in a QHP offered through an Exchange or enroll in a BCBSAZ plan not sold through an Exchange.

"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 contract of insurance between an individual member and BCBSAZ.

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.

"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.

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

"Chiropractic Benefits Administrator (CBA)" means American Specialty Health Networks, Inc., the independent company that administers chiropractic benefits for 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 is a Dependent.

"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.

"Cost-Sharing Reductions" means reductions in cost-sharing for an eligible individual enrolled in a silver level QHP through an Exchange or for an individual who is an Indian enrolled in any level QHP through an Exchange.

"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.

"Exchange" means a governmental agency or non-profit entity that meets the applicable standards of federal and state law and makes QHPs available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to state Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.

"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.

“Habilitation Services” are services and devices that assist an individual with an illness, injury, disability, or chronic disease in partially or fully keeping, acquiring, or improving skills and functioning for daily living to the maximum extent possible.

“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.

“PPACA” means the Patient Protection and Affordable Care Act of 2010, as amended.

“Pediatric Eyewear Benefits Administrator” means EyeMed Vision Care, an independent company that is contracted with BCBSAZ to provide a network of participating vision services providers, and customer service and claims administration services for the pediatric eyewear benefits covered under this 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 requesting Pharmacy Coverage Guidelines 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.
“Qualified health plan or QHP” means a health plan that has in effect a certification that it meets the standards issued or recognized by each Exchange through which such plan is offered.

“Qualified health plan issuer or QHP issuer” means a health insurance issuer that offers a QHP in accordance with a certification from an Exchange.

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

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

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

“Special enrollment period” means a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through an Exchange outside of the initial and annual open enrollment periods.

“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, 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.
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 an Alliance 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.

Changes

You will be notified of any changes to this plan as required by law.

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 a provider who is acting within the provider’s scope of practice, as determined by BCBSAZ or BCBSAZ’s contracted vendor.

Experimental or Investigational Services

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

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

In addition to classifying a service as experimental or investigational using the above criteria, BCBSAZ 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.
PROVIDERS

Know your provider’s network status before you receive services.

**Network Providers**

BCBSAZ has a network of health care providers who have an Alliance contract with BCBSAZ or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ members (network providers). However, the fact that a service is rendered by a network provider does not guarantee that the service will be covered. Except for emergency situations, services are covered only if rendered by network providers. Also, to be eligible for coverage, a service must be rendered by a provider acting within his or her scope of practice, and when applicable, performed at a facility that is licensed or certified for the type of procedure and services rendered.

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.

The BCBSAZ provider directory of Alliance providers is available online at [www.azblue.com](http://www.azblue.com). If you do not have Internet access, or you have questions about a provider’s Alliance network participation, please call BCBSAZ Customer Service before you receive services.

**Network Availability Outside Arizona**

You also have limited coverage outside Arizona for urgent care and authorized follow-up care received from BlueCard network providers.

Network providers will file your claims with BCBSAZ or the Host Blue plan with which they are contracted. In most cases the provider's contract doesn't allow the provider to charge you more that 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 source. Their contracts do allow them to charge you up to billed charges for noncovered services. We recommend that you discuss costs with your provider before you obtain noncovered services.

BCBSAZ directly reimburses network providers for BCBSAZ’s portion of the allowed amount of a claim. You will be responsible to pay your member cost-share.

**Out-of-Network Providers**

Generally, you have coverage for services from out-of-network providers only in emergency situations. An out-of-network provider in or outside of Arizona is not required to file a claim for you. If the provider does not file your claim, send a copy of the itemized bill and a completed claim form to BCBSAZ. BCBSAZ generally does not send claim payments to out-of-network providers. Unless BCBSAZ agrees to pay the provider directly, BCBSAZ will send payment to you for whatever benefits are covered under your plan. You will be responsible for paying the out-of-network provider.

**Differences in Financial Responsibility**

The following example shows how out-of-pocket expenses can differ depending on the provider you choose.

In the following example, the member has a $500 copay when using a network provider and no benefits when using an out-of-network provider.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>$5,000</td>
<td>$3,500</td>
<td>BCBSAZ pays</td>
<td>$3,000</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>You pay:</td>
<td>$500 Copay</td>
<td>$5,000</td>
</tr>
</tbody>
</table>
Locating a Network Provider

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

If you cannot get an appointment with a network provider, you may either call BCBSAZ or ask a 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 the BCBSAZ Alliance network. Not all providers will contract with health insurance plans. If you believe or have been told there is no network provider available to render covered services that you need, you may ask your treating provider to request precertification for services from an out-of-network provider. BCBSAZ will not issue this precertification if we find that a 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 network level for services provided by 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 a network facility, you will not have coverage for facility services.

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

<table>
<thead>
<tr>
<th>New Members</th>
<th>Current Members</th>
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<tr>
<td>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:</td>
<td>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:</td>
</tr>
<tr>
<td>The member has:</td>
<td>The member has:</td>
</tr>
<tr>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>The member’s physician agrees in writing to do all of the following:</td>
<td></td>
</tr>
<tr>
<td>1. Accept the BCBSAZ allowed amount applicable to covered services as if provided by a network physician, subject to the cost-share requirements of this benefit plan;</td>
<td>1. Accept the BCBSAZ allowed amount applicable to covered services as if provided by a network physician, subject to the cost-share requirements of this benefit plan;</td>
</tr>
<tr>
<td>2. Provide BCBSAZ with any necessary medical information related to your care; and</td>
<td>2. Provide BCBSAZ with any necessary medical information related to your care; and</td>
</tr>
<tr>
<td>3. Comply with BCBSAZ’s policies and procedures, as applicable, including precertification, network referral, claims processing, quality assurance and utilization review.</td>
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</tr>
</tbody>
</table>

Out-of-Area Services

BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliate (“Licensees”) referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of Arizona but inside the United States (not BlueCard Worldwide), the claims for these services may be processed through one of these Inter-Plan Programs.
Typically, when accessing care outside Arizona, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-contracted healthcare providers. BCBSAZ’s payment practices in both instances are described in this benefit book.

BCBSAZ covers only limited healthcare services received outside Arizona. As used in these sections, “Out-of-Area Covered Healthcare Services” include emergency services, urgent care and authorized follow-up care obtained outside Arizona. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. Emergency services are covered when provided by providers contracted with a Host Blue and when provided by non-contracted providers. Urgent care and authorized follow-up care is covered only when provided by providers contracted with a Host Blue.

BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for fulfilling BCBSAZ’s contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will file a claim for Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the cost-sharing noted in this benefit plan booklet.

Emergency Care Services: If you experience an emergency while traveling outside Arizona, call 911 or go directly to the nearest hospital or emergency facility. Member cost-sharing will apply to covered emergency services. See the Emergency Services section of this benefit book.

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

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

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

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

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

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

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

See the “Provider” section and the definition of “Allowed Amount” in this benefit book for information regarding payment for services provided by non-contracted providers outside Arizona.
BlueCard Outside the United States (BlueCard Worldwide)

If you experience an emergency while traveling outside the United States, go directly to the nearest hospital or emergency facility. Emergency services are covered outside the United States. Member cost-sharing will apply to covered emergency services. See the Emergency Services section of this benefit book.

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

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

Except for emergencies, you cannot obtain services from providers located outside the United States. Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. Except for emergencies, services received from a provider who is contracted with the BlueCard Worldwide program are not covered.

- **Inpatient Services**

  In most cases, hospitals contracted with the BlueCard Worldwide program will not require you to pay for covered emergency services, except for your member cost-share. In such cases, the BlueCard Worldwide hospital will submit your claim for processing.

- **Outpatient Services**

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

**Services Received on Cruise Ships**

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

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

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

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

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

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

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.

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 is a network provider;
• 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 Network Cost-Share for Services from an Out-of-Network Provider

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

If BCBSAZ Precertifies Your Service

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

If BCBSAZ Denies Your Precertification Request

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

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

Filing Claims

In most cases, 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.

All claims for services provided by a chiropractor must be sent to the CBA for processing.

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 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

Most EOBs are consolidated and sent to you in a monthly Member Health statement rather than as single EOBs.

Notice of Determination

If your request for precertification is denied, or your claim is denied in whole or in part, you will receive a notice of adverse benefit determination. In most cases, your EOB or monthly statement will serve as the notice, and will:

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

Pharmacy Prescriptions; Submission of Claims by Members

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

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

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

Time Period for Claim Decisions:

Post-Service Claims

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

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

Pre-Service Claims

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

If BCBSAZ requires more time to make a precertification decision, BCBSAZ may extend the time by an additional fifteen (15) days by notifying you, within the initial ten (10)-day period of need for an extension, the expected decision date, and any additional information needed for the decision. You and your provider will have at least forty-five (45) days to submit any requested information.
**Concurrent Care Decisions**

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

**Urgent Claims**

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

When you request coverage for an urgent care claim, a determination will be made as soon as possible in accordance with medical exigencies, but no later than seventy-two (72) hours after receipt of the request.
GENERAL PROVISIONS

Appeal and Grievance Process

Members may participate in BCBSAZ’s appeals and grievance processes, which are described in detail in the BCBSAZ Appeal and Grievance Guidelines, a separate document provided to you. You may obtain another copy of the BCBSAZ Appeal and Grievance Guidelines at any time by visiting us at www.azblue.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, 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.

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

Blue Cross and Blue Shield Association

The Contractholder, on behalf of self and all Dependent members, expressly acknowledges and agrees that:

i. This Agreement is a contract solely between Contractholder 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. Contractholder has not entered into this Agreement based on any representations by the Association or any other Blue Cross or Blue Shield plan other than BCBSAZ; and

iv. Contractholder and members shall not seek to hold the Association or any Blue Cross or Blue Shield plan other than BCBSAZ accountable or liable for BCBSAZ’s obligations created under this Agreement.

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.

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 Contractholder terminates his or her relationship with the broker and notifies BCBSAZ, or the broker becomes ineligible for receipt of commissions. Brokers are required under their agreement with BCBSAZ to provide information on commission rates with BCBSAZ. More detailed information about broker commissions and compensation to BCBSAZ employees who are Licensed Sales Representatives for BCBSAZ individual products is available for review at www.azblue.com or you may obtain a copy by calling BCBSAZ at (602) 864-4021.

Claim Editing Procedures

In order to process claims accurately, BCBSAZ uses a computer system to verify benefits, eligibility, claims accuracy and compliance with BCBSAZ coding guidelines and the Medical Coverage Guidelines. BCBSAZ uses claims coding and editing logic to process professional and outpatient facility claims. This system logic is designed to identify the following: procedure unbundling (billing multiple procedure codes to represent a
procedure that can be described with a more comprehensive code), separate billing for included (incidental) services, procedures not usually performed together (mutually exclusive) procedures, correct use of coding guidelines, member’s age and sex edits. The system logic does not audit the diagnosis code to change or modify the intensity of service of office visit (evaluation and management) codes. BCBSAZ periodically updates its computer system claim edits. These claims edits can affect the allowed amount for claims.

**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, network providers are independent contractors and not employees, agents or representatives of BCBSAZ. Their contracts with BCBSAZ address reimbursement and administrative policies. Each provider exercises independent medical judgment in deciding what services to provide you, and how to provide them. BCBSAZ’s role is limited to administration of the benefits under this benefit plan. Your provider may recommend services or treatment not covered under this benefit plan. You and your provider should decide whether to proceed with a service that is not covered. BCBSAZ has no control over any diagnosis, treatment, care or other services rendered by any provider and disclaims any and all liability for any loss or injury to you caused by any provider by reason of the provider’s negligence, failure to provide treatment or otherwise.

**Lawsuits against BCBSAZ**

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

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

- Attn: Legal Department
- Mail Stop: C300
- Blue Cross Blue Shield of Arizona, Inc.
- 8220 N. 23rd Avenue
- Phoenix, AZ 85021-4872
Failure to comply with these provisions may result in dismissal of the lawsuit. A member must complete all applicable levels of appeal before bringing a lawsuit other than a suit filed pursuant to the Health Care Insurer Liability Act. Failure to complete the mandatory levels of the appeal process may result in dismissal of the lawsuit for failure to exhaust BCBSAZ’s administrative remedies.

By providing this notice BCBSAZ does not waive, but expressly reserves all applicable defenses available under Arizona and federal law.

**Legal Action and Applicable Law**

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

**Jurisdiction and Venue**

Maricopa County, Arizona is the exclusive site of jurisdiction and venue for any legal action or other proceeding that arises out of or relates to the contract or this benefit plan.

**Lawsuits by BCBSAZ**

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

**Non-Assignability of Benefits**

The benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against BCBSAZ and imposes no duty or obligation on BCBSAZ. BCBSAZ will not honor any such purported sale, assignment, pledge, transfer or grant.

**Medicaid Reimbursement**

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

**Member Notices and Communications**

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

**Payments Made in Error**

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

Plan Amendment

There is no guarantee to continued benefits as outlined in this plan. BCBSAZ may amend this plan and add, delete or change benefits, limitations, cost share amounts, and all other provisions on notice to the Contractholder as required to comply with state or federal laws. 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 receives rebate payments based on the volume and/or market share of pharmaceutical products used by BCBSAZ members. BCBSAZ and/or the Pharmacy Benefit Manager (PBM) enter into contracts with pharmaceutical manufacturers, pursuant to which BCBSAZ receives these rebate payments. These rebate contracts are subject to renegotiation and/or termination from time to time. The rebate contracts with pharmaceutical manufacturers generally work as follows: BCBSAZ or the PBM sends the pharmaceutical manufacturer data on member use of specific medication(s) for comparison to the utilization level and/or market share requirements of the applicable rebate contract. If the utilization and/or market share meets the requirements of the rebate contract, the manufacturer issues a rebate payment after receipt of the data. As utilization and/or market share increases, the amount of the rebate may increase.

The rebates BCBSAZ receives on your pharmacy utilization are not reimbursable to you, including prescription costs applied to any copay, deductible, coinsurance calculation or out-of-pocket maximum that may apply under your plan. You acknowledge and agree that BCBSAZ will keep all rebates.

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

Provider Contractual Arrangements

The 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 cost share for a particular service can vary based on the network provider you choose because not all network 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.

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. 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.
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 “Legal” link at the bottom of the home page.

If you would like BCBSAZ to mail you another copy of the “Notice of Privacy Practices,” please call the customer service telephone number listed on the back of your BCBSAZ identification card, or call (602) 864-4400 or (800) 232-2345 to make your request.
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 an access fee, coinsurance, copay, deductible or some combination of these payments. Each cost-share and other payment type is explained below. This section, the benefit descriptions in this book and your SBC will explain which cost-share types and other payments 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.

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. An individual member cannot contribute more than his or her individual deductible toward the family’s deductible.

The deductible is calculated based on the allowed amount. Amounts you pay for copays and access fees do not count toward the deductible.

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for certain covered services after meeting any applicable deductible. BCBSAZ subtracts any applicable access fees 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 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.

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost-Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMBULANCE SERVICES</td>
<td>Deductible is waived. You pay coinsurance.</td>
</tr>
<tr>
<td>BEHAVIORAL AND MENTAL HEALTH SERVICES (Outpatient Facility and Professional Services):</td>
<td>You pay one copay per member, per provider, per day for services provided during an office, home or walk-in clinic visit. You pay deductible and coinsurance for services delivered in locations other than the provider’s office, the member’s home or a walk-in clinic.</td>
</tr>
<tr>
<td>BEHAVIORAL THERAPY SERVICES FOR THE TREATMENT OF AUTISM SPECTRUM DISORDER</td>
<td>You pay one copay per member, per provider, per day for services provided during an office, home or walk-in clinic visit. You pay deductible and coinsurance for services delivered in locations other than the provider’s office, the member’s home or a walk-in clinic.</td>
</tr>
<tr>
<td>CLINICAL TRIALS</td>
<td>You pay applicable copays, deductible and coinsurance.</td>
</tr>
<tr>
<td>CATARACT SURGERY &amp; KERATOCONUS</td>
<td>You pay applicable copays, deductible and coinsurance.</td>
</tr>
<tr>
<td>CHIROPRACTIC SERVICES</td>
<td>You pay one copay per member, per provider, per day for services provided during an office, home or walk-in clinic visit. You pay deductible and coinsurance for services delivered in locations other than the provider’s office, the member’s home or a walk-in clinic.</td>
</tr>
<tr>
<td>DENTAL SERVICES BENEFIT - MEDICAL</td>
<td>You pay deductible and coinsurance.</td>
</tr>
<tr>
<td>DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS</td>
<td>You pay applicable copays, deductible and coinsurance. Your cost-share is waived for one FDA-approved manual or electric breast pump and breast pump supplies per female member, per calendar year.</td>
</tr>
<tr>
<td>EDUCATION AND TRAINING (Diabetes and Asthma Education and Training)</td>
<td>Your cost-share is waived.</td>
</tr>
<tr>
<td>EDUCATION AND TRAINING (Nutritional Counseling and Training)</td>
<td>Your cost-share is waived.</td>
</tr>
</tbody>
</table>
| EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)                          | Emergency Room: You pay one copay per member, per facility, per day for emergency room facility charges. Deductible and coinsurance are waived for professional and ancillary services provided while in the emergency room.

   Admission to the Hospital from the Emergency Room: The emergency room copay is waived if you are admitted for an inpatient stay to the hospital. Following admission, you pay 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 the provider’s billed charges.

   For all non-emergency services following the emergency treatment and stabilization, you pay applicable cost-share. |
| **EOSINOPHILIC GASTROINTESTINAL DISORDER** | You pay 25 percent of the allowed amount for amino-acid based formula ("Formula"). |
| **FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)** |  
  **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 a physician office. You pay applicable cost-share when the location of service is outside a physician office.  
  **Sterilization Procedures:** Your cost-share is waived for professional and facility charges 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 cost-share for FDA-approved sterilization procedures provided to male members.  
  **Hormonal Contraceptive Methods:** Your cost-share is waived for oral contraceptives, patches, rings and contraceptive injections. See the "Physician Services" and "Pharmacy Benefit" sections for benefits.  
  **Emergency Contraception:** Your cost-share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a physician or other provider. See the "Physician Services" section for benefits.  
  **Barrier Contraceptive Methods:** Your cost-share is waived for diaphragms, cervical caps, cervical shields, female condoms and sponges and spermicides for female members. See the "Physician Services" and the "Pharmacy Benefit" sections for benefits. |
| **HOME HEALTH SERVICES** | You pay deductible and coinsurance. |
| **HOSPICE SERVICES** | Your cost-share is waived. |
| **INPATIENT DETOXIFICATION** | You pay deductible and coinsurance. |
| **INPATIENT HOSPITAL** | You pay deductible and coinsurance.  
Your cost-share is waived for facility charges 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. |
<p>| <strong>INPATIENT REHABILITATION SERVICES – EXTENDED ACTIVE REHABILITATION (EAR) AND SKILLED NURSING FACILITY (SNF) SERVICES</strong> | You pay deductible and coinsurance. |
| <strong>LONG-TERM ACUTE CARE (INPATIENT)</strong> | You pay deductible and coinsurance. |</p>
<table>
<thead>
<tr>
<th><strong>MATERNITY</strong></th>
<th><strong>Inpatient Services:</strong> You pay deductible and coinsurance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Global Charge” is a fee charged by the delivering provider that includes certain prenatal, delivery and postnatal services.</td>
<td><strong>Outpatient Services:</strong> You pay one (1) physician visit copay for your first prenatal office or home visit, which covers all physician services included in the physician’s Global Charge. You pay one copay, per member, per provider, per day for other physician office or home visits not included in the Global Charge. You pay applicable copays, deductible and coinsurance for other covered maternity services from other providers.</td>
</tr>
</tbody>
</table>

| **MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS** | You pay 50 percent of the allowed amount. |
| **NEUROPSYCHOLOGICAL AND COGNITIVE TESTING** | You pay applicable copays, deductible and coinsurance. |

| **OUTPATIENT SERVICES** | **Diagnostic Laboratory Services:** You pay a physician visit copay for services in a physician’s office (copay is waived if you receive only covered laboratory services during your visit), except professional services provided by a pathologist or dermopathologist will be subject to deductible and coinsurance. You pay deductible and coinsurance for services provided in other locations. |
| You pay an access fee for all bariatric surgeries, in addition to applicable deductible and coinsurance. The access fee applies toward the professional charges for bariatric surgery. | **Radiology Services:** You pay a physician visit copay for services received in a network physician’s office, except covered professional services provided by a radiologist will be subject to deductible and coinsurance. You pay deductible and coinsurance for services provided in other locations. |

| **Outpatient Facility Services (Including Outpatient Surgery):** You pay deductible and coinsurance. Your cost-share is waived for facility charges 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. |

| **PHYSICAL THERAPY (PT) - OCCUPATIONAL THERAPY (OT) - SPEECH THERAPY (ST) – CARDIAC AND PULMONARY REHABILITATION SERVICES** | You pay deductible and coinsurance. |
| **PHYSICAL THERAPY (PT) - OCCUPATIONAL THERAPY (OT) - SPEECH THERAPY (ST) – COGNITIVE THERAPY (CT) - CARDIAC AND PULMONARY HABILITATION SERVICES** | You pay deductible and coinsurance. |

| **PHYSICIAN SERVICES** | If you receive preventive services, your cost-share may be waived. |
| You pay one copay per member, per provider, per day for services provided during an office, home or walk-in clinic visit. You pay deductible and coinsurance for services delivered in locations other than the provider’s office, the member’s home or a walk-in clinic. Your copay is waived if you only receive the following services and no other covered service during your home or office visit: |
| • Covered allergy injections |
| • Covered immunizations |
| • Covered laboratory services |
| • Covered physical therapy, speech therapy, occupational therapy (PT, OT, ST); these services are subject to deductible and coinsurance) |

| 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 (including follow-up care) 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 generic and brand with no generic equivalent 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 for female members.

You pay deductible and coinsurance for professional services provided by a radiologist or pathologist, including a dermapathologist, even when the services are provided in a physician’s office.

You pay deductible and coinsurance for physician services for sterilization procedures provided to male members.

**POST-MASTECTOMY SERVICES**

You pay applicable copays, deductible and coinsurance.

**PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER**

You pay applicable copays, deductible and coinsurance.

**PHARMACY BENEFIT**

If you are currently obtaining a Specialty Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact 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 Medication from a retail pharmacy instead of a Specialty Pharmacy.

If you believe you have paid more for a self-administered version of a Cancer Treatment Medication than for an injected or intravenously administered version of a Cancer Treatment Medication, please contact the Pharmacy Benefit customer service number listed in the front of this benefit book.

**Medications Obtained From Retail/Mail Order Pharmacies:** You pay a Level 1 prescription copay for medications on Level 1. You pay a prescription medication deductible, then you pay a Level 2 or 3 prescription copay for medications on Levels 2 and 3. You pay a Level 3 copay 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.

If you purchase a brand name medication when a generic equivalent is available, you will pay the Level 1 copay plus the difference between the allowed amount for the generic and the brand name medication, even if the prescribing provider indicates on the prescription that the brand name medication should be dispensed. If you have completed Step Therapy and are taking a brand name medication with a generic equivalent as a result of the Step Therapy process, you pay the copay applicable to the brand name medication (after meeting deductible for Levels 2 and 3 medications).

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.

You may obtain up to a 90-day supply of Maintenance Medications. If you receive a 31 to 60 day supply of medication, you will pay two times the applicable cost-share for a 30 day supply. If you receive a 61-90 day supply of medication from a retail pharmacy, you will pay three times the applicable cost-share for a 90 day supply.

If you obtain a 90-day supply of Maintenance Medications from a network mail order pharmacy, you will pay two times the applicable cost-share for a 30-day supply.

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:

- 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.

**Specialty Medications Obtained from Specialty Pharmacies:** Deductible is waived. You pay coinsurance applicable to Specialty Medications. See your SBC for the coinsurance percentage applicable to “Specialty Drugs.”
<table>
<thead>
<tr>
<th>Service Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENTIVE SERVICES</td>
<td>You pay applicable cost-share for any tests, procedures, or services not listed in the Preventive Services section. Your cost-share is waived, regardless of the location where services are provided, if:</td>
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<tr>
<td></td>
<td>- You receive one of the services listed in the Benefit Description subsection of the Preventive Services section;</td>
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<tr>
<td></td>
<td>- The procedure code, the diagnosis code or the combination of procedure codes and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive; and</td>
</tr>
<tr>
<td></td>
<td>- The primary purpose of the visit at which services were rendered was for preventive care.</td>
</tr>
<tr>
<td>RECONSTRUCTIVE SURGERY AND SERVICES</td>
<td>You pay applicable copays, deductible and coinsurance.</td>
</tr>
<tr>
<td>TELEMEDICINE SERVICES</td>
<td>You pay all cost-share amounts applicable to the services provided via telemedicine. Cost share applies for the service provided at your physical location, and also for the service rendered remotely by the telemedicine provider. To illustrate: if you are in a PCP's office and receiving a consultation from a remote specialist, you will pay the cost share applicable for a PCP office visit and the cost share applicable for a specialist office visit or consultation. If you are at home and receiving a consultation from a remote specialist, you would pay only the cost share for the specialist because no other provider is involved at your location. The cost share applicable to the services rendered by each provider involved in your telemedicine care, as shown in each specific benefit section, determine whether you pay deductible, coinsurance, copays and/or access fees.</td>
</tr>
<tr>
<td>TRANSPLANTS - ORGAN - TISSUE - BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES</td>
<td>You pay applicable copays, deductible and coinsurance.</td>
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<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>TRANSPLANT TRAVEL AND LODGING</td>
<td>Your cost-share is waived.</td>
</tr>
<tr>
<td>URGENT CARE</td>
<td>You pay an urgent care copay per member, per provider, per day for services received from a provider who is contracted with the Alliance Network to render urgent care services. You pay applicable cost-share if you receive urgent care services from an Alliance network provider who is not specifically contracted for urgent care services.</td>
</tr>
<tr>
<td>VISION EXAMS (ROUTINE)</td>
<td>For Members Under Age 5: Your cost-share is waived.</td>
</tr>
<tr>
<td></td>
<td>For Members Age 5 and Older: You pay a routine vision exam copay per member, per provider, per day.</td>
</tr>
<tr>
<td>PEDIATRIC CONTACT LENS FIT AND FOLLOW UP</td>
<td>Your cost-share is waived.</td>
</tr>
<tr>
<td>PEDIATRIC EYEWEAR</td>
<td>Your cost-share is waived.</td>
</tr>
<tr>
<td>PEDIATRIC LOW VISION EVALUATION AND FOLLOW UP</td>
<td>Your cost-share is waived.</td>
</tr>
<tr>
<td>PEDIATRIC LOW VISION HARDWARE</td>
<td>Your cost-share is waived.</td>
</tr>
<tr>
<td>HEARING SERVICES</td>
<td>You pay applicable copays, deductible and coinsurance.</td>
</tr>
<tr>
<td>SERVICES TO DIAGNOSE INFERTILITY</td>
<td>You pay applicable copays, deductible and coinsurance.</td>
</tr>
</tbody>
</table>
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 a provider who is acting within the provider’s scope of practice, as determined by BCBSAZ or BCBSAZ’s contracted vendor.

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.

A. AMBULANCE SERVICES

Precertification: Not required.

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 Inpatient Hospital:

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your network provider fails to obtain precertification.

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

Benefit Description: Benefits are available for:

- Diagnostic testing
- Intensive care units and other special care units
- Medications, biologicals and solutions
- 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).
**Benefit-Specific Exclusions:**

- Medications dispensed at the time of discharge from a hospital
- Private Duty Nursing, except when medically necessary or when skilled nursing is not available from the facility

**B.2 Inpatient Rehabilitation - Behavioral Health Facility Services**

**Precertification:** Required. You will not be penalized if your network provider fails to obtain precertification.

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

**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 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 has 24/7 onsite registered nursing coverage;
- The facility has sufficient behavioral or mental health professional staff to provide appropriate treatment; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

**Benefit-Specific Exclusions:**

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Medications dispensed at the time of discharge from a hospital
- Private Duty Nursing, except when medically necessary or when skilled nursing is not available from the facility
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

**B.3 Outpatient Facility and Professional Services:**

**Precertification:** Not required.

**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, partial hospitalization, electroconvulsive therapy (ECT), and counseling for personal and family problems.
B.4 Behavioral Therapy Services For The Treatment Of Autism Spectrum Disorder

**Precertification:** Not required.

**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 for all Behavioral and Mental Health Services and Substance Abuse Treatment:**

- 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 treatment provided by the following facilities: Group homes, boarding schools, halfway houses, assisted living centers, shelters, foster homes or wilderness programs,
- IQ testing
- Lifestyle education and management services
- Neurofeedback
- Sensory integration, LOVAAS therapy and music therapy

C. CLINICAL TRIALS

**Precertification:** Required for services directly associated with a clinical trial. 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 requirements.

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.

**Benefit Description:** Benefits are available for covered services directly associated with a clinical trial meeting all requirements specified by applicable 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
- 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

D. **CATARACT SURGERY AND KERATOCONUS**

**Precertification:** Required for inpatient cataract surgery. You will not be penalized if your network provider fails to obtain precertification.

**Benefit Description:** Benefits are available for the removal of cataracts, including placement of a single intraocular lens at the time of the cataract removal. Benefits are also available for the first pair of external contact lenses post-cataract surgery or for treatment of keratoconus.

**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.

**Benefit Description:** Benefits are available for chiropractic services.

Physical therapy services provided by a chiropractor apply towards the sixty (60) visit limit on rehabilitative and habilitative physical therapy, speech therapy, occupational therapy and cardiac and pulmonary rehabilitation and habilitation 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. **DENTAL SERVICES BENEFIT - MEDICAL**

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

F.1 **Dental Accident Services**

**Precertification:** Not required.

**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

**F.2 Dental Services Required for Medical Procedures**

**Precertification:** Required for non-emergency inpatient admissions. You will not be penalized if your network provider fails to obtain precertification.

**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

**F.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 network provider fails to obtain precertification.

**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
- Diabetes
- Hemophilia
G. DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS

Precertification: Not required.

Benefit Maximum: Benefits are limited to one (1) manual or electric (not hospital grade) breast pump and breast pump supplies per female member, per calendar year.

G.1 Durable Medical Equipment (DME)

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

- Be designed for appropriate use in the home setting;
- Be specifically designed to improve or support the function of a body part;
- 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

G.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.

G.3 Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- Foot orthotics for the treatment of conditions resulting from diabetes
- Orthopedic shoes that are:
therapeutic shoes (depth inlay or custom-molded) along with inserts, **for individuals with diabetes**; and
- attached to a brace; and
- covered in accordance with BCBSAZ medical necessity criteria.

- 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
- Testicular implants following medically necessary removal of the testicles

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:**

- Biomechanical devices, which are any external prosthetic device operated through or in conjunction with nerve conduction or other electrical impulses
- Certain equipment and supplies that can be purchased over-the-counter, as determined by 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, elevators, exercise equipment, foot stools, garter belts, grab bars, health spas, hearing aid batteries except as stated in this plan, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, mineral baths, myoelectric limbs, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas and vehicle or home modifications.
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for help in daily living, socialization, personal comfort, convenience or other non-medical 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
- Wigs, hair pieces and hair transplants, regardless of the reason for the hair loss

**H. EDUCATION AND TRAINING**

**Precertification:** Not required.

**H.1 Diabetes and Asthma Education and Training**

**Benefit Description:** Benefits are available for diabetes and asthma education and training services that are:

- Provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Conducted in person; and
- Prescribed by a patient’s health care provider as part of a comprehensive plan of care to enhance therapy compliance and improve self-management skills and knowledge for a patient diagnosed with diabetes or asthma.

**H.2 Nutritional Counseling and Training**

**Benefit Description:** Nutritional counseling and training is available for members diagnosed with one or more of the following conditions:

- Cardiovascular Disease
- Coronary Artery Disease
- Eating Disorders
- Food Allergies
• Gastrointestinal Disorders
• Heart Failure
• High Cholesterol
• Hyperlipidemia
• Hypertension
• Kidney Disease
• Obesity
• Pre-Diabetes and Diabetes
• Renal Failure/Renal Disease

I. EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)

Precertification: Not required.

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, and 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.

J. EOSINOPHILIC GASTROINTESTINAL DISORDER

Precertification: Not required.

Benefit Description: Benefits are available from network and out-of-network providers for amino acid based formula (“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.

K. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your network provider fails to obtain precertification.

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.

L. HEARING AIDS AND SERVICES

Precertification: Required for cochlear implants received in an inpatient or outpatient facility. You will not be penalized if your network provider fails to obtain precertification.

Benefit Maximum: There is a maximum benefit of one (1) hearing exam per member, per calendar year and one (1) hearing aid per member, per ear, per calendar year.
**Benefit Description:** Benefits are available for routine hearing exams, (except hearing screenings performed as part of a routine well exam), hearing aids, dispensing fees for hearing aids, new or replacement hearing aids no longer under warranty, cochlear implants, cleaning and repair of hearing aids and batteries for cochlear implants.

**Benefit Specific Exclusions:**

- Assistive listening devices, including but not limited to, hearing aids that sync wirelessly with MP3 players, laptops, televisions and/or wireless devices
- Disposable hearing aids
- Batteries or battery replacement for hearing aids other than cochlear implants
- Additional warranties for hearing aids
- Replacement of lost, stolen or damaged hearing aids when the member has already met the benefit maximum of one (1) hearing aid per member, per ear, per calendar year
- Earmolds
- Direct audio input, Bluetooth capability or other additional features
- Return or exchange fees for hearing aids that are returned or exchanged
- Follow-up visits in addition to the original hearing exam

**M. HOME HEALTH SERVICES**

**Precertification:** Required. You will not be penalized if your network provider fails to obtain precertification.

**Benefit-Specific Definition:** “Sole source of nutrition” is defined as the inability to orally receive more than 30 percent of daily caloric needs.

**Benefit Maximum:** Any combination of skilled nursing services necessary to provide home infusion medication administration, enteral nutrition and/or other services requiring skilled nursing care, up to a maximum of forty-two (42) home health visits per member, per calendar year. A visit is any period of time up to four (4) hours. Any time in excess of a four (4) hour increment constitutes another visit. The forty-two (42) home health visit limit does not apply to home health services provided in lieu of hospitalization.

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

**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:

- All services in excess of the 42-visit calendar year maximum, except as described in this section.
- Custodial Care
- Private Duty Nursing
- Respite Care

N. 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 network provider fails to obtain precertification.

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

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. If you are moving to a level of care that requires 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 RN or LPN during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- **Inpatient Acute Care**: Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- **Routine Care**: Intermittent visits provided by a member of the hospice team

Benefit-Specific Exclusion: Respite Care

O. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

Precertification: Required for non-emergency admissions. You will not be penalized if your network provider fails to obtain precertification.

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.

P. INPATIENT HOSPITAL

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your network provider fails to obtain precertification.
**Changing Types of Inpatient Care:** Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires 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 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).

**Benefit-Specific Exclusions:**

- Medications dispensed at the time of discharge from a hospital
- Private Duty Nursing, except when medically necessary or when skilled nursing is not available from the facility

**Q. INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR) AND SKILLED NURSING FACILITY (SNF) SERVICES**

**Precertification:** Required. You will not be penalized if your network provider fails to obtain precertification.

**Benefit Maximum:** Ninety (90) combined days of EAR and SNF services 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, inpatient rehabilitation and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

**Benefit Description:** Benefits are available for:

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

- 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.

- 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).

**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, except when medically necessary or when skilled nursing is not available from the facility
• Respite Care
• Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

R. **LONG-TERM ACUTE CARE (INPATIENT)**

**Precertification:** Required. You will not be penalized if your network provider fails to obtain precertification.

**Changing Types of Inpatient Care:** Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires 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. Room and board is only covered 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).

**Benefit-Specific Exclusions:**

• Custodial Care
• Private Duty Nursing, except when medically necessary or when skilled nursing is not available from the facility
• Respite Care

S. **MATERNITY**

**Precertification:** Not required. Notify BCBSAZ customer service during your first trimester to facilitate maternity care coordination.

**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. Professional services provided in the member’s home must be rendered by an eligible provider.

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 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, health insurance issuers 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 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, 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 issuer.

T. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Precertification: Not required.

Benefit-Specific Definitions:

"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.”

U. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Precertification: Not required.

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

V. OUTPATIENT SERVICES

Precertification: Not required.

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

• Allergy testing, antigen administration and desensitization treatment
• Blood transfusions, whole blood, blood components and blood derivatives
• Diagnostic testing, including laboratory and radiology services
• Dialysis
• Orthognathic treatment and surgery
• 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
• Treatment of TMJ

W. PHARMACY BENEFIT

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

Information About This Benefit

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

• A list of Formulary Medications;
• Information regarding Non-Formulary Medications;
• A list of covered medications that require precertification;
• A list of Specialty Medications;
• Information regarding Maintenance Medications;
• A list of covered vaccines;
• A Formulary Exception;
• 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.
**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.

“**Formulary**” means the list of medications BCBSAZ and/or the PBM has designated as covered under this Pharmacy Benefit. Medications not on the Formulary are not covered unless BCBSAZ and/or the PBM authorizes a Formulary Exception for a Non-Formulary Medication. BCBSAZ and/or the PBM decide which medications are on the Formulary.

“**Formulary Exception**” means BCBSAZ and/or the PBM has authorized coverage of a Non-Formulary Medication for a member. BCBSAZ and/or the PBM decide whether to authorize Formulary Exceptions for coverage of Non-Formulary Medications.

“**Maintenance Medications**” are medications taken on an extended and continual basis for treatment of a chronic or ongoing health condition, and which are not subject to frequent dosage or other adjustments, all as determined by BCBSAZ or the PBM. BCBSAZ and/or the PBM may designate or use national databases to designate certain medications as Maintenance Medications.

“**Narcotics Designated Network Program**” is a program that requires certain members taking narcotic medications to obtain prescriptions for all covered narcotic medications from one designated eligible physician or other provider and to obtain all covered narcotic medications from one network pharmacy designated by BCBSAZ and/or the PBM.

“**Non-Formulary Medications**” means all medications except medications on the Formulary. Members may ask their prescribing provider to request that BCBSAZ make a Formulary Exception for a Non-Formulary Medication. BCBSAZ and/or the PBM decide which medications are Non-Formulary Medications and whether to authorize Formulary Exceptions for Non-Formulary Medications.

“**Specialty Medications**” are medications that treat chronic or complex conditions. BCBSAZ and/or the PBM determine which medications are Specialty Medications.

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

“**Step Therapy**” is a program that requires members to take the generic version of certain medications before BCBSAZ and/or the PBM will consider coverage of the brand-name version of that medication. The Step Therapy program also requires members to take certain medications on the Formulary before BCBSAZ and/or the PBM will consider approval of a Formulary Exception for a Non-Formulary Medication. BCBSAZ and/or the PBM determines which medications are part of the Step Therapy program.

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

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

You may obtain prescription medications covered under this benefit from retail pharmacies, the network mail order pharmacy or from network Specialty Pharmacies. Compounded medications are eligible for coverage only when purchased through retail pharmacies. For medications subject to added controls under a government “340-B program,” you may be required to obtain prescriptions from designated providers and to obtain those medications from designated pharmacies, or those
medications will not be covered. Certain Specialty Medications must be obtained from specific Specialty Pharmacies to be covered. Contact the Pharmacy Benefit Customer Service number listed in the front of this book to obtain more information about Specialty Medications and Specialty Pharmacies.

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

Covered medications are subject to limitations, including quantity, age, gender, dosage, 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.

Certain medications are not covered unless the member participates in the Step Therapy program. Certain members, as determined by BCBSAZ and/or the PBM, will be required to participate in the Narcotics Designated Network Program to obtain coverage of narcotic medications under this benefit plan. BCBSAZ and/or the PBM decide which network pharmacies are eligible to dispense narcotics to members in the Narcotics Designated Network Program.

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 plan
- 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
- Non-Formulary Medications, unless BCBSAZ and/or the PBM authorizes a Formulary Exception
- For medications subject to the Step Therapy program, medications not approved through the Step Therapy program
- Medications obtained from an out-of-network pharmacy, except for emergencies or urgent care
- 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
• Narcotic medications prescribed by an ineligible provider or dispensed by an unapproved pharmacy to members enrolled in the Narcotics Designated Network Program
• 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, spoiled, spilled 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
• Medications for sexual dysfunction
• Medications for transsexual services and treatment

X. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST), AND CARDIAC AND PULMONARY REHABILITATION SERVICES

Precertification: Not required.

Benefit Description: Benefits are available for PT, OT, ST and cardiac and pulmonary rehabilitation services.

Benefit Maximum: Benefits are limited to a maximum of sixty (60) combined PT, OT, ST, CT and cardiac and pulmonary rehabilitative visits per member, per calendar year. Evaluations count toward the sixty (60) rehabilitative visit limit. Visits provided in the home count toward the sixty (60) rehabilitative visit limit.

Benefit-Specific Exclusions:
• Activity therapy and milieu therapy including community immersion or integration and home independence
• Any care for comfort and convenience
• All services in excess of the sixty (60) visit limit
• 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
• Occupational therapy for any purpose other than training the member to perform the activities of daily living.
• 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

Y. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST), COGNITIVE THERAPY (CT) AND CARDIAC AND PULMONARY HABILITATION SERVICES

Precertification: Not required.

Benefit Description: Benefits are available for PT, OT, ST, CT and cardiac and pulmonary habilitative services.

Benefit Maximum: Benefits are limited to a maximum of sixty (60) combined PT, OT, ST, CT and cardiac and pulmonary habilitative visits per member, per calendar year. Evaluations count toward the sixty (60) habilitative visit limit. Visits provided in the home count toward the sixty (60) habilitative visit limit.
Benefit-Specific Exclusions:

- Activity therapy and milieu therapy, including community immersion or integration and home independence, unless related to an illness, injury, disability, or chronic disease
- All services in excess of the sixty (60) visit limit
- Any care for comfort and convenience
- Computer speech training and therapy programs and devices
- Custodial Care
- Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines
- Occupational therapy for any purpose other than training the member to perform the activities of daily living.
- 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, unless related to an illness, injury, disability, or chronic disease
- Services to prevent future injury
- Services to maintain posture, unless related to an illness, injury, disability, or chronic disease
- 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.

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

- 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 determine whether the surgical assistant and anesthesiologist selected by your physician are 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
- Allergy testing, antigen administration and desensitization treatment
- Orthognathic treatment and surgery
- Treatment of TMJ

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 network provider fails to obtain precertification.

**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 “Members 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. 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.**

**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.

**CC. PREVENTIVE SERVICES**

**Precertification:** Not required.

**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 Maximums:** Benefits are limited to: one (1) preventive physical exam per member, per calendar year, unless additional visits are necessary for the member to obtain all covered Preventive Services. Benefits are also limited to one (1) manual or electric (not hospital grade) breast pump and breast pump supplies per female member, per calendar year.
**Benefit Description:** Benefits are available for the following services, as appropriate for the member’s age and gender, and as recommended by your provider. If a preventive service has been denied due to 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.

- Preventive physical examination, i.e. routine physical examination, including the following services when done for screening purposes only:
  - resting electrocardiogram (EKG)
  - lung function test (spirometry)
  - vision and hearing screening (this may include newborn audiological evaluation in the hospital)
  - fecal occult blood test
  - general health laboratory panel (bilirubin, calcium, carbon dioxide, chloride, creatinine, alkaline phosphatase, potassium, total protein, sodium, ALT, SGPT, AST, SGOT, BUN, TSH)
  - thyroid function testing (TSH)
  - complete blood count (CBC)
  - lipid panel (cholesterol panel and triglycerides)
  - fasting glucose (blood sugar); HbA1c
  - urinalysis
  - blood lead
  - sexually transmitted disease (STD) counseling and testing, including HIV and HPV screening
  - prostate specific antigen (PSA) testing
  - TB testing

- 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 for tobacco cessation and augmented pregnancy counseling for members who use tobacco
- Counseling on contraceptive methods for all women with reproductive capacity
- Developmental/Behavioral Assessments including developmental screening, Autism screening, developmental surveillance, and psychosocial/behavioral assessment for children from newborns through 21 years of age
- FDA-approved contraceptive methods for female members, as prescribed. See the “Family Planning,” “Physician Services,” and “Pharmacy Benefit” sections.
- FDA-approved sterilization procedures for female members, as prescribed. See the “Family Planning” and “Physician Services” benefit sections.
- Folic acid supplementation prescribed for females. See the “Pharmacy Benefit” section.
- Interventions, including counseling and education, to prevent initiation of tobacco use in school-aged children and adolescents
- Intensive behavioral 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

Mammogram

Oral fluoride supplementation prescribed for children starting at age 6 months who live in areas where the water service is deficient in fluoride

Physical therapy or exercise for members age 65 and older living in community dwellings to minimize falls

Prophylactic ocular topical mediation for all newborns for the prevention of gonococcal ophthalmia neonatorum

Rental or purchase of manual or electric breast pumps and breast pump supplies when obtained from durable medical equipment (DME) providers. See the “Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics” benefit section.

Repeated antibody testing for unsensitized Rh(D)-negative pregnant women at 24-28 weeks gestation, unless the biological father is known to be Rh(D) negative

Routine gynecologic exam including Pap test and other cervical cancer screening test

Routine immunizations and immunizations for foreign travel, as determined by BCBSAZ

Routine iron supplementation prescribed for asymptomatic children ages 6 months through 12 months who are at increased risk for iron deficiency anemia

Screening (annually) for lung cancer with low-dose computed tomography (LDCT) for members age 55 to 80 with a 30 year or more year history of smoking and who currently smoke or have quit smoking within the past 15 years. Screenings will be discontinued if the member (1) has not smoked for 15 years or more; (2) develops a health problem that limits life expectancy; or (3) is unwilling to have curative lung surgery.

Screening and counseling (annually) for interpersonal and domestic violence

Screening, counseling and behavioral intervention for obesity, including children age 6 and older

Screening for 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 for alcohol misuse and behavioral counseling interventions for pregnant women

Screening for alcohol and drug use/misuse in children age 11 years and older

Screening for asymptomatic bacteriuria for pregnant women at 12-16 weeks gestation or at first prenatal visit, if later

Screening for depression for members age 11 and older

Screening for gestational diabetes mellitus (GDM) at (1) the first prenatal visit (2) prior to 24 weeks of gestation based upon risk factors for type 2 diabetes, such as obesity, family history of type 2 diabetes or fetal macrosomia during a previous pregnancy; and (3) after 24 weeks of gestation.

Screening for Hepatitis B (HBV) virus infection 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 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

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.

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

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.

DD. RECONSTRUCTIVE SURGERY AND SERVICES

Precertification: Required for non-emergency inpatient admissions. You will not be penalized if your network provider fails to obtain precertification.

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.

EE. SERVICES TO DIAGNOSE INFERTILITY

Precertification: Not required.

Benefit Description: Benefits are available for services to diagnose infertility.

Benefit-Specific Exclusion: Services, medications, treatments and procedures to achieve fertility or treat infertility.

FF. TELEMEDICINE SERVICES

Precertification: Not required.

Benefit-Specific Definitions:

“Burn” means tissue injury caused by contact with heat, chemicals, electricity, friction, or radioactive agents.

“Cardiologic condition” means disease or disorder of the heart or blood vessels.

“Dermatologic condition” means skin disease, disorder or lesions.
“Infectious Disease” means an illness caused by a person’s reaction to the entrance, growth and multiplication of microorganisms, such as bacteria or viruses, in the person’s body.

“Interactive audio-video electronic media” means a form of electronic communications that allows the participants to simultaneously see and speak to each other.

“Mental health disorder” means a condition defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM).

“Neurologic disease” means a disorder of the neuromuscular or nervous systems.

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

**Benefit Description:** Benefits are available for telemedicine services delivered by network provider through interactive audio-video electronic media to treat the following conditions:

- Burns
- Cardiologic conditions
- Dermatologic conditions
- Infectious diseases
- Mental health disorders
- Neurologic diseases, including strokes
- Trauma

Benefits are also available for emergency or urgent telemedicine services from out-of-network providers to treat one of the covered conditions.

**Benefit-Specific Exclusions:**

- Non-emergency and non-urgent telemedicine services from an out-of-network provider
- Services delivered through the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail
- Telemedicine services for diseases or disorders not listed above

**GG. TRANSPLANTS - ORGAN - TISSUE - BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES**

**Precertification:** Required. You will not be penalized if your network provider fails to obtain precertification.

**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 do not include complications and follow-up care related to the donation
• Pre-transplant testing and services

Benefit-Specific Exclusions:
• Donor expenses for complications and follow-up care related to the donation, even when medically necessary
• 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

HH. TRANSPLANT TRAVEL AND LODGING

Precertification: Not required.

Benefit Maximum: Maximum of $10,000 per member, per transplant. Covered expenses incurred by a Caregiver accumulate toward the member’s $10,000 per transplant maximum.

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

Benefit Description: Coverage is available for reimbursement of the travel and lodging expenses listed below, when all the following criteria are met:

• The expenses are incurred by a member receiving a covered transplant procedure, or the member’s Caregiver,
• BCBSAZ has precertified the transplant procedure;
• The distance from the member’s or Caregiver’s residence must be more than sixty (60) 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 the Alliance Network, a provider contracted with the local Blue Cross and/or Blue Shield plan where services are rendered or a Blue Distinction Centers for Transplants (BDCT) facility;
• The member must be receiving medically necessary pre and post-operative treatments, including without limitation, treatment of complications related to the covered transplant or routine follow-up care for a covered transplant or a transplant that occurred while the member was covered by another insurance plan; and
• The expenses are for any of the following:
  • Meal expenses;
  • Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; bus; train or air fare; and
  • Room charges from hotels, motels and hostels or apartment rental.

Benefit-Specific Exclusions:
• Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or internet service charges; spa services; gym facilities; or other hotel or motel amenities
• All travel and lodging expenses incurred by a donor or the donor’s caregiver
• All travel and lodging expenses in excess of $10,000 per member, per transplant
• 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 or Caregivers when the member or Caregiver does not travel more than sixty (60) miles for an authorized transplant or transplant-related services
• Travel and lodging expenses for donors, even when the donor has to travel more than sixty (60) miles from the donor’s residence to provide or obtain transplant or transplant-related services
• Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement

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

II. URGENT CARE

Precertification: Not required.

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 free-standing urgent care provider contracted with the Alliance Network. These providers are listed in your provider directory and on the BCBSAZ Web site at www.azblue.com under “Urgent Care Centers.”

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

JJ. VISION EXAMS (ROUTINE)

Precertification: Not required.

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, and may include routine ophthalmologic exams with refractions.

Benefit Description: Benefits are available for one (1) routine vision exam per member, per calendar year.

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
For the following pediatric benefit sections, benefits are only available for eligible members until the end of the policy year in which the member turns 19.

KK.  PEDIATRIC CONTACT LENS FIT AND FOLLOW UP

Precertification: Not required.

Benefit-Specific Definitions:

- **Standard Fit and Follow-Up**: Applications of clear, soft, spherical, daily-wear contact lenses for single-vision prescriptions; does not include extended/overnight wear.

- **Premium Fit and Follow-Up**: More complex applications including but not limited to toric, multifocal/monovision, post-surgical and gas permeable; includes extended/overnight wear for any prescription.

Benefit Description: Benefits are available for standard and premium fit and follow-up services, for contact lenses covered under this benefit plan. Benefits are available only through the pediatric eyewear benefits administrator.

Benefit-Specific Exclusion:

- Services not provided through the pediatric eyewear benefits administrator
- Services not meeting accepted standards of optometric practice
- Office infection control charges
- State or territorial taxes on vision services performed

LL.  PEDIATRIC EYEWEAR (EYEGLASSES OR CONTACT LENSES)

Precertification: Not required.

Benefit-Specific Definitions:

**Single vision lenses**: Lenses with one power

**Bifocal lenses**: Lenses with two focal lengths: One for distance and one for near vision.

**Trifocal lenses**: Lenses with three areas of viewing, each with its own focusing power.

**Lenticular lenses**: Lenses composed of a thin carrier which has an area of high plus power molded to the front surface. This area of power is usually located in the center of the lens and takes on the appearance of a bubble.

**Progressive lenses**: Lenses with no lines and gradient of increasing lens power. Lenses are designated as standard or premium depending on the date the design was introduced to the market, the lens’ technology and design features, and the wholesale list price from the manufacturer’s laboratory.

**Conventional contacts**: Lenses intended for ongoing, daily use.

**Frequently replaced contacts**: Lenses that are discarded after a prescribed usage period typically ranging from one day to one month.

**Medically necessary contact lenses**: Contact lenses that are necessary and appropriate for the treatment of certain conditions, as determined by Medical Coverage Guidelines.

Benefit Description: Benefits are available for one pair of prescription glasses and frames, OR one set of conventional or frequently replaced contact lenses, OR one set of medically necessary contact lenses. Coverage is limited to one pair or set per calendar year. Benefits are available only through the pediatric eyewear benefits administrator.

If you choose prescription glasses, coverage is available for single vision, bifocal, trifocal, lenticular or progressive lenses, and for the following optional lenses and treatments:
• Ultraviolet protective coating
• Polycarbonate lenses
• Blended segment lenses
• Photochromic glass lenses
• Plastic progressive lenses
• Polarized lenses
• Standard, premium or ultra anti-reflective coating
• Hi-index lenses

If you choose prescription glasses, coverage for frames will be limited to frames designated as “pediatric frames” by the provider.

If you choose contact lenses, coverage is available for hard or soft conventional single or bifocal lenses, or for frequently replaced contact lenses.

Coverage is available for medically necessary contact lenses in accordance with the applicable Medical Coverage Guidelines.

**Benefit-Specific Exclusions:**

• Eyewear not provided through the pediatric eyewear benefits administrator
• Non-prescription (plano) lenses or contact lenses
• Non-prescription sunglasses
• Replacements for lost or broken lenses, frames or contact lenses when the member has exhausted the eyewear benefit quantity limit for the year
• Services provided at a discounted rate available to the general public
• Services provided after the member’s coverage termination date, except when eyewear ordered before coverage ended are delivered, and services are rendered to the former member within 31 days of the date of such order
• Two pairs of glasses in lieu of bifocals
• Lens designs or coatings that are not listed in the benefit description
• Services and materials not meeting accepted standards of optometric practice
• Services or materials resulting from your failure to comply with professionally prescribed treatment
• Services or materials provided as a result of intentionally self-inflicted injury or illness
• Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection
• State or territorial taxes on vision services performed
• Prosthetic devices and services

**MM. PEDIATRIC LOW VISION EVALUATION AND FOLLOW UP**

**Precertification:** Not required.

**Benefit-Specific Definition:** “Low vision” is a significant loss of vision, but not total blindness.

**Benefit Description:** Benefits are available for one comprehensive low vision evaluation per member every five (5) years, and for up to four (4) follow-up visits per member in any five (5) year period. Benefits are available only from a provider contracted with the Alliance Network or with the pediatric eyewear benefits administrator.

**Benefit-Specific Exclusions:**

• Services from an out-of-network provider
• Services not meeting accepted standards of optometric practice
• Office infection control charges
• State or territorial taxes on vision services performed

**NN. PEDIATRIC LOW VISION HARDWARE**

**Precertification:** Not required.
**Benefit Description:** Benefits are available for low vision hardware, including but not limited to high-power spectacles, magnifiers and telescopes. Benefits are limited to one low vision aid per member, per year. Benefits are available only through the pediatric eyewear benefits administrator.

**Benefit-Specific Exclusion:**

- Services not provided through the pediatric eyewear benefits administrator
- Services and materials not meeting accepted standards of optometric practice
- Office infection control charges
- State or territorial taxes on vision services performed
WHAT IS NOT COVERED

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

Abortions

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, including but not limited to, open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding

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

Biofeedback and hypnotherapy, except biofeedback for pain management is covered

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, boarding schools, halfway houses, assisted living centers, shelters or foster homes or wilderness programs

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, except as stated in this plan

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

Computer Speech Training, Therapy Programs and Devices

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

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

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

**Experimental or Investigational Services**

**Fees** – Associated with the collection or donation of blood or blood products

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

**Fees** – Fees for concierge medicine services

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

**Flat Feet** – Services for treatment of flat feet, weak feet and fallen arches, except arch supports may be covered when medically necessary for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

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

**Foot orthotics, corrective orthopedic shoes, and arch supports for treatment of conditions other than diabetes**

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

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

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

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

**Hearing Services and Devices**, except as stated in this plan

**Inpatient or Outpatient Long Term Care**

**Lifestyle education and management services**

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

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

Private Duty Nursing, except when medically necessary or when skilled nursing is not available from the facility

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, sports physical examinations 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**

**Reversal of Sterilization**

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

**Sensory Integration, LOVAAS Therapy and Music Therapy**

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

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

**Services for Weight Loss and Gain**, except as stated in this plan

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

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

**Services Paid for By Other Organizations; Services Required by Law to be Paid for By Other Organizations** – Services paid for by other organizations and/or services required by law to be paid for by other organizations. Other organizations include, but are not limited to, the government, a school, and/or biotechnical, pharmaceutical or medical device industry organizations. Examples of services that are paid for or required by law to be paid for by other organizations are services that are part of a child’s individual education program and/or worksite and ergonomic evaluations.

**Services Prior to Member’s Coverage Effective Date**

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

**Services Provided by Out-Of-Network Providers**, except for emergencies and urgent care and authorized follow-up care as stated in this benefit plan

**Services Related to or Associated with Developmental Delays**, 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, and medications for the treatment of sexual dysfunction

**Smoking Cessation**, except as stated in this plan

**Spinal Decompression or Vertebral Axial Decompression Therapy (VAX-D)**

**Strength Training** – Services primarily designed to improve or increase fitness, strength or athletic performance, including strength training, cardiovascular endurance training, fitness programs and strengthening programs, except as stated in this plan
Surgical Treatment of Hyperhidrosis

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

Therapy Services, except as stated in this plan

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

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

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

Transsexual Treatment, Surgery, Medications and Related Services

Vision – Vision therapy; eye exercises; all types of refractive keratoplasties including but not limited to radial keratotomy and/or lasik surgery; any other procedures, treatments and devices for refractive correction; eyeglass frames and lenses, contact lenses and other eyewear; vision examinations for fitting of eyeglasses and contact lenses, except as stated in this plan

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

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

Notify BCBSAZ Membership Services about changes to the following:

- Individuals being added to the benefit plan: Spouse, newborns, adopted children, children placed for adoption, children being placed as foster children, 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

If you do not tell us about address changes, correspondence 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.

Open Enrollment

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

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

Child-Only Coverage

A parent or other legal guardian contracts on behalf of a child for the benefits described in this plan. The parent or guardian is responsible for the child’s compliance with all terms, conditions, and requirements of this Plan, including premium payments, precertification, cost-sharing, and consent requirements necessary to provide plan benefits.

Dependents

The following persons are Dependents who can be covered under this benefit plan:

- The Contractholder’s spouse under a legally-valid existing marriage.
- The Contractholder’s children or the children of the Contractholder’s spouse, if under age 30, including:
  - Children placed for adoption
  - Children under legal guardianship substantiated by a court order and living with the Contractholder
  - Children who are entitled to coverage under a medical support order
  - Disabled dependent children meeting the criteria set forth in this benefit book
  - Legally-adopted children
  - Natural children
  - Step-children
  - Foster children

You cannot add your Dependent’s child as a Dependent on your plan unless you are the legal guardian of your Dependent’s child.

Eligibility Requirements

- Contractholder – A Contractholder becomes eligible to enroll for coverage after meeting the eligibility requirements of BCBSAZ.
• **Children** – Children are eligible for Dependent coverage until their 30th birthday. A child is automatically eligible for coverage for the first thirty-one (31) days beginning on the date of birth, adoption, placement for adoption or placement in foster care (“qualifying date”), if the parent or guardian covered under this plan remains eligible for coverage during that period and the child is otherwise an eligible Dependent under this plan. **COVERAGE WILL CONTINUE FOR THE CHILD AFTER THE THIRTY-ONE (31) DAY PERIOD AND YOU WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM**, unless you provide notice in writing to remove the child from the plan. The additional premium is prorated. Even if no additional premium is required (for example, you already have family coverage), you must provide notice in writing if you wish to remove the child from the plan.

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

  ◦ Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;
  ◦ Is continuously incapable of self-sustaining employment because of mental or physical disability on the date the Dependent reaches age 30; 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 30. 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.

**Effective Date of Coverage**

BCBSAZ will notify the Contractholder of the effective date of coverage for the Contractholder and/or any Dependents.

• **Contractholder** – A Contractholder’s effective date of coverage is the date determined by BCBSAZ.

• **Dependent** – A Dependent’s effective date of coverage is the date determined by BCBSAZ.

• **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.

• Newborn/Adopted Child/Child Placed for Adoption/Placement in Foster Care – Coverage is effective on the date of birth, adoption, placement for adoption or placement in foster care.

**Loss of Eligibility**

BCBSAZ will notify the Contractholder if the Contractholder and/or any Dependents lose eligibility for coverage under this benefit plan.

**Reasons for Termination of Coverage**

Unless coverage is earlier terminated by request of the Contractholder and/or any Dependent(s) or due to the death of the Contractholder and/or any Dependents, BCBSAZ will notify the Contractholder and Dependent(s) of any termination dates of coverage for the Contractholder and/or any Dependent(s) a minimum of thirty (30) days prior to the last day of coverage.

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
• Non-payment of premiums by the Contractholder, after expiration of any grace period available under applicable law
• Coverage for the Contractholder and/or Dependents is rescinded
**Termination Date of Coverage**

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

- The last day of coverage allowed by applicable law for a grace period for non-payment of premium.
- If the Contractholder gets divorced, the termination date for the Contractholder’s spouse is the date of the final divorce decree.
- When an adult Dependent turns age 30 and does not qualify as a disabled Dependent, the termination date is the adult Dependent’s 30th birthday.
- When an adult Dependent’s disability ends, the termination date is the date disability or incapacity ends.
- When a Dependent child covered by a qualified medical support order is no longer eligible under the court order or administrative order, the termination date is the last day of the time period specified in the court order or administrative order.
- When a Contractholder dies, BCBSAZ terminates the Contractholder’s policy on the date of death and transfers any Dependents to a new policy on the date of death.
- Any other termination date allowed under applicable law.

BCBSAZ does not automatically terminate a Contractholder or Dependent when that person turns age 65 or becomes eligible for Medicare for some other reason. For persons who are eligible for Medicare and at least age 65, BCBSAZ has other coverage options that may offer lower premium rates. Please call us for additional information. If you continue your coverage under this plan, BCBSAZ will not duplicate benefits for covered services paid by Medicare as primary payer.

**Voluntary Termination of Coverage**

Except as provided in this section for Dependents subject to court order or administrative order, the Contractholder may voluntarily cancel coverage at any time for the Contractholder and all Dependents by notifying BCBSAZ. BCBSAZ will terminate the plan on the 1st day of the month following BCBSAZ’s receipt of the request.

**Special Enrollment Periods**

A special enrollment period is available for the following triggering 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 from the date of the triggering event and provides evidence of the triggering event:

- A person gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, placement of a foster child or through a child support order or other court order.
- A person is determined newly eligible or ineligible for the Advance Payment of the Premium Tax Credit or has a change in eligibility for Cost-Sharing Reductions, regardless of whether that person is already enrolled in a QHP.
- A person loses coverage because an eligible employer-sponsored plan will no longer be affordable or provide minimum value, as those terms are defined in applicable law.
- A person’s enrollment or non-enrollment in a QHP is unintentional, inadvertent or erroneous and is the result of error, misrepresentation, misconduct or inaction of an officer, employee or agent of the Exchange, or HHS, or its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the Exchange.
- A person demonstrates to the Exchange that the QHP he/she is enrolled in substantially violated a material provision of its contract in relation to the person.
- A person moves permanently and gains access to new QHPs as a result of a permanent move.
- A person loses coverage because of the death of the covered employee.
- A person loses coverage because the person has coverage through his or her spouse and the spouse dies.
- A person loses coverage because of the death of a Contractholder.
- A person loses a Dependent or is no longer a Dependent due to death.
- A person loses coverage because the person has coverage through his or her spouse or parent and a divorce or legal separation occurs.
• A person loses coverage because of the termination (other than by reason of the employee’s gross misconduct), or reduction of hours, of the covered employee’s employment
• A person loses coverage because of the divorce or legal separation of the covered employee from the covered employee’s spouse
• A person loses a Dependent or is no longer a Dependent due to divorce or legal separation
• A person loses coverage because a covered person 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
• A person loses coverage because of exhaustion of COBRA coverage
• A person loses coverage because of termination of the employer’s contribution toward coverage
• A person loses coverage because of termination of the covered employee’s eligibility for coverage
• A person loses coverage because the covered employee’s employer terminates or discontinues coverage
• The covered employee is employed by an employer that offers multiple health benefit plans and the covered employee elects a different plan during open enrollment
• A person loses eligibility for Medicaid or the Children’s Health Insurance Program (CHIP)
• A person received notice that he or she is eligible for a Medicaid or CHIP premium assistance subsidy
• A person exhausts a lifetime maximum on all benefits under the other policy or plan (triggering 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
• A person in a non-Medicaid expansion state who was previously ineligible for Advance Payment of the Premium Tax Credit solely due to household income below 100 percent FPL and was concurrently ineligible for Medicaid experiences a change in household income and becomes eligible for Advance Payment of the Premium Tax Credit; and

A special enrollment period is available for the following triggering 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 before and after the date of the triggering event and provides evidence of the triggering event:

• A person loses minimum essential coverage, as that term is defined in applicable law. Loss of minimum essential coverage includes, but is not limited to the following:

  Person Is Enrolled in Non-COBRA coverage:
  ♦ A person loses coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing
  ♦ In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, a person loses coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual)
  ♦ In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, a person loses coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual
  ♦ A person loses coverage because the person incurs a claim that would meet or exceed a lifetime limit on all benefits
  ♦ A person loses coverage because a plan no longer offers any benefits to a class of similarly situated individuals
  ♦ A person loses coverage at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

Person Is Enrolled in COBRA Coverage: An employee or dependent who has COBRA continuation coverage exhausts COBRA continuation coverage
  ♦ A person loses pregnancy-related coverage, as that term is defined in applicable law
  ♦ A person loses medically needy coverage, as that term is defined in applicable law
  ♦ A person enrolled in an employer-sponsored plan is determined newly eligible or ineligible for the Advance Payment of the Premium Tax Credit, based in part of a finding that such person is ineligible
for coverage in an employer-sponsored plan because it is no longer affordable or no longer provides
minimum value, including as a result of the employer discontinuing or changing available coverage
within the next 60 days, provided that such person is allowed to terminate existing coverage
• A person is enrolled in any non-calendar year group health plan or individual health insurance
coverage, even if the person or his or her Dependent has the option to renew such coverage; and
• Any other special enrollment rights available under applicable state or federal law.

**Premiums**

BCBSAZ determines premiums as follows:

**Applicants will not be denied coverage due to a medical condition.** Applicants must be underwritten, but
the results of the underwriting will not be a factor in determining eligibility for coverage. Premiums vary based
upon age, family composition and whether any applicants are tobacco users. Premiums also vary based upon
deductible amount and geographic rating area.

When a child covered by a child-only policy reaches age 19, the child is automatically considered an adult
Contractholder.

Premium payments must be made to BCBSAZ on or before the due date. If premiums are paid by check,
premiums must be paid in U.S. dollars and drawn from a bank located and based in the United States.

**Grace Period**

If you do not pay your premium by the premium due date, BCBSAZ allows you a thirty (30) day grace period
to make the payment. BCBSAZ is not responsible or liable for claims incurred during the grace period, unless
BCBSAZ receives payment before the end of the grace period. A premium not paid when due and not paid
within the grace period, is in default. This plan terminates as of the date the premium was originally due. If this
plan is terminated for non-payment of premium, the Contractholder may request reinstatement. BCBSAZ has
sole discretion and authority as to whether to allow reinstatement. If reinstatement is not granted, the contract
holder must reapply for coverage. The same coverage may not be available. If the application is approved,
members are subject to applicable deductibles and out-of-pocket maximums required under the new plan. If
BCBSAZ precertified a service during the grace period, that precertification is null and void if the plan is later
retroactively terminated for non-payment of premium. The member is responsible for all medical expenses
incurred during the grace period if the plan is later retroactively terminated for non-payment of premium.

**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.

**Continuing Coverage for Terminated Dependents**

Eligible Dependents who are terminated may be able to continue coverage on a separate plan.

**New Policy Required For Individuals Who Relocate Outside Arizona**

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

**Rescission**

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

**What Happens If Your Plan is Rescinded**

• Any precertification given is null and void as though it never existed.
If the Contractholder’s coverage is rescinded but one or more Dependent children retain coverage, BCBSAZ will convert the policy to a child-only plan, as of the effective date for the rescinded policy. You must pay any required premium for the child-only policy.

The Contractholder or Dependent whose coverage was rescinded is responsible for all medical expenses incurred in excess of premiums paid to BCBSAZ.

Dependants may be able to keep their coverage or switch to certain other products.

The policy is null and void for the Contractholder and/or Dependent whose coverage is rescinded, and that person has no benefits.

Retroactive Adjustment of Premium

If you made a false statement or material omission on your application that enabled you to receive a lower premium than you should have received if you had truthfully and fully disclosed all information, BCBSAZ may, in lieu of rescinding your policy, permit you to retain your coverage at the correct premium, if you pay all difference in premium owed since the start of coverage and are otherwise current on premium payments in accordance with this plan.

Court Orders for Health Insurance Coverage

Coverage may be available to a Contractholder’s child in accordance with any court order or administrative order issued by a court of competent jurisdiction to provide health benefits coverage to a child of the contract holder if the child meets BCBSAZ eligibility requirements. The order must clearly specify the name of the Contractholder, the name and birth date of each child covered by the order and the time period to which the order applies. The court’s order applies to the Contractholder. It does not bind BCBSAZ. To obtain coverage for the child, the Contractholder must submit an application. After receiving the Contractholder’s application for the child, BCBSAZ will underwrite the child for the purpose of setting a premium for the child. Coverage will not be effective until the date assigned by BCBSAZ and the Contractholder is required to pay any required premium. If the effective date coincides with a retroactive court order date, we will prorate the premium from the first day of the time period specified in the order.

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

Benefit-Specific Eligibility

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

- If a transplant recipient is covered by BCBSAZ and the donor is not a member, the donor may be eligible for limited benefits (see benefit description 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, 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. Benefits for complications of pregnancy are not available for surrogate birth mothers who are not members if the above requirements for legal adoption of the child are not met.

Non-Duplication of Benefits

**Medicare:** This plan will not duplicate benefits for covered services that are paid by Medicare as primary payer. When a member is enrolled in Medicare Part A or Part B, the benefits available under this plan are coordinated with Medicare as primary payer. Medicare must process the claim first. If Medicare Part A or Part B is the primary payer and denies coverage for a service that is covered under this plan, BCBSAZ will process the claim as if it were the primary payer, subject to all of the terms of this plan. We do not coordinate
benefits with Medicare Part D. The combined total payment by Medicare and BCBSAZ will never exceed the amount a provider is permitted to bill the member under applicable Medicare law.

**Secondary Coverage Under a BCBSAZ Group Plan**

If a member has coverage under this plan and also under a BCBSAZ group benefit plan, this plan is primary. This plan pays benefits first. Payment of the claim is subject to all applicable deductibles, coinsurance and copays. Any combined benefit payments will not exceed 100 percent of the allowed amount under the plan offering the higher level of benefits.

**Coverage Under Another BCBSAZ Individual Plan**

If a member has coverage under this plan and also under one or more additional BCBSAZ individual plans, the order of benefits is:

- If the member is covered as a Contractholder under one plan and as a Dependent under another, the Contractholder coverage pays first. If a child is covered under a child-only plan, the child-only coverage pays first.

- If a child is enrolled as a Dependent under more than one individual BCBSAZ plan and the parents are married, living together or share custody of the child, then the plan of the parent whose birthday occurs earlier in the calendar year covers the child first. If both parents have the same birthday, the benefits of the plan that has covered a parent longer covers the Dependent child first.

If the Dependent child's parents are legally separated or divorced and do not share custody, the following applies when the parents or stepparents are covered under a BCBSAZ individual plan:

- Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health insurance expenses, that parent's coverage pays first.

- If there is no court decree establishing responsibility for the child's health insurance expenses, the custodial parent's coverage pays first. If the custodial parent has remarried, the stepparent's coverage pays second. The noncustodial parent's coverage pays next and a noncustodial stepparent's coverage pays last.

- When none of the above applies, the coverage in force for the longest continuous period of time pays first.

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

**Coverage Under Non-BCBSAZ Plans (Including Other BCBS Plans)**

BCBSAZ does not coordinate coverage with non-BCBSAZ plans.