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CUSTOMER SERVICE INFORMATION
www.azblue.com

Blue Cross Blue Shield of Arizona (BCBSAZ) will assume you have read and understand this benefit plan booklet. If you have any questions concerning benefits or limitations, please contact the Customer Service department.

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

Customer Service (benefit questions or claim information)	Maricopa Pima	(602) 864-4400 (520) 745-1883
Outside of Maricopa/Pima Counties	Northern Arizona Southern Arizona Statewide	(928) 526-0232 (800) 423-6484 (520) 745-1883 (800) 752-0193 (800) 232-2345
Hearing Impaired (TDD) (claim information)	Maricopa	(602) 864-4823
Spanish-Language Telephone Service en Español - preguntas sobre su aplicación, beneficios, reclamación, o pagos	Maricopa Statewide	(602) 864-4884 (800) 232-2345 Ext. 4884
Enrollment ordering additional ID cards, changing mailing address, adding or removing dependents, termination of coverage	Maricopa/Other Pima	(602) 864-4456 (800) 232-2345 Ext. 4456 (520) 745-1446 (800) 621-5563
Precertification (your doctor must contact)	Maricopa Statewide	(602) 864-4320 (800) 232-2345 Ext. 4320
Provider's BCBSAZ Participation or network status online provider directory	Maricopa Statewide	(602) 864-4400 (800) 232-2345 www.azblue.com

☎	**BlueCard® Program** BCBS Association Web Site		(800) 810-2583 www.bcbs.com
☎	**Supply Line** provider directories, claim forms, health coverage appeal information packet, mail order packet	Maricopa Statewide	(602) 995-6960 (800) 232-2345 Ext. 6960
☎	**Behavioral Services Administrator (BSA)**		(800) 224-2125
☎	**Pharmacy Benefit Information**	Maricopa Statewide	(602) 864-4273 (800) 232-2345 Ext. 4273
☎	**Mail Order Pharmacy Services** **(Walgreen's Healthcare Plus**)	Statewide Refills	(800) 345-1985 (800) 797-3345

MAIL CLAIMS AND CORRESPONDENCE TO:

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

CUSTOMER WALK-IN OFFICE LOCATIONS:

Phoenix (main office)	2444 West Las Palmaritas Drive, 85021-4883 2 blocks north of Northern Avenue between the Black Canyon Freeway (I-17) and 23rd Avenue
Tucson	5285 E. Williams Circle, Suite 1000, 85711-7411
Flagstaff	1500 E. Cedar Avenue, Suite 56, 86004-1643
Tempe	4415 S. Wendler Dr., Suite 100, 85282-6411

References to "you," "your," or "subscriber" are used interchangeably and refer to anyone covered under this benefit plan.

UNDERSTANDING THE BASICS

Before you receive any services, you need to understand both what is covered and the limitations or exclusions of coverage. Not all services recommended or prescribed by a physician or other healthcare providers are covered. Read this benefit plan booklet carefully to understand the limitations of your benefit plan.

- **BCBSAZ ID Card**

  Your ID card includes basic eligibility and cost sharing information - group number, card issue date, deductible(s), office visit copayment (if applicable), and pharmacy copayments. More information on cost sharing is on your Schedule Page and in the Cost Sharing section of this benefit booklet.

  - Bring your BCBSAZ ID card with you when receiving health care services.
  - When calling BCBSAZ, have your ID card available for reference.

- **Covered Services**

  Covered services are the services described as covered in this booklet when performed by eligible providers within the scope of their practice, not excluded, precertified where precertification is required, and which are medically necessary as determined by BCBSAZ. Services provided in excess of a benefit maximum or benefit plan maximum are not covered.

  Benefits of this plan are available only for expenses incurred for covered services if furnished during the term it is in effect and while the subscriber claiming benefits is actually covered by this benefit plan. Benefits may be modified during the term of this plan as specifically provided under the terms of this benefit plan or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for covered services processed on or after the effective date of the modification, subject to the preceding conditions. There is no vested right to receive the benefits of this benefit plan.

- **Coverage Requirements**

  If you are seeing a provider for a particular service or treatment, review this booklet to determine:

  - Is it a benefit - or is it excluded? (*See "Description of Benefits and Services" and "What is Not Covered.")*
  - Are there benefit limitations and/or benefit maximums?
  - Is precertification required? Specific requirements are indicated within the separate benefit provisions, and you will need to have your provider contact BCBSAZ for precertification when it is required. (*See "Precertification.")*

- **Medically Necessary**

  The fact that a provider has prescribed, ordered, recommended, or approved a service or supply does not make it medically necessary or make the charge eligible for benefits, even though it is not expressly excluded.

  Medically necessary care or treatment is care or treatment that meets **all** of the following requirements as determined by BCBSAZ in its sole and absolute discretion:

  - Is consistent with the symptoms, diagnosis and/or treatment of an illness, disease or injury;

  - Meets medical policy requirements relied upon by BCBSAZ* at the time the service is requested or received and is not considered investigational as determined by BCBSAZ. Such medical policy requirements may include, but are not limited to, one or more of the following:

    - InterQual
    - Medical Policy Reference Manual (MPRM)
    - Technology Evaluation Center (TEC) of the Blue Cross and Blue Shield Association

- Medicare Guidelines
- Association of Community Cancer Centers Compendia-Based Drug Bulletin/Oncology
- Blue Cross and Blue Shield Association Medical Policy Clearinghouse and/or
- BCBSAZ Plan Medical Coverage Guidelines (local medical policy)

♦ Is not primarily for the convenience of a subscriber or a provider;

♦ Is the most appropriate site, supply or service level that can safely be provided; and

♦ Is not experimental or investigational as determined by BCBSAZ using the following criteria:

- The technology must have final approval from the appropriate government regulatory bodies if applicable
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes
- The technology must improve the net health outcome
- The technology must be as beneficial as any established alternative, and
- The improvement must be attainable outside the investigational settings

***Please note:** BCBSAZ uses all or some of these criteria in developing its medical policy. Additional or different criteria may be adopted by BCBSAZ from time to time after publication of this benefit booklet. BCBSAZ does not rely on each of these criteria for every service. To determine the specific criteria used by BCBSAZ for rendering a medical necessity benefit determination for any given procedure or service, please contact BCBSAZ at (602) 864-4614 or (800) 232-2345, extension 4614. The behavioral services administrator (BSA) contracted with BCBSAZ may also make medical necessity determinations based on its own medical necessity criteria, which are on file with BCBSAZ and available to you upon request.

BCBSAZ's interpretation of medical necessity is a benefits determination made in accordance with the provisions of this benefit plan, not a decision regarding a course of treatment. Therefore, BCBSAZ's medical necessity benefit determination may differ from your provider's determination of medical necessity. BCBSAZ will interpret whether a service or supply is a medically necessary covered benefit. Whether to proceed with the service is a patient care decision to be made between you and your provider.

- **Medical Terminology**

  It is necessary to include certain medical terminology to explain your health care benefits. If you have any questions concerning the medical terminology, including medical conditions, procedures or treatment specifically outlined in this booklet, BCBSAZ recommends that you bring this booklet to discuss your questions with your treating physician or other health care provider. To better understand the benefits, limitations and exclusions of your coverage, please call BCBSAZ Customer Service.

- **Provider Network Status**

  Check your provider's eligibility and participation status with BCBSAZ <u>before</u> you receive services. (See "*Providers.")*

  ♦ Is your provider an eligible provider?
  ♦ Is your provider a PPO provider? If you don't know, call BCBSAZ Customer Service or check the BCBSAZ Web site for our online provider directory at www.azblue.com.

- **Schedule Page**

  BCBSAZ provides you with a schedule page that lists the persons covered, applicable access fees, copayments, coinsurance percentages, deductible amounts, effective date of your coverage, and other important information. Please keep your current schedule page with your benefit plan booklet. **Review your schedule page for cost-sharing (e.g., access fee, copayment, coinsurance or deductible) information.**

- **Your Responsibilities**

  To be sure your claims can be processed appropriately and that we can keep you informed about administrative or benefit changes, we need you to notify us of:

  - Address changes
  - Dependents added to the benefit plan - newborns, spouse, adopted children, children placed for adoption, step-children
  - Dependents leaving the benefit plan - in cases of divorce, death, child no longer a full-time student or marriage of a dependent child

  If you do not keep us informed of these types of changes, your mail from BCBSAZ may not reach you in a timely manner, and you may have to reimburse BCBSAZ for claims payments we make on behalf of dependents who became ineligible, but who incurred claims before you provided notice. You may also have to pay costs incurred by BCBSAZ for collection of claims payments made for ineligible dependents.

COST SHARING
(Including Access Fees, Copayment, Coinsurance, Benefit Maximums and Deductible)

Subscribers pay a share of the costs for covered services. Such share may be in the form of an access fee, copayment, coinsurance percentage and/or a deductible. The amount of your share varies depending on the provider you choose and the nature of the services received.

This benefit plan has both in-network and out-of-network benefits. Your out-of-pocket costs are reduced when you receive services from providers within the BluePreferred (PPO) network. **Please note**: Some services are covered only when provided by a PPO provider, as indicated within the specific benefit.

Your schedule page shows your share of costs for in-network and out-of-network covered services (see "*Schedule Page*"), and the cost-sharing components are described in detail below.

- **Access Fee**

  An access fee is a specific dollar amount you must pay to the provider at the time you receive certain covered services. When an access fee applies to a covered service, it is paid each time you receive services, except as otherwise described in this benefit booklet. You may have to pay an access fee for emergency room visits. See your schedule page for specific amounts. Also see "*Emergency or Accident*." Access fees do **not** apply to the calendar year deductible.

- **BCBSAZ Allowed Amount**

  The BCBSAZ allowed amount is the amount payable by or through BCBSAZ for a covered service, including any contractual arrangements and amounts payable by the subscriber, i.e., deductibles, access fees, coinsurance or copayments. The BCBSAZ allowed amount is generally calculated using the lesser of billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements. For inpatient admissions where the billed charge is less than the BCBSAZ fee schedule, your coinsurance is calculated using the lesser billed charge amount, including any contractual arrangements. In those situations, BCBSAZ may reimburse the provider the BCBSAZ fee schedule, including any contractual arrangements, pursuant to its contract with the provider.

- **Benefit Plan Maximum**

  No benefits will be paid by or through BCBSAZ under the Group BluePreferred benefit plan in excess of $3,000,000 per subscriber (see *"Benefit Plan"*). BCBSAZ will notify you when the Group BluePreferred benefit plan maximum is met.

- **Coinsurance**

  Coinsurance is a percentage you pay for covered services after meeting any applicable deductibles. Unless specified within the benefit, coinsurance still applies even when the deductible is waived. Except as described in "*The BlueCard Program*," this percentage is calculated using the BCBSAZ allowed amount. You pay a higher coinsurance percentage when you use an out-of-network provider (see *"Schedule Page"*).

- **Copayment**

  A copayment is a specific dollar amount you must pay to the provider at the time you receive covered services. When a copayment applies to a covered service, it is paid each time you receive services, except as otherwise described in this benefit plan. You may have different copayments for various covered services. You may have to pay a copayment for any of the following services (see your schedule page for specific amounts):

- PPO physician office visits

  The office visit includes services provided by a physician or the physician assistant or nurse practitioner employed in the physician's office when the service is within their scope of practice. When no office visit is charged (e.g., a visit is made for injection or laboratory test or as a follow-up after surgery), there is no copayment.

- Urgent care facility/center visits

- Outpatient services provided by the behavioral services administrator (BSA)

- Most prescription drugs dispensed through a network pharmacy

- Routine vision exam provided by a provider contracted with the vision services administrator (VSA)

- Other services as specifically listed on your schedule page

The office visit copayment <u>does not apply</u> to the following, but these services may be subject to applicable deductible and coinsurance:

- Covered services rendered by a PPO radiologist (e.g., mammograms), or pathologist

- Dental accident services rendered by dental providers

- Behavioral health services, including services from a PPO psychiatrist, even when covered services are rendered by a PPO physician

- Office visits to non-physician providers such as physical, speech or occupational therapists or similar eligible practitioners

If a copayment does not apply to a service, you pay the applicable deductible and coinsurance, unless otherwise specified within the benefit provision.

- **Deductible**

  - **Calendar Year Deductible**

    A calendar year deductible is the amount you must pay for covered services each calendar year (January through December) before this benefit plan begins to pay for covered services.

    Until the deductible is met, it applies to all covered services you receive outside the physician's office, except as described below. The deductible applies regardless of whether a provider has referred you for services or you have self-directed to a provider to obtain services. For example, if your physician refers you to a radiologist for x-rays, if you have not yet paid your deductible, the BCBSAZ allowed amount will be applied to the deductible for services rendered by the radiologist and/or the facility where you obtain x-rays, and you are responsible for paying that amount. Once you have satisfied the calendar year deductible, you would then pay your coinsurance percentage for those services, up to the out-of-pocket maximum described on your schedule page.

    Amounts applied to an additional deductible (see *"Additional Deductibles/Loss of Benefits"*) do not count toward the calendar year deductible.

  - **Additional Deductibles/Loss of Benefits**

    If you do **not** obtain required precertification, you may have to pay an additional deductible or, in some cases, **you may lose your benefit entirely**. Refer to "*Precertification*" for more information on the precertification process. The amount of the additional deductible is shown on your schedule page.

Important information:

- Copayments and access fees do **not** count toward the calendar year deductible (see "*Copayment*" and "*Access Fee*").
- The BCBSAZ allowed amount for covered services will count toward the deductible.
- Make sure you or your providers file **all** your claims so we can keep track of covered expenses and track your deductible. The deductible for a calendar year is applied in the order in which claims are processed by BCBSAZ (not the date services were rendered).
- Amounts applied to the deductible do **not** count toward the out-of-pocket maximum.
- Amounts applied to an additional deductible (see *"Additional Deductibles/Loss of Benefits"*) do **not** count toward the calendar year deductible or out-of-pocket maximum.
- **Family Deductible Maximum**

  An amount applied toward each subscriber's calendar year deductible will count toward a family deductible maximum. Once the family deductible maximum is met, no further calendar year deductible(s) is required. No family member may contribute more than the individual calendar year deductible amount toward the family maximum.

- **Out-of-Pocket Maximum**

When the amount of coinsurance you pay reaches the out-of-pocket maximum shown on your schedule page, BCBSAZ begins paying 100% of the BCBSAZ allowed amount for covered services for the remainder of the calendar year. Even after the out-of-pocket maximum is met, you are still responsible for copayments, access fees and additional deductibles. BCBSAZ's payment is calculated using the BCBSAZ allowed amount.

The following expenses do **not** count toward the out-of-pocket maximum:

- Any deductibles, copayments or access fees
- Any amounts above specific benefit maximums
- Mental or behavioral health care benefits and/or any complications related to any of these services
- Any expenses for medical foods (see "*Medical Foods*")
- Any prescription drug coinsurance and/or copayments (refer to your schedule page)
- Any amounts charged by a provider for non-covered services
- Amounts above the BCBSAZ allowed amount billed by a non-contracted provider
- Coinsurance for days 61-120 of inpatient rehabilitation services (see *"Inpatient Rehabilitation Services"*)
- Coinsurance for days 91-180 of skilled nursing services (see *"Skilled Nursing Facility"*).

There are separate out-of-pocket maximums, depending on whether you choose an in or out-of-network provider.

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- **Family Out-of Pocket Maximum**

  Amounts applied to each subscriber's OOP maximum will be applied to the family OOP maximum. Once the family OOP maximum is met, BCBSAZ begins paying 100% of the BCBSAZ allowed amount for covered services for the remainder of the calendar year. The family OOP maximum is listed on your schedule page. Even after the out-of-pocket maximum is met, you are still responsible for copayments, access fees, and additional deductibles. BCBSAZ's payment is calculated using the BCBSAZ allowed amount.

- **Specific Benefit Maximum**

  Some benefits may have a specific dollar maximum. Amounts applied to the benefit maximum are calculated based on the BCBSAZ allowed amount. A benefit maximum is shown in the benefit description. Only amounts paid by BCBSAZ count toward the benefit maximum, not cost-sharing amounts paid by the subscriber.

  No benefits will be paid over the maximum amount specified in a benefit provision. Once your benefit maximum has been reached, any additional services are non-covered services and the provider may bill you up to their billed charges for these services. If a benefit maximum is met on a particular line of a claim, the provider of services may bill you for the difference between the benefit maximum and the BCBSAZ allowed amount.

PROVIDERS

"Provider" is the general term used in this benefit plan booklet to describe any properly licensed person or facility furnishing medical care to you, such as a doctor, hospital, laboratory or other health professional (see "*Choosing a Provider"*).

- **Primary Care Providers (PCPs)**

  A primary care provider (PCP) is a physician 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 and any other classification of provider approved as a PCP by BCBSAZ. Certain pediatric physicians, e.g., pediatric cardiologists, pediatric allergists and pediatric surgeons are classified as specialists.

  Although the BluePreferred benefit plan does **not** require that you have a PCP from whom you must obtain authorization for referrals and other services, BCBSAZ recommends you find a PCP with whom you can establish a relationship. This way you will have a doctor who can become familiar with your complete personal and family health history, someone who will know you and can assist you with coordination of care. While not having to authorize referrals, your PCP may be a good source of information about which specialists you need to see.

- **Specialist**

  Physicians who practice in a specific area other than those practiced by primary care providers. You do not need authorization or a referral to see a specialist.

- **Blue Cross and/or Blue Shield Plan Providers Outside of Arizona - The BlueCard Program**

  Many providers outside of Arizona have agreements with other independent Blue Cross and/or Blue Shield (BCBS) plans. For covered services received outside of Arizona, the health care provider who participates with the local BCBS plan will file your claim for you.

  If you receive covered services outside Arizona from a provider who participates as a PPO provider with the local BCBS plan, benefits are paid at the in-network level. Amounts for covered services received outside of Arizona from a provider who does **not** participate as a PPO provider with the local BCBS plan are paid at the out-of-network level.

  Precertification requirements and other benefit plan limitations apply to services received outside Arizona. If precertification is required prior to receiving services, you are responsible for making sure the provider obtains precertification. When you do not obtain necessary precertification, your benefits may be denied or you may have to pay an additional deductible *(see "Precertification").*

  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**.**

  BlueCard Outside the United States

  You may also call (800) 810-BLUE (2583) when traveling outside the United States for assistance with locating an international provider, in translating foreign languages and submitting claims (see *"Claim Filing Information").*

- **Choosing a Provider**

  - **In-Network Providers**

    BluePreferred (PPO) Providers - Arizona health care providers who are part of the BluePreferred (PPO) network. These providers have agreed to accept the BCBSAZ allowed amount for covered services, and they will file claims with BCBSAZ for you. Reimbursement and coinsurance is based on the BCBSAZ allowed amount. Except in certain circumstances, BluePreferred providers will not charge you more than the BCBSAZ allowed amount for covered services (see "*Billing Limitations and Exceptions"*).

It is indicated in the specific benefit provisions when you must use only a PPO provider.

- **Out-of-Network Providers**

  You pay a higher coinsurance percentage when using an out-of-network provider. There are two categories of out-of-network providers. Participating providers do have a contract with BCBSAZ, but they are not part of the BluePreferred (PPO) network. Non-contracted providers have no agreement with BCBSAZ. Below is more information on how this affects your out-of-pocket costs.

  - **BCBSAZ Participating Providers** - Arizona health care providers who are not contracted for BCBSAZ's **PPO** plans, but are part of the BCBSAZ Participating provider network. These providers have agreed to accept the BCBSAZ allowed amount for covered services, and they will file claims with BCBSAZ for you. Except in certain circumstances, Participating providers will not charge you more than the BCBSAZ allowed amount for covered services (see "*Billing Limitations and Exceptions"*).

  - **Non-Contracted Providers -** Providers who have **no** agreement with BCBSAZ. Reimbursement and coinsurance are based on the BCBSAZ allowed amount for covered services. You will have more out-of-pocket expense, and non-contracted providers are not obligated to file your claims with BCBSAZ for you.

    In addition, non-contracted providers may charge you for the difference between the provider's billed charges and the BCBSAZ allowed amount. This difference may be substantial. Please check with the non-contracted provider regarding the amount of your financial responsibility **before** you receive services.

    To receive the in-network level of benefits, you are responsible for verifying that all of your providers are in-network (PPO) providers. This includes, but is not limited to, assistant surgeons, anesthesiologists and other providers when you have scheduled services.

- **Differences in Financial Responsibility**

  Below is an example of how out-of-pocket coinsurance expenses can differ depending on the provider you choose. (You would also have to pay any unmet deductible, copayments and access fees.) The example assumes that you pay 20% coinsurance if you choose a BluePreferred PPO network provider, and 40% coinsurance for an out-of-network provider. Out-of-network providers who are also non-contracted can also bill you for the difference between their billed charges and the BCBSAZ allowed amount (this is called a "balance bill" charge).

  An example of your financial responsibility:

			In-Network Providers	**Out-of- Network Providers**	
Billed Charges	BCBSAZ Allowed Amount	Financial Responsibility	PPO Contracted Providers	BCBSAZ Participating Contracted Providers	Non-Contracted Providers
$1,000	$300	BCBSAZ pays	$240	$180	$180
		You pay:	**$ 60** coinsurance amount	**$120** coinsurance amount	**$120** coinsurance **+700** balance bill **$820**

The above figures are for demonstration purposes only. Your savings may vary, depending on your benefit plan and the providers from whom you receive services.

Billed charges: *what the provider bills for services*

You pay (your financial responsibility*): what you must pay after BCBSAZ has paid its share of the allowed amount*

- **Continuing Physician Care from an Out-of-Network Physician (MD, DO)**

  BCBSAZ will allow a new subscriber to continue an active course of treatment with an out-of-network physician in Arizona during the transitional period after the subscriber's effective date if **both** of the following apply:

  - The subscriber has:
    - 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**
    - Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered physician services for delivery and any care that is related to the delivery for up to six (6) weeks from the delivery date; **and**
  - The subscriber's physician agrees **in writing** to do **all** of the following:
    - Accept the BCBSAZ allowed amount applicable to covered services as if provided by a PPO physician, subject to the deductible, coinsurance and copayment requirements of this benefit plan; **and**
    - Comply with BCBSAZ's quality assurance and utilization review procedures and provide to BCBSAZ any necessary medical information related to your care; **and**
    - Comply with BCBSAZ's policies and procedures, including precertification, network referral and claims processing (as applicable).

  If BCBSAZ terminates a physician from the network, except for reasons of medical incompetence or unprofessional conduct, BCBSAZ will allow a subscriber to continue an active course of treatment with the out-of-network physician during a transitional period if **both** of the following apply:

  - The subscriber has:
    - 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**
    - 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 delivery and any care that is related to the delivery for up to six (6) weeks from the delivery date; **and**
  - The subscriber's physician agrees **in writing** to do **all** of the following:
    - Accept the BCBSAZ allowed amount applicable to covered services prior to the transitional period, subject to the deductible, coinsurance and copayment requirements of this benefit plan; **and**
    - Comply with BCBSAZ's quality assurance and utilization review procedures and provide to BCBSAZ any necessary medical information related to your care; **and**
    - Comply with BCBSAZ's policies and procedures including precertification, network referral and claims processing (as applicable).

  Services provided during an approved transitional period must be otherwise covered services under this benefit plan. Continuity of care applies **only** to out-of-network physician services. If the hospital at which your physician practices is not part of the PPO network, the out-of-network provisions of coverage will apply to covered hospital services**.**

Payment for covered services rendered during the continuity of care period will be paid at the in-network level of benefits described in your benefit plan, subject to applicable deductible, coinsurance and/or copayment. Services rendered during the continuity of care period are also subject to all other applicable provisions of the benefit plan, including waiting periods, limitations, exclusions, and benefit maximums.

To request continuity of care, please contact BCBSAZ at (602) 864-5841 or (800) 232-2345, extension 5841.

- **Eligible Providers**

  Benefits are available **only** when services are rendered by the following properly licensed providers:

  - Doctor of medicine (MD)
  - Doctor of podiatry (DPM)
  - Doctor of medical dentistry (DMD)
  - Doctor of osteopathy (DO)
  - Doctor of dental surgery (DDS)
  - Doctor of chiropractic (DC)
  - Doctor of optometry (OD)
  - Psychologist (PhD)
  - Speech, occupational, or physical therapist

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

  Licensed facilities are eligible providers when approved by BCBSAZ.

  Not all eligible providers are contracted with BCBSAZ. Check your directory or the BCBSAZ online provider directory at www.azblue.com, or call the BCBSAZ Customer Service telephone number listed at the front of this book to see if the provider is contracted with BCBSAZ.

- **Referrals to Non-BluePreferred (PPO) Providers**

  BCBSAZ does not guarantee that every specialist or facility will be represented in the PPO network. Not all specialists will agree to contract with health insurance carriers.

  When there is no PPO network specialist available to provide covered services to you, BCBSAZ may precertify the in-network level of benefits for services rendered by an out-of-network provider. This precertification is separate from, or must be included with, any precertification already required for a particular procedure or service. Your treating provider must obtain precertification from BCBSAZ for both the procedure or service (if required) and for the in-network level of benefits prior to your receiving services from an out-of-network provider for you to receive the in-network level of benefits. "In-network level of benefits" means the services will be subject to the in-network deductible, paid at the in-network coinsurance percentage, and your out-of-pocket expenses will count toward the in-network out-of-pocket maximum.

  Even if BCBSAZ issues a precertification to receive services at the in-network level of benefits, when the provider is a non-contracted provider, you are still responsible for the difference between the provider's billed charges and the BCBSAZ allowed amount. A non-contracted provider's charges may be significantly higher than the BCBSAZ allowed amount. We recommend that you find out from the provider what the difference is before you receive services.

  If BCBSAZ does not precertify the out-of-network services at the in-network level of benefits, expenses for covered services will be paid at the out-of-network level of benefits.

PRECERTIFICATION

- **Precertification**

  Precertification is the process BCBSAZ uses to determine eligibility for the requested procedure or service.

  When your provider requests precertification, BCBSAZ will review whether your coverage is active, if the treating provider or location of service is within the appropriate network, and the applicability of other benefit plan provisions (waiting periods, limitations, exclusions, and benefit maximums). **Some of these provisions may not be readily identifiable at the time precertification is given, but they will still apply if discovered later in the claim process after services have been provided.**

  Precertification is **not** a pre-approval or a guarantee of payment. Precertification made in error by BCBSAZ does not constitute a waiver of any right of BCBSAZ to deny payment for non-covered services.

  Some procedures or treatments, as specified by BCBSAZ, are also reviewed during the precertification process for medical necessity, according to BCBSAZ's periodic evaluation of clinical standards and other medical information. Providers may review the criteria upon request (see "*Medically Necessary*").

  Patient care is decided between the provider and the patient. BCBSAZ's interpretation of medical necessity is a benefits determination made in accordance with the provisions of this benefit plan. 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. Whether to proceed with the service or procedure if benefits have been denied by BCBSAZ is an issue to be decided between you and your provider.

- **Services Requiring Precertification**

  The following services must be precertified**:**

  - Inpatient admissions - including hospital, long-term acute care, detoxification, skilled nursing facility, and extended active rehabilitation (emergency and maternity admissions do not require precertification)
  - Surgery and other procedures, i.e., epidural and various scope procedures, performed in an outpatient facility or the outpatient department of a hospital
  - Organ, tissue or bone marrow transplants and stem cell procedures
  - Home health services, home health infusion therapy and physical, occupational or speech therapy services when such services are provided in the home
  - Services directly associated with a cancer clinical trial
  - Dental-related facility and anesthesia services
  - Requests for services by out-of-network providers for in-network level of benefits.

- **How to Get Precertification**

  Where precertification is required, your provider must contact BCBSAZ to get precertification prior to your services or treatment. Your provider must contact us because he/she has the information and medical records BCBSAZ needs to make a benefit determination. **You are responsible for making sure the provider obtains precertification where required.**

- **If Precertification is Not Obtained**

  - Your benefits may be denied
  - You may have to pay an additional deductible

  Whether an additional deductible is imposed or benefits are denied for failure to obtain precertification is indicated in each benefit where precertification is required.

- **If a Precertification Request is Denied**

  You may still have the service or treatment, but you will be obligated for additional costs (as described above). You or your provider may appeal a precertification denial by calling, writing or faxing BCBSAZ. **See *"Appeal and Grievance Process"* or the Health Coverage Appeal Information Packet for an explanation of the appeal process.**

DESCRIPTION OF BENEFITS AND SERVICES

The following benefits and services are listed alphabetically. Please review this section for a full explanation of covered services and certain limitations and exclusions. Also, be sure to review "*What is Not Covered.*"

All services must be medically necessary and covered services as determined by BCBSAZ. Medical necessity and/or whether a service is a benefit may not be determined until after services are rendered and you or your provider submits a claim to BCBSAZ.

Please note: Some benefits are **only** available if services are rendered by a BluePreferred (PPO) provider or other specially-contracted provider, as indicated within the applicable benefit provision. **Remember that your out-of-pocket costs will be higher when you use an out-of-network provider**.

Benefits are listed in alphabetical order.

Accident – See "Emergency or Accident"

A. Ambulance Services

Benefits are available for:

- Ground ambulance transportation from the site of an emergency, accident or acute illness to the nearest facility capable of providing appropriate treatment.
- Interfacility ground ambulance transfers between an acute care facility, extended active rehabilitation facility or skilled nursing facility. Each of the facility services must be medically necessary and precertified where precertification is required for the ambulance service to be covered.
- Air ambulance transportation to the nearest facility capable of providing appropriate treatment when the accident and/or illness occurs in an area inaccessible by ground vehicles, or transport by ground ambulance would be harmful to the subscriber's medical condition

You are not required to pay your deductible, and covered services are paid at 80% of billed charges. Your coinsurance is applied to the PPO out-of-pocket maximum.

B. Behavioral and Mental Health Services (including Chemical Dependency or Substance Abuse Treatment)

Benefits are available for inpatient and outpatient behavioral and mental health treatment, as well as certain emergency room services. You may obtain non-emergency outpatient treatment either from the behavioral services administrator (BSA) or from other eligible providers (see "*Eligible Providers"*). Some behavioral health services (e.g., family counseling) are **only** covered when provided by the BSA, and your out-of-pocket costs are lower when you use the BSA.

Behavioral Health Benefit Maximums:

The following benefit maximums apply under this benefit:

- Inpatient: Two (2) admissions up to a combined total of thirty (30) days per subscriber during any calendar year.
- Outpatient Professional Services (except from the BSA): Fifty-two (52) visits per calendar year, per subscriber.

Subject to the above maximums, benefits are available for mental and behavioral health services as follows:

1. Inpatient Hospitalization

Precertification is required prior to receiving elective or scheduled inpatient services. Otherwise covered non-emergency inpatient services are subject to an additional $300 deductible if services are not precertified.

Your inpatient coverage is limited to two (2) admissions up to a combined total of thirty (30) days per subscriber during any calendar year.

- In-network facility - If you receive services in an in-network facility, you pay the same deductible and coinsurance as for any other covered inpatient service

- Out-of-network facility - Covered services received from an out-of network provider will be paid at 50% of the BCBSAZ allowed amount. In addition to applicable deductible and 50% coinsurance at non-contracted facilities, you will also be responsible for the difference between the provider's billed charges and the BCBSAZ allowed amount,

Once the inpatient maximum benefit has been exhausted, you are responsible for the total cost of all inpatient professional and facility behavioral and mental health services for the remainder of the calendar year.

Detoxification

Benefits for inpatient medical services associated with detoxification are available under the ***"Detoxification"*** provision of this benefit plan. If you receive both detoxification services and inpatient therapy (rehabilitation) services in a facility that provides both acute medical treatment and inpatient mental health therapy (either concurrently or subsequent to the detoxification services), that admission will count toward the inpatient mental and behavioral health care benefit maximum described above.

2. Emergency Room Services for Behavioral/Mental Health

Emergency room services for behavioral or mental health conditions are available for covered behavioral health services received in a hospital emergency room when considered emergency services. These services are subject to the emergency access fee and PPO calendar year deductible, and are paid at 50% of the BCBSAZ allowed amount.

When there is an admission from the emergency room for a behavioral or mental health condition and the inpatient benefit maximum has been exhausted, coverage for that emergency admission is limited to the time required to stabilize the patient**.**

Benefits are not available for any non-emergency inpatient services after the inpatient benefit maximum has been exhausted.

3. Outpatient Services

Behavioral Services Administrator (BSA) - Precertification from the BSA is required prior to receiving outpatient services from the BSA. The following services are not subject to the outpatient fifty-two (52) visit benefit maximum described below.

Outpatient behavioral and mental health care services are available in Arizona from the BSA, a specially-contracted behavioral health provider. The telephone number for the BSA is listed on the Customer Service page at the front of this book. Services include psychological/psychiatric counseling and treatment, individual and group counseling for substance abuse, personal and family problems, lifestyle education and stress management.

Counseling for personal and family problems and lifestyle education and management services are available **only** when provided by the BSA. You pay a copayment for each visit. The copayment amount is shown on your schedule page. Outpatient services received from the BSA are not subject to a pre-existing condition waiting period.

The BSA services are **only** available in Arizona.

Outpatient Services for Chemical Dependency or Substance Abuse - Outpatient therapy services for chemical dependency or substance abuse are also available from other eligible providers and accumulate toward the fifty-two (52) visit outpatient benefit maximum per subscriber, per calendar year, as described below.

Other Eligible Providers – In addition to services available through the BSA, benefits are available for the following outpatient services received from other eligible providers (e.g., psychiatrist, psychologist). Covered professional outpatient and facility services are subject to the calendar year deductible, then will be paid at 50% of the BCBSAZ allowed amount. **The PPO physician office visit copayment does not apply to behavioral or mental health care visits (see "*Copayment*").** Benefits are limited to a maximum of fifty-two (52) visits per subscriber per calendar year for psychotherapy or diagnostic office visits. Some intensive outpatient therapy may involve more than one (1) visit per day. In this case, each visit will accumulate toward the fifty-two (52) visit outpatient benefit maximum.

Laboratory, radiology and certain diagnostic procedures are treated as medical services even when a behavioral and mental health care diagnosis is indicated and are not subject to the mental and behavioral benefit limits indicated above.

Behavioral and Mental Health benefits are not available for:

- Activity therapy, milieu therapy or any care primarily intended to assist an individual in the activities of daily living, or treatment in non-acute care facilities (e.g., residential and skilled nursing facilities). **Note:** Residential means the patient is living at a facility but does not meet criteria for an acute inpatient admission for mental health treatment.
- Biofeedback, neurofeedback and/or hypnotherapy
- IQ testing, except as part of medically necessary neuropsychological testing (see *"Neuropsychological and Cognitive Testing"*)
- Development of a learning plan and treatment /education for learning disabilities (e.g., reading and arithmetic disorders)
- Services related to treatment of disturbance of conduct, mental retardation, autism, and learning disabilities, except for the initial evaluation to diagnose the condition
- Marital, family or group counseling services, except as may be available through the BSA
- Services related to developmental delays, except for the initial evaluation to diagnose the cause of the delay, including neuropsychological testing (see *"Neuropsychological and Cognitive Testing"*).

C. Cancer Clinical Trials

Benefits are available for covered services directly associated with a cancer clinical trial in Arizona meeting all of the requirements specified by Arizona law. A copy of these requirements is available to you or your provider upon request by calling BCBSAZ at (602) 864-5869. To be eligible for benefits, you must participate in the trial voluntarily.

Benefits are limited to those services eligible for coverage under this benefit plan that would be required if you received usual and customary (standard, non-investigational) treatment. If you have any questions concerning whether a particular service or complication will be covered, please contact BCBSAZ by calling the Customer Service telephone number listed at the front of this benefit plan booklet.

To obtain precertification for services directly associated with a cancer clinical trial, your provider must contact BCBSAZ at (602) 864-5869. To obtain precertification for all other services requiring precertification, your provider must contact BCBSAZ at (602) 864-4320. Please review the benefit plan booklet to determine those services requiring precertification.

Please note: Unless you or your provider inform BCBSAZ that you are enrolled in a cancer clinical trial, determined by you and your provider to meet the requirements of Arizona law, and that the services to be rendered are directly associated with the trial, BCBSAZ will administer benefits in accordance with the other terms of the benefit plan, which may result in a denial of benefits.

Benefits are subject to applicable copayment, deductible and/or coinsurance amounts, and benefit plan limitations and exclusions. See both "*What is Not Covered*" and the specific limitations and exclusions described below.

Benefits are not available for:

- Any investigational drug (except as specifically provided in "*Prescription Drugs for the Treatment of Cancer*") or device
- Non-health services that might be required for a person to receive treatment or intervention, e.g., travel transportation and/or lodging expenses
- Costs of managing the research of the clinical trial
- Treatment or services provided outside of Arizona
- Costs/services customarily paid for by the government, biotechnical, pharmaceutical or medical device industry sources
- Services otherwise not covered under this benefit plan

Disclaimer - please read carefully: In administering claims for covered services directly associated with an eligible cancer clinical trial, BCBSAZ does not represent or warrant that the cancer clinical trial meets all of the requirements specified by Arizona law. BCBSAZ also does not represent or warrant that the treatment, device, drug, service or other item provided through the cancer clinical trial is safe, effective or appropriate for any subscriber.

Decisions regarding whether the cancer clinical trial meets the criteria specified by Arizona law and whether the cancer clinical trial is safe, effective and appropriate for you, are decisions to be made by you and your provider and/or the trial investigator, using his/her independent medical judgment. BCBSAZ will review the criteria and eligibility for benefits when services require precertification upon being specifically notified that the procedure to be precertified is directly associated with a cancer clinical trial (see "*Precertification*"). If you have any questions concerning whether the cancer clinical trial is safe and effective and/or meets the criteria established by Arizona law, BCBSAZ encourages you to speak with your treating provider and provide him/her with a copy of this disclaimer for discussion.

D. Cardiac and Pulmonary Rehabilitation – Outpatient Services

Benefits are available for an outpatient Phase I and/or II cardiac rehabilitation program and for pulmonary rehabilitation services when prescribed by your physician and rendered by an eligible provider.

E. Care Management

BCBSAZ offers care management services that provide assistance with the coordination of health care benefits for individuals who have certain complex, catastrophic or chronic care needs. Participation with care management is voluntary, is offered at no additional cost and does not alter other benefits provided in this benefit plan.

A BCBSAZ registered nurse care manager will work with you or your representative, your physician and other health professionals to identify benefits/services available through this benefit plan, and/or assist you in identifying other resources potentially available to you through your community or other sources.

Cases are identified for possible care management based on the presence of various parameters, certain conditions known to require extensive follow-up care and/or treatment or by request for evaluation for care management services. Contact the care management department for further information regarding an illness or injury you or your doctor believe may be appropriate for care management services.

For more information about care management services, how to contact a care manager, or how to make a referral, call the Care Management Department Support line at (602) 864-5135 or (800) 232-2345, extension 5135.

F. Cataract Surgery

Precertification is required for cataract removal surgery. Otherwise covered cataract surgery services are subject to an additional $300 deductible if services are not precertified.

Benefits are available for removal of cataracts. Following surgery, benefits are available for one pair of standard eyeglasses, including standard lenses and frames ($100 maximum for the eyeglass frames), or standard contact lenses when prescribed within 6 months of surgery.

Chiropractic – See "Physical Therapy (PT) - Occupational Therapy (OT) - Speech Therapy (ST)"

Contraceptives – See "Family Planning"

G. Dental Accident Benefit

Precertification is required in the following situations:

- **Non-emergency surgical services received at an outpatient facility. Otherwise covered outpatient surgical services are subject to an additional $300 deductible if services are not precertified.**
- **Non-emergency services received from an out-of-network provider (dentist or physician) at the in-network level of benefits. If covered services are received from an out-of-network provider but not precertified, they will be paid at the out-of-network level of benefits, and you will have higher out-of-pocket costs.**

Benefits are available for repair of sound, natural teeth damaged by an accidental injury. The office visit copayment does **not** apply to dental accident services rendered by a dental provider.

An "accidental injury" is an injury which is caused by an external force or element such as a blow or fall, and which requires immediate attention. An injury to a tooth while chewing is **not** considered an accidental injury, even if the injury is due to chewing on a foreign object.

A “sound and natural” tooth is defined as a tooth that is:

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

Covered services:

- Extraction of damaged teeth
- Original placement of crowns and/or fixed or removable complete or partial dentures
- Original placement of porcelain/resin-based veneers, office or laboratory-cured
- Orthodontic services directly related to a covered accidental injury.

Benefits are <u>not</u> available for:

- Replacement of crowns or bridges; placement or replacement of implants; routine extractions
- Procedures associated with the fitting of new dentures or any fixed dental reconstruction of the teeth, including orthodontics, unless required to repair accidental injuries to sound, natural teeth.

Please note: Services covered under this benefit are not covered under any other benefit provision of this benefit plan.

H. Dental-Related Services (Facility and Anesthesia)

Precertification is required prior to dental-related facility and anesthesia services. Otherwise covered services are not covered if services are not precertified.

When it is medically necessary for dental procedures to be performed outside a dentist's office, limited coverage is available only for facility and anesthesia services related to such procedures. *“Medically Necessary,”* for purposes of this benefit, means a subscriber who requires preventive or restorative, non-cosmetic dental treatment and has a documented history of one of the following:

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

I. Detoxification

Precertification is required for an admission for detoxification treatment, except in emergencies. Otherwise covered detoxification services are subject to an additional $300 deductible if services are not precertified.

Benefits are available for detoxification, defined as medical intervention and/or observation to stabilize a patient who has developed substance intoxication due to the ingestion, inhalation or exposure to a substance or multi-substances. Detoxification may occur prior to or concurrently with psychological intervention (see *"Behavioral and Mental Health Services"*).

J. Diabetes and Asthma Supplies and Disease Management

Supplies - Benefits are available for the following diabetes and asthma supplies when prescribed by a physician:

- Blood glucose monitor (standard model)
- Blood glucose monitors for the legally blind and visually impaired
- Test strips for glucose monitors and urine test strips
- Injection aids
- Syringes and lancets
- Drawing-up devices
- Peak flow meters
- Small volume nebulizers
- Any other device, medication, equipment or supply for which coverage is required under Medicare, when purchased through an eligible durable medical equipment provider or as specifically listed as covered under "*Retail Pharmacy Benefit."*

The following supplies are available through *"Retail Pharmacy*" and *"Durable Medical Equipment (DME)*": medication-related items (e.g. syringes); glucometers and other related items (e.g., lancets & test strips); therapeutic shoes (depth inlay or custom-molded) along with inserts and peak flow meters. You may also call the network providers directly to determine availability of the prescribed supplies.

Disease Management - BCBSAZ offers health management programs that support members with diabetes and/or asthma. An analysis of medical and drug claims identifies BCBSAZ members with diabetes or asthma. These members will receive a letter about the program, as well as educational tools and information about the specific disease and its effects. They will also be provided a toll-free number to contact a nurse care manager.

Diabetes and/or asthma education and training is also available to members with these conditions to improve self-management skills.

- Training must be prescribed by your health care provider as part of a comprehensive plan of care related to your condition to enhance therapy compliance, improve self-management skills and knowledge
- Training must be conducted in person, i.e., "face-to-face"
- Both individual and group training sessions are eligible for coverage
- **Network providers must be utilized**

- For education and training provided in the **outpatient setting** (outpatient hospital, physician office or other network training provider, excluding home health), the coinsurance and deductible is waived when that is the only service provided

Some members may be considered at high risk for complications. These members may be contacted by a nurse care manager who will work with the member and the physician to promote self-care and asthma/diabetes management.

Participation is completely voluntary and confidential. If you would like additional information about these conditions or would like more information about the programs, call the BCBSAZ Disease Management voice mail line at (602) 864-5650 or (800) 232-2345, extension 5650.

K. Durable Medical Equipment (DME) - Medical Supplies - Prosthetic Appliances and Orthotics

1. DME

DME refers to those standard items prescribed by an eligible provider that are:

- Designed for repeated medical use and appropriate in the home setting
- Medically necessary to treat an illness or injury
- Specifically designed to improve or support the function of a body part
- Intended to prevent further deterioration of the medical condition for which the equipment has been prescribed
- Not primarily for comfort, convenience, or assistance in daily living
- Not primarily useful to a person in the absence of an illness or injury, and
- Not available as an over-the-counter item.

Benefits are available for the rental or purchase of DME prescribed by an eligible provider and not otherwise excluded under this benefit plan.

Benefits are limited to the BCBSAZ allowed amount for standard equipment. DME rental is allowed and covered **only** up to the BCBSAZ purchase allowed amount. Deluxe or upgraded equipment will be assessed for medical necessity based upon the attending physician's documentation of the need for such equipment. Equipment lacking documented medical necessity beyond the standard level will be covered as any standard item, with the subscriber responsible for additional charges to upgrade the equipment.

Certain DME items may not be deemed medically necessary by BCBSAZ; please have your physician contact BCBSAZ for information.

DME repair or replacement required because of normal use or the growth of a child is covered, but repair or replacement is subject to review by BCBSAZ.

2. Medical Supplies

Benefits are available for the following:

- Medical supplies prescribed by an eligible provider and not otherwise excluded
- Medical supplies furnished through a home health agency in connection with another covered service
- Disposable supplies required to operate and/or maintain a covered prosthesis or item of durable medical equipment

- Diabetic supplies required by law, (see *"Diabetes and Asthma Supplies"* and *"Retail Pharmacy Benefit")*

- Ostomy supplies when purchased at an eligible DME provider.

3. Prosthetic Appliances and Orthotics

Benefits are available for the following (one unit or one pair, as applicable, per calendar year):

- Prosthetic appliances to replace all or part of the function of an inoperative or malfunctioning body organ or to replace an eye or limb lost as a result of trauma or disease

- Orthotics (e.g., collars, braces, molds) prescribed by an eligible provider to protect, restore or improve impaired bodily function

- Orthopedic shoes **only** when an integral part of a brace, except for therapeutic shoes (depth inlay or custom-molded) along with inserts, for individuals with diabetes, or if covered in accordance with BCBSAZ medical necessity criteria

- Repair or replacement of prosthetic appliance or orthotic required as the result of normal use or due to the growth of a child. Repair or replacement of a prosthetic appliance or orthotic is subject to review by BCBSAZ

Benefits are also available per calendar year for:

- Wig(s), for the diagnosis of alopecia (absence of hair) resulting from illness or injury (up to a maximum benefit of $300)

- External or internal breast prostheses when needed solely and directly as a result of a medically necessary mastectomy

DME - Medical Supplies - Prosthetic Appliances and Orthotics benefits are <u>not</u> available for:

- Repair costs that exceed the replacement cost of the item

- Repair or replacement of DME or other items lost or damaged due to neglect or use not recommended by the manufacturer

- Medical equipment and/or supplies that can be purchased over-the-counter

- Disposable medical supplies that can be purchased over-the-counter, except as described above

- Items primarily for assistance in daily living, socialization, personal comfort, convenience, or other non-medical reasons

- Supplies used by a provider during office treatments

- Artificial organs determined investigational by BCBSAZ

- Dentures, dental implants, or replacement teeth

- Wig(s), when hair loss results from male or female-pattern baldness or natural or premature aging

- Hair transplants

- Adjustable beds, air cleaners, air conditioners, air purifiers, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, breast pumps, car seats, cushions, disposable hygienic items, elastic/support stockings (except TED hose), elevators, exercise equipment, foot stools, grab bars, heating and cooling units, humidifiers, incontinence devices/alarms, language/communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, portable Jacuzzi equipment, recliner chairs, vehicle or home modifications, whirlpool units

- Tilt or inversion tables or suspension devices

- Strollers of any kind, including but not limited to, specialty or customized strollers

L. Emergency or Accident

Benefits are available for covered services for an emergency or accident.

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

Accident: a sudden, unexpected bodily injury caused by an unintentional, external chance event or circumstance.

The initial treatment of an emergency or accident, as defined above, does not require precertification (prior approval or advance notice) before benefits can be obtained. There is no precertification requirement for emergency services regardless of the place of service (e.g., ambulance, hospital, emergency room).

The initial treatment of an emergency or accident is subject to the emergency room access fee, the PPO deductible and coinsurance, whether the services are received from a PPO or a non-PPO (including a non-contracted) provider. When the provider is not a contracted provider (with BCBSAZ or another BCBS plan), the BCBSAZ allowed amount is based on billed charges.

The emergency room access fee shown on the schedule page applies each time you go to the emergency room, even when referred by a provider. The emergency room access fee is paid in addition to the deductible and PPO coinsurance requirements. The emergency room access fee is waived if you are admitted to an inpatient room in the hospital.

Benefits for covered services received subsequent to initial emergency treatment are paid the same as non-emergency covered services. This means if you receive such services from a non-PPO provider, benefits will be paid at the non-PPO level. In addition, you may be responsible for paying the difference between the billed charges for services rendered by a non-contracted provider and BCBSAZ's allowed amount. For follow-up services please be sure to check your physician's or other provider's participation or network status with BCBSAZ.

Extended Active Rehabilitation (EAR) – See "Inpatient Rehabilitation Services"

M. Family Planning

Precertification is required for outpatient surgery. Otherwise covered services are subject to an additional $300 deductible if services are not precertified.

Benefits are available for vasectomy and tubal ligation, as well as other methods of contraception (e.g., IUD, Norplant). Oral and transdermal contraceptive medication and diaphragms are covered under the "*Retail Pharmacy Benefit."*

N. Home Health Services and Home Infusion - Medication Administration Therapy

Precertification is required for Home Health Services and Home Infusion - Medication Administration Therapy. You pay an additional $300 deductible if otherwise covered services are not precertified.

To be eligible for benefits for home health services and home infusion - medication administration therapy, as described below, you must meet **all** of the following criteria:

- Services are either:
  - In lieu of hospitalization, meaning the subscriber's condition meets criteria for an inpatient admission at an acute hospital (not a skilled nursing facility or rehabilitation hospital/facility), **or**
  - Medically necessary, as determined by BCBSAZ, even if the patient's condition does not meet criteria for an inpatient admission at an acute hospital, **and**
- Services are ordered by an eligible physician and include a specific plan of home treatment for recovery from an illness or injury, **and**
- Services are provided by a licensed home health agency approved by BCBSAZ, **and**
- Services are for skilled nursing care. Skilled care means services required to be provided by a licensed practical nurse (LPN) or a registered nurse (R.N.) or by an eligible licensed provider, and **expressly excludes custodial care**. **Custodial care** means any health services and other related services that are for the comfort or convenience of the subscriber or family member, or do not seek to cure, or are provided to support or assist with activities of daily living, e.g., personal hygiene, nutrition (except as covered under "*Home Infusion - Medication Administration Therapy*") or other self care, or are provided when acute care is not required, or do not require continued administration by licensed skilled medical personnel, e.g., LPN, RN, licensed therapist as determined by BCBSAZ, **and**
- Services are prescribed and reviewed by your treating physician at least every thirty (30) days or as appropriate based on your treatment plan. Ongoing services require precertification by BCBSAZ, **and**
- When appropriate, as determined by BCBSAZ, the patient or primary caregiver (not compensated by BCBSAZ) agrees to participate in the home plan of care by learning the techniques and performing the procedures, for transition of care to the patient or primary caregiver.

When **all** of the above criteria are met, benefits are **only** available for the following Home Health Services and Home Infusion - Medication Administration Therapy:

- Services provided on a visiting basis in a subscriber's home. A **"visit"** is defined as **2 hours or less**. Coverage is limited to a maximum of 3 visits per day, which includes any combination of services performed by an eligible provider (see *"Outpatient Services"*).
- Medical supplies, including drugs and biologicals
- Durable medical equipment (see "*Durable Medical Equipment*")
- Home Infusion - Medication Administration Therapy, including:
  - Intravenous, intramuscular, or subcutaneous administration of medication, except for those injectables specifically listed as covered under "*Retail Pharmacy Benefit*"
  - Hydration therapy
  - Blood/blood component
  - Total parenteral nutrition
  - Intravenous catheter care

- Enteral nutrition/tube feeding when it is the **sole source of nutrition**. Skilled nursing visits will be covered **only** for the purpose of instructing the patient and/or caregiver (not compensated by BCBSAZ) to initiate and terminate the feeding, unless the patient or caregiver cannot perform these tasks, in which case, the covered skilled nursing visits (with a "visit" defined as **2 hours or less)** are limited to **3 visits per day**.

Home Health - Home Infusion benefits are not available for:

- Home health or home infusion/medication administration services in addition to those described above, even if the services are prescribed and/or are medically necessary

- Continuous home health services or shift nursing (typically rendered in 4 to 12 hour shifts), including 24-hour care, or visits exceeding 2 hours (except for limited hospice benefits - see "*Hospice*")

- Custodial care, as defined above

- Home health and/or home infusion/medication administration therapy services when the patient or caregiver (not compensated/reimbursed by BCBSAZ) has demonstrated proficiency in providing the service. In this instance, precertification may be given **only** for the drug and supplies, if continued administration of the drug or use of the supply is ordered by the physician and determined to be medically necessary by BCBSAZ.

O. Hospice Services

Note: If a subscriber receiving Hospice services requires inpatient care other than for pain management or respite care, such admission requires precertification.

You are not required to meet your deductible or pay coinsurance for hospice benefits.

Hospice care must be prescribed by a physician and provided by a licensed hospice agency in the subscriber's or caregiver's home.

Hospice services are an alternative multidisciplinary approach to medical care for the terminally ill. When a subscriber elects to use the hospice benefit, it is in lieu of other medical benefits available under this benefit plan, except when care unrelated to the terminal illness or related complications is required. No curative or aggressive treatments are used. Instead, specially trained members of the hospice team make intermittent visits to the patient's home to provide comfort, care and support.

Once you have selected the hospice benefit, the hospice agency is responsible for coordinating all your health care needs, but coverage for services provided under this benefit are still subject to the medical necessity provisions of this benefit plan.

When the subscriber meets the requirements of the hospice agency, benefits are available for:

- Routine care - intermittent visits provided in the subscriber's or caregiver's home by any member of the hospice team.

- Respite care - admission of the subscriber to an approved facility for up to five (5) days to provide rest to the subscriber's family or primary caregiver; respite care is available once every twenty-one (21) days.

- 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 subscriber at home; continuous care is generally delivered in four (4) to eight (8) hour blocks, and is not covered for more than seventy-two (72) hours during such period of crisis.

- Inpatient acute care - inpatient admission for pain control or symptom management that cannot be provided in the home setting.

P. Inpatient Hospital

Precertification is required prior to receiving elective or scheduled inpatient services. Otherwise covered inpatient services are subject to an additional $300 deductible if services are not precertified, except for emergency and maternity admissions.

Benefits are available for the following hospital services when ordered in connection with a covered service:

- Room and board - semi-private room, unless a hospital has only private rooms, then a standard private room (not deluxe)
- Intensive care units and other special care units
- Operating, recovery and treatment rooms and equipment for covered procedures
- Diagnostic testing, including radiology and laboratory services
- Blood transfusions, whole blood, blood components and blood derivatives
- General, spinal and caudal anesthetic in connection with a covered service
- Radiation therapy or chemotherapy, except in conjunction with a non-covered transplant
- Drugs, biologicals and solutions

Drugs dispensed at the time of discharge from a hospital are not covered

Q. Inpatient Rehabilitation Services - Extended Active Rehabilitation (EAR)

Precertification is required prior to an admission or transfer to an EAR facility and before EAR services are rendered. **Otherwise covered EAR services are not covered if services are not precertified.**

To obtain precertification, your provider must submit a plan of care, that will be evaluated according to BCBSAZ guidelines for EAR services. Copies of the guidelines are available upon request.

Benefits are available for **up to a maximum of one hundred twenty (120) days of care per calendar year per subscriber**, but are covered at two different levels of benefits.

- The first sixty (60) days are subject to applicable deductible and coinsurance, depending on your choice of provider.
- The second sixty (60) days are also subject to deductible. BCBSAZ pays 50% of the BCBSAZ allowed amount at both in and out-of-network providers. Your coinsurance is the remaining 50% of the BCBSAZ allowed amount at both in and out-of-network providers and does not count toward your out-of-pocket maximum.

If you choose to receive EAR services at a non-contracted provider for any days between 1-120, you will be responsible for the difference between the provider's billed charges and the BCBSAZ allowed amount, in addition to applicable coinsurance and deductible.

EAR benefits are <u>not</u> available for:

- Services rendered after a patient has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

- Activity therapy, milieu therapy or any care intended to assist an individual in the activities of daily living or for the comfort or convenience of the subscriber or family member, except for limited hospice benefits

- Custodial therapy (see definition of custodial care under *"Home Health Services"*).

R. Long-Term Acute Care (Inpatient)

Precertification is required for all admissions for long-term acute care. Otherwise covered long-term acute care services are <u>not</u> covered if services are not precertified.

Long-term acute care provides specialized acute hospital care for medically complex patients who are critically ill, have multisystem complications and/or failures, and require hospitalization on an extended basis in a facility offering specialized treatment programs and aggressive clinical and therapeutic interventions on a 24 hour/7day-a-week basis. When medical necessity criteria for long-term acute care are met, benefits are available for no more than a lifetime maximum per subscriber of three hundred sixty-five (365) days of long-term acute care.

Please note: Beds within a facility may be licensed for different levels of care. Even within the same facility, an "admission" occurs when you move from a bed licensed for one level of care to a bed licensed for a different level of care.

Mammography – See "Preventive Care – Mammography – Routine Physical Exams"

S. Maternity

Benefits are available for covered services related to pregnancy.

The PPO physician office copayment applies only to the first pre-natal office visit for services rendered by in-network providers. Deductible and coinsurance for physician maternity service are waived.

The office visit copayment includes all prenatal visits and the physician's delivery fee. Other covered maternity services (e.g., facility) are subject to applicable deductible and coinsurance, depending on your choice of provider.

Maternity benefits are also available for the expense incurred by the birth mother for the birth of any child legally adopted by the subscriber, provided that:

- The child is adopted within one year of birth;

- The subscriber is legally obligated to pay the costs of birth; and

- The subscriber has provided notice to BCBSAZ within sixty (60) days of their acceptability to adopt children.

This adopted child maternity benefit is considered secondary to any other coverage available to the natural mother.

Pregnancy is not considered a pre-existing condition and therefore will not be subject to any pre-existing condition waiting period that may apply to this benefit plan.

Group health plans and health insurance plans generally may not, under federal law, 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans may not, under federal law, require that a provider obtain authorization from the group benefit plan or health insurance plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

T. Medical Foods

Subject to the calendar year deductible, benefits are available for 50% of the cost of medical foods (modified low protein foods and metabolic formulas as defined below) prescribed by a physician to treat inherited metabolic disorders up to a total benefit of $5,000 per subscriber per calendar year.

"**Cost"** is defined as either billed charges, if you purchased the medical foods directly, or the BCBSAZ allowed amount, if purchased through a BCBSAZ contracted provider. Expenses for medical foods do not count toward your out-of-pocket maximum.

Medical food benefits are available for inherited metabolic disorders included in the newborn screening program prescribed by law, including: Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Medical food benefits are **not** available for any condition not included in the newborn screening program, including lactose intolerance without a diagnosis of Galactosemia.

To be eligible for benefits for medical foods, **all** of the following criteria must be met:

- The subscriber must be diagnosed with one of the inherited metabolic disorders, as defined above
- The inherited metabolic 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
- The subscriber must require specially processed or treated medical foods generally available only under the supervision of an allopathic or osteopathic physician
- The medical foods must be prescribed or ordered under the supervision of an allopathic or osteopathic physician as medically necessary for the therapeutic treatment of one of the inherited metabolic disorders identified above; and
- The prescribed/ordered specially processed or treated medical foods must be consumed throughout life, without which, the subscriber may suffer serious mental or physical impairment.

It may be necessary for BCBSAZ to obtain medical record documentation to determine whether the above criteria are met.

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

- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an allopathic or osteopathic physician
- Processed or formulated to contain less than one gram of protein per unit of serving (modified low protein foods only)
- Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs (metabolic formula only)

- Administered for the medical and nutritional management of a subscriber with limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation, and

- Essential to the subscriber's optimal growth, health and metabolic homeostasis.

Benefits are <u>not</u> available for the following:

- Medical foods for any medical condition other than those inherited metabolic disorders defined above

- Natural foods that are naturally low in protein and/or galactose

- Spices/flavorings

- Foods/formulas available to any person, even those without an inherited metabolic disorder, as defined above, that may be purchased without a physician prescription or order and/or that do not require supervision by an allopathic or osteopathic physician.

Claim submission for medical foods

You may purchase medical foods from any source. To receive benefits when you purchase medical foods from a non-contracted provider, you must submit a claim form outlining the following information:

- Subscriber's name, identification number and group number
- Prescribing/ordering physician
- Subscriber's diagnosis for which the medical foods were prescribed or ordered
- Where the medical food was obtained
- The amount paid for the medical foods
- The name, telephone number and address of the medical food supplier
- The original dated receipt/proof of purchase.

Please contact BCBSAZ at (602) 864-5885 or (800) 232-2345, extension 5885 to request copies of the special Medical Foods Claim Form. To obtain reimbursement for medical foods you purchased directly, please submit the Medical Foods Claim Form and the <u>original dated receipt</u> to the following address:

<u>Attn:</u> Medical Foods
Mail Stop: A-116
Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ 85002-3466

Please do **not** submit claims for other covered services to this address.

Medical Supplies - See "Durable Medical Equipment (DME) - Medical Supplies - Prosthetic Appliances and Orthotics"

Mental Health - See "Behavioral and Mental Health"

U. Neuropsychological and Cognitive Testing

Services are covered for evaluation of mental function when integral to medical care following head trauma, cerebral vascular accident (stroke), transient ischemic attack (TIA) or other decreased mental function related to a documented medical condition, and/or as part of a medically necessary evaluation of a developmental delay. After the initial evaluation of a developmental delay, regardless of the cause of the delay, the only services eligible to treat the delay are physical therapy, occupational therapy and speech therapy, within the benefit limitations outlined in this benefit plan (see *"Physical Therapy – Occupational Therapy – Speech Therapy"*).

Benefits are not available for psychological, neuropsychological and cognitive testing from the behavioral services administrator.

V. Outpatient Services

Precertification is required prior to receiving outpatient surgery in an outpatient surgery center or other outpatient facility or the outpatient department of a hospital. "Outpatient surgery" is defined as operative procedures and other invasive procedures such as epidural injections for pain management and various scope procedures, including, but not limited to, colonoscopies. Otherwise covered services are subject to an additional $300 deductible if services are not precertified.

Benefits are available for the following outpatient services:

- Outpatient surgery
- Radiation therapy or chemotherapy (except if performed in conjunction with a non-covered transplant)

Benefits are available for the following when ordered in conjunction with a covered service:

- Pre-operative testing
- Blood transfusions, whole blood, blood components and blood derivatives.
- Diagnostic testing, including laboratory and radiology
    - **Laboratory services** may be received in a free-standing independent clinical laboratory, a physician's office, or a hospital's laboratory department. When services are received at a contracted free-standing laboratory, covered services are paid at 100% of the BCBSAZ allowed amount, and are not subject to the deductible or coinsurance. Laboratory services provided in a physician's office are subject to the office visit copayment or deductible and coinsurance, depending on your choice of provider. Laboratory services received in a hospital are subject to the applicable deductible and coinsurance.
    - **Radiology services** may be received in a free-standing radiology facility, a physician's office, or a hospital's radiology department. Covered x-rays or other radiology services may be subject to the applicable deductible and coinsurance, depending on your choice of provider.

Outpatient Therapy - See "Physical Therapy (PT) - Occupational Therapy (OT) - Speech Therapy (ST)"

Pharmacy Benefit – See "Retail Pharmacy"

Physical Exams (Routine) - See "Preventive Care - Mammography - Routine Physicals"

W. Physical Therapy (PT) - Occupational Therapy (OT) - Speech Therapy (ST)

Benefits are available for the following outpatient therapy services:

PT/OT - any combination of PT and/or OT up to a maximum of 160 modalities and/or therapeutic services per calendar year. The average number of modalities or services performed per visit is 4. One hundred sixty (160) modalities or services are roughly equivalent to 40 visits per year.

"Modalities" are physical agents such as traction, electrical stimulation, and ultrasound.

"Therapeutic services" means the application of clinical skills and/or services, such as exercise, gait training, and manual therapies.

The calendar year deductible is waived for PT/OT; you pay the benefit plan coinsurance amount shown on your schedule page. **Note:** The calendar year deductible is **not** waived for evaluations prior to the start of therapy or periodic review evaluations.

Additional modalities and/or services for PT and/or OT exceeding the limit of 160 described above are subject to 50% coinsurance up to the annual out-of-pocket maximum shown on your schedule page.

Covered services provided by a chiropractor other than outpatient PT and OT are not subject to the above limitation on modalities and therapeutic services.

ST - speech therapy up to a maximum of 20 visits per calendar year. The calendar year deductible is waived; you pay the benefit plan coinsurance amount shown on your schedule page. **Note:** The calendar year deductible is **not** waived for evaluations prior to the start of therapy or periodic review evaluations. Additional visits for ST exceeding the 20-visit limit described above are subject to 50% coinsurance up to the annual out-of-pocket maximum shown on your schedule page.

Please note: PT, OT and/or ST services provided under the home health benefit do not count toward the limits described in this Physical – Occupational – Speech Therapy benefit provision, but they must still be precertified as required (see *"Home Health Services"*). Other than in the home, PT/OT/ST services received in any outpatient setting (e.g., physician's office, therapist's office, urgent care facility) will be reimbursed according to the terms of this benefit provision.

Benefits are <u>not</u> available for:

- Cognitive therapy (see *"Neuropsychological and Cognitive Testing"*)
- Services rendered after a patient has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ
- Activity therapy, milieu therapy or any care intended to assist an individual in the activities of daily living or for the comfort or convenience of the subscriber or family member, except for limited hospice benefits
- Custodial therapy (see definition of custodial care under *"Home Health Services"*)
- Massage therapy
- Computer speech training and/or therapy programs and devices

X. Physician Services

Benefits are available for the following:

- Home or office visits and consultations

  The office visit copayment shown on your schedule page applies to each PPO physician office visit, except for certain prenatal visits (see *"Maternity"*). See "*Copayment*" for detailed information on when the copayment applies to different types of services.

- General surgical procedures (including assistance at surgery)

  Surgical assistants (physicians or other eligible providers) are reimbursed at a reduced percentage of the BCBSAZ fee schedule for the surgeon's covered services. Only certain providers are eligible for reimbursement for assisting at surgery**.** Your out-of-pocket costs will be higher if services are provided by a non-network provider.

  Please contact BCBSAZ to determine the assistant's eligibility and network status. Benefits for such services provided by a non-eligible provider may be denied, in which case you will be responsible for the full charges from that provider.

Also, multiple surgical procedures performed during a single operative session are reviewed to determine appropriate benefits. In general, eligible secondary procedures are reimbursed at reduced levels; incidental procedures are non-reimbursable.

- Inpatient medical visits, including care provided during those visits
- Second surgical opinions

Y. Post-Mastectomy Services

Benefits are available for breast reconstruction following a medically necessary mastectomy, in accordance with state and/or federal law. Benefits include 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, treatment of physical complications for all stages of the mastectomy, including lymphedemas.

Benefits under this provision are subject to all applicable limitations and exclusions of this benefit plan.

Prescription Drugs – See "Retail Pharmacy Benefit"

Z. Prescription Drugs for the Treatment of Cancer

Arizona law requires coverage for off-label use of prescription drugs and services directly associated with the physical/actual administration of the prescription drugs for the treatment of cancer. "Off-label prescription drug" for purposes of this provision means the drug your physician prescribed for the treatment of cancer has not been approved by the FDA for that specific medical condition, and the drug meets all of the requirements specified in Arizona law.

Claims for an off-label prescription drug will be processed and your out-of-pocket expense calculated as any other eligible prescription drug based on where and by whom the drug is dispensed /administered. All other applicable benefit limitations and exclusions will apply.

Disclaimer - please read carefully: In administering claims for an off-label prescription drug, BCBSAZ does not represent or warrant that the prescribed drug is safe or effective for the cancer for which your treating provider has prescribed the drug. Further, BCBSAZ does not represent or warrant that: 1) the FDA has or has not approved the drug for any indication; 2) the FDA has or has not determined that the drug is contraindicated for treatment of the specific type of cancer for which it has been prescribed; and/or 3) there are no standard medical reference compendia or acceptable medical literature (as prescribed by law) finding that the drug is contraindicated for treatment of the specific type of cancer for which it has been prescribed.

Decisions regarding whether the drug meets the above criteria, 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/her independent medical judgment. BCBSAZ will review the criteria and eligibility for benefits when services require precertification upon being specifically notified that the precertification request involves a prescription drug for the treatment of cancer (see "*Precertification*").

If you have any questions concerning whether the prescribed drug for the treatment of cancer is safe and effective and meets the above criteria, BCBSAZ encourages you to speak with your provider and provide him/her with a copy of this disclaimer for discussion.

AA. Preventive Care, Mammography, Routine Physical Exams

The following services do not have to meet the medical necessity requirement as long as they are not investigational (see *"Medically Necessary"*). **Sigmoidoscopy, colonoscopy and routine physical exam services are covered only when provided by a BluePreferred (PPO) provider.**

1. Preventive Care

For covered preventive services received from PPO providers (except sigmoidoscopy and colonoscopy), the deductible is waived and you pay only the office visit copayment for covered services received in a physician's office and coinsurance for covered services received outside a physician's office. For covered preventive care services received from non-PPO providers, you pay applicable deductible and coinsurance.

- Well-child care from birth to age 6, including routine immunizations and the following tests, as appropriate to the child's age and gender: newborn hearing exam, annual hearing/vision screening test, blood lead, fasting blood glucose.

- Well-woman care - Routine gynecologic exam, including, as appropriate for the patient's age: pap test and/or other cervical cancer screening test; and STD (sexually transmitted disease) testing as recommended by the treating physician. Basic laboratory tests associated with the routine gynecologic exam are also covered under this benefit.

- Well-man care - PSA testing

- Plan pays 100% for sigmoidoscopy or colonoscopy; the periodic frequency of either test should be determined by your treating physician based on your specific history or condition.

  Please note: Precertification is required for sigmoidoscopy and colonoscopy when performed in an outpatient facility.

- Routine immunizations, as determined by BCBSAZ; immunizations for foreign travel are **not** covered

2. Mammography

Deductible and coinsurance are waived for mammography services received from PPO providers**.** Deductible is waived and coinsurance applies for mammography services received from non-PPO providers.

Mammography services in accordance with your physician's recommendations.

Please note: Tests covered under the physical exam benefit below may be provided in conjunction with a well-woman or well-man exam or separately.

3. Routine Physical Exam

Deductible and coinsurance do not apply to physical exam services. You have a maximum benefit of $300 for physical exam services received from PPO Providers.

Routine physical exam for subscribers age 6 and over, including the following, as appropriate for the patient's age and gender: history and physical examination, resting EKG, stress EKG, lung function test (spirometry), vision and hearing screening, fecal occult blood test, metabolic panel, complete blood count, lipid panel, fasting glucose, urinalysis, PSA, bone density testing to screen for osteoporosis; and STD (sexually transmitted diseases) testing as recommended by the treating physician.

Any otherwise covered tests, procedures or services not listed above are subject to applicable deductible and coinsurance.

BB. Reconstructive Surgery and Services

Precertification is required for reconstructive surgery and services performed in an outpatient surgery center or outpatient department of a hospital. Otherwise covered reconstructive surgery and services are subject to an additional $300 deductible if services are not precertified.

Benefits are available for reconstructive surgery, defined as surgery primarily performed to improve or restore the impaired function of a body part or organ where the dysfunction is a result of the following:

- Injury/trauma
- Illness/disease
- Surgery
- Therapeutic intervention, or
- Congenital defects.

Benefits under this provision are subject to all applicable limitations and exclusions of this benefit plan, including but not limited to cosmetic surgery, procedures, treatment, office visits, consultations and/or other services for cosmetic purposes. "Cosmetic" means surgery, procedures, or treatment and other services performed primarily to enhance or improve appearance, even if such services will improve emotional, psychological or mental condition or function. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy.

CC. Retail Pharmacy

A prescription drug is eligible for coverage when:

- Approved by the U. S. Food and Drug Administration (FDA) for the diagnosis for which the drug has been prescribed (except as specifically provided in "*Prescription Drugs for the Treatment of Cancer*"), and
- Dispensed by a pharmacy located in the U.S. and by a pharmacist licensed in the U.S., and
- Not otherwise excluded by BCBSAZ

Please note: Prescriptions dispensed by pharmacies outside the U.S. are covered only when they are prescribed for an urgent or emergent medical situation while the subscriber is traveling outside of the U.S. Claims submitted must include documentation of the medical situation. Claims will be subject to the U.S. dollar exchange rate on the date the claim is paid.

Prescription Drug Copayments and Coinsurance

This benefit has four cost-sharing levels as described below. The amount you pay will depend on the specific drug dispensed by the pharmacy. The pharmacy will charge you a Level 1, 2, 3 or 4 copayment. Your copayments for each level are listed on your schedule page.

The level of benefit you receive is based on the level of the drug at the time you fill your prescription. Drugs may change cost-sharing levels without notice. Many drugs are listed on the BCBSAZ Prescription Medication Guide available at www.azblue.com or by calling BCBSAZ at (602) 864-4273 or (800) 232-2345, extension 4273. **You or your provider may contact BCBSAZ to check on the status of a drug.**

Level 1

Generally, the most cost-effective drugs on the market today are generic drugs. The majority of generic drugs are available at the Level 1 copayment. A few brand drugs may also be on Level 1.

Level 2

Many brand name drugs are on Level 2. Some generic drugs may be on Level 2.

Level 3

This level includes most of the drugs that are not on Level 1 or 2. An alternative drug at a lower cost may be available on Level 1 or 2; ask your doctor if one is appropriate for you.

Level 4

This level includes brand drugs that have the highest cost-sharing amount. An alternative drug at a lower cost may be available on Level 1, 2, or 3; ask your doctor if one is appropriate for you.

When you fill a covered prescription at a non-contracted pharmacy, you pay for your prescription in full and submit a prescription drug claim form to BCBSAZ. When BCBSAZ processes your prescription claim, you will be responsible for the difference between the usual and customary price charged by the pharmacy and the BCBSAZ prescription drug price, in addition to any applicable copayment or coinsurance.

Please note: Prescription drug copayment or coinsurance amounts do not apply toward any applicable medical benefit plan out-of-pocket maximum.

When your prescription drug price is less than your copayment

When the price BCBSAZ pays a contracted pharmacy for a drug is less than your copayment, some pharmacies will charge you the BCBSAZ price. However, most pharmacies will charge you their usual and customary price (if also less than the copayment), rather than the BCBSAZ price. You will never be required to pay more than your copayment for a Level 1, 2, 3 or 4 drug at a contracted pharmacy.

Coverage Specifics

- No exceptions will be made concerning which level a drug is in or the copayment or coinsurance that will apply, regardless of the medical reasons that might necessitate use of a particular prescription drug. This means if you are taking a Level 2, 3 or 4 drug, you will pay the applicable copayment for that level even when there is no equivalent drug at a lower copayment or if you are unable to take a drug at the lower copayment level for any reason.

- The presence of a drug on any BCBSAZ prescription medication list does not guarantee coverage of that drug for a particular subscriber; benefit plan limitations and exclusions, pre-existing condition limitations, and other factors will determine if coverage is available. In addition, the assignment of a drug to any particular level does not constitute a recommendation on the use of a drug. Always consult with your provider to determine which drugs are appropriate for you.

- Drugs newly approved by the FDA are assigned to Level 3 or 4 until they can be evaluated for possible inclusion on another level.

- Coverage for each prescription filled at a retail pharmacy is limited to a maximum of a 30-day supply, based on FDA dosage limitations and BCBSAZ per-copayment dosage and quantity limits. FDA dosage limitations may not apply to certain cancer drugs, as required by law. Other applicable limitations include FDA age and gender guidelines on certain drugs.

- For certain prescription drugs the quantity of medication covered per copayment may be limited by dose or by the number of units, even though your physician may prescribe a higher dose or greater number of units. For a listing of these drugs, see the BCBSAZ Prescription Medication Guide available at www.azblue.com or by calling BCBSAZ at (602) 864-4273 or (800) 232-2345, extension 4273. When your physician prescribes more than the specified dosage or quantity, you may obtain the prescribed amount as long as it is within the FDA dosage limitations, up to the

FDA-approved maximum dosage for a 30-day supply. However, you will have to pay an additional copayment each time the quantity limit is exceeded. For example, if a medication has a limit per copayment of 12 tablets, a prescription of up to 12 tablets is available for one copayment, and a prescription for more than 12 and up to 24 tablets will require two copayments. This per-copayment limitation also applies when you obtain prescriptions through the "*Mail Order Program*."

Total Amount Prescribed	42 tablets	
BCBSAZ per-copayment quantity limit	12 tablets	
Copayment per amount dispensed	1-12 tablets	$20
	13-24 tablets	$40 (2 copayments)
	25-36 tablets	$60 (3 copayments)
	37-48 tablets	$80 (4 copayments)

The above figures are for illustration only. Your cost will vary, depending on the amount prescribed and your benefit plan. The above example applies whether you obtain your prescription drugs at a retail pharmacy or through mail order.

- Refills are covered when approximately ¾ of the medication is used as prescribed.

- Coverage is available for the following diabetic equipment and supplies: test strips for glucose monitors and visual reading and urine testing strips, insulin preparations and glucagon, syringes and lancets, and prescribed oral agents for controlling blood sugar. See "*Durable Medical Equipment (DME) - Medical Supplies - Prosthetic Appliances and Orthotics*" for additional diabetic supplies and equipment coverage information.

- Coverage is available for prenatal vitamins and prescription-strength vitamin K and vitamin D when a prescription is written by a physician.

- Injectable drugs - only certain categories of injectable drugs are available under this benefit: You can check the list of injectable drugs available under this benefit at www.azblue.com or by calling BCBSAZ at (602) 864-4273 or (800) 232-2345, extension 4273.

  Other injectables may be covered under "*Home Health Services*," subject to BCBSAZ medical necessity guidelines.

  Note: Injectable drugs available at a retail pharmacy do not require precertification. A list of injectable drugs available from retail pharmacies is available online at www.azblue.com. All injectable drugs obtained through a home health agency or from a provider other than a retail pharmacy require precertification. Otherwise covered eligible drugs will not be covered if precertification is not obtained when required. If a covered injectable drug requires precertification, but you must obtain the drug outside of BCBSAZ hours of operation (8:00-4:30 M-F), you may be required by the provider to pay for the drug at the time it is dispensed to you. In such cases, you may then file a claim to BCBSAZ. The claim for such drug will not be denied for lack of precertification, but all other exclusions and limitations of your benefit plan still apply.

Compounded Drugs

Compounded drugs are drugs containing at least one FDA-approved component and are custom-mixed by a pharmacist. Your share of the cost of covered compounded drugs will be the greater of the Level 3 copayment or 50% of the BCBSAZ allowed amount.

Mail Order Program

Up to a 90-day supply of maintenance drugs (the same drug and drug strength) may be obtained through the prescription drug mail order program. Maintenance drugs are drugs you take consistently. FDA dosage limitations and BCBSAZ per-copayment dosage and quantity limits apply to mail order prescriptions. (For a complete description of these limitations, see "*Coverage Specifics*" above). The copayment for a 90-day supply is shown on your schedule page.

Regardless of the number of days supply you order, if your prescription for a drug subject to BCBSAZ quantity/dosage limits exceeds the per-copayment limit, you will pay an additional copayment for each quantity increment over the limit. Generally, there is no cost-savings to you if you obtain quantity-limited drugs through the mail order program.

Retail Pharmacy Benefit Limitations and Exclusions

The fact that a drug is recommended or prescribed by a physician does not make it a benefit. Prescription drug benefits are subject to **all** the limitations and exclusions stated within your benefit plan in addition to the following specific limitations and exclusions:

- Any drug, medicine, device, equipment, supply (except for diabetic supplies and inhaler spacers) that is lawfully obtainable without a prescription, i.e., over-the-counter items
- Any vitamins, minerals, dietary and nutritional supplements, special foods or diets, except as specifically provided within this benefit. Medical benefits are also available for certain medical foods as specifically described in this benefit plan under "*Medical Foods*."
- Drugs for sexual dysfunction
- Drugs to improve or achieve fertility or treat infertility
- Performance, athletic performance, or lifestyle enhancement drugs or supplies
- Smoking cessation drugs, devices or medicines, regardless of whether a prescription is required
- Immunizing agents or biological serums sold as separate items
- Drug delivery implants
- Administration of a covered medication
- Any drug, medicine or medication labeled "Caution - Limited by Federal Law to Investigational Use," or words to that effect, and/or any experimental drug, medicine or medication as determined by BCBSAZ, even though you would be charged for this drug, medicine or medication, except as specifically provided in *"Prescription Drugs for the Treatment of Cancer*"
- Any prescription drug dispensed in unit-dose packaging, unless that is the only form in which the drug is available
- Any drug designed for weight gain or loss, including, but not limited to, Xenical® and Meridia®, regardless of the condition for which it is prescribed
- Drugs dispensed to a subscriber while an inpatient in any facility. To the extent facility coverage is available, drugs are included in the reimbursement to the facility, and are not separately covered under this *"Retail Pharmacy Benefit*." If the facility services are not covered, there is no coverage for drugs dispensed at the facility**.**
- Prescriptions or refills for drugs that are lost, stolen, spilled, spoiled or damaged
- Any drug used for any cosmetic purpose, including but not limited to, hair growth or hair removal
- Any drug used to treat a condition not covered under this benefit plan

Please note: Benefits for prescription drugs may differ depending on whether the drug is obtained at a pharmacy, administered in a physician's office or through home health services, or acquired under other coverage provisions within this benefit plan booklet.

DD. Skilled Nursing Facility (SNF)

Precertification is required prior to admission or transfer to a skilled level of care. Otherwise covered SNF services are not covered if not precertified.

Covered services for skilled nursing may be rendered in a facility that provides only skilled nursing services or in a facility providing other services but whose license includes skilled nursing level of services.

Benefits are available for **up to a maximum of one hundred eighty (180) days of care per calendar year**, but are covered at two different levels of benefits.

- The first ninety (90) days are subject to applicable deductible and coinsurance, depending on your choice of provider.

- The second ninety (90) days are also subject to deductible. BCBSAZ pays 50% of the BCBSAZ allowed amount at both in and out-of-network providers. Your coinsurance is the remaining 50% of the BCBSAZ allowed amount at both in and out-of-network providers and does not count toward your out-of-pocket maximum.

If you choose to receive SNF services at a non-contracted provider for any days between 1-180, you will be responsible for the difference between the provider's billed charges and the BCBSAZ allowed amount, in addition to applicable deductible and coinsurance.

To be eligible for coverage, SNF services must meet both of the following criteria:

- Care is ordered by a physician; **and**

- Care is at a skilled level - level of care will be evaluated. Skilled care means services provided by a licensed practical nurse (LPN) or a registered nurse (RN) or by an eligible provider, and **expressly excludes custodial care.** Custodial care means any health services and other related services that are for the comfort or convenience of the subscriber or family member, or do not seek to cure, or are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition (except as covered under "*Home Infusion – Medication Administration Therapy"*) or other self care, or are provided when acute care is not required, or do not require continued administration by licensed skilled medical personnel, e.g., LPN, RN, licensed therapist.

When skilled nursing facility benefits are exhausted, or if the subscriber resides in a custodial status in an eligible institution, benefits **may** be available for the following otherwise covered services when furnished by an eligible provider:

- Durable medical equipment (DME)

- Drugs not covered under the retail pharmacy benefit but otherwise covered under the benefit plan (see *"Home Infusion Therapy"*)

- Wound care supplies in conjunction with complex wound dressing changes

- Enteral feeding and supplies only when the feeding is the sole source of nutrition

- Physical therapy, occupational and speech therapy services, subject to all limitations described under "*Physical Therapy – Occupational Therapy – Speech Therapy*"

- Physician services

Benefits for any of the above services will only be provided to the extent the benefits would have otherwise been provided on an outpatient basis under this benefit plan.

Sterilization – See "Family Planning"

EE. Transplants - Organ - Tissue - Bone Marrow Transplants and Stem Cell Procedures

Precertification is required prior to any organ, tissue or bone marrow transplant or stem cell procedure. It is your responsibility to make sure precertification is obtained. Failure to obtain precertification will result in denial of benefits.

This benefit contains medical terminology and descriptions of medical conditions, procedures or treatments that may be unknown to you. BCBSAZ recommends that you bring this booklet to your treating physician or health care provider to discuss any questions you may have concerning the benefits and limitations of this coverage. You may also contact the BCBSAZ Customer Service Department.

Definitions

The following definitions apply to terms used in this benefit and elsewhere in the benefit plan booklet:

- **High Dose Chemotherapy (HDC):** a form of chemotherapy wherein the dose and/or manner of administration is expected to result in damage to the bone marrow or suppression of its function so as to warrant or require receipt by the patient of allogeneic or autologous bone marrow/stem cell transplantation

- **High Dose Radiotherapy (HDR):** a form of radiotherapy wherein the dose and/or manner of administration is expected to result in damage to the bone marrow or suppression of its function so as to warrant or require receipt by the patient of an allogeneic or autologous bone marrow stem cell transplantation

- **Bone Marrow Transplant:** a medical and/or surgical procedure comprised of several steps or stages, including:

  - The harvest of stem cells, whether from the bone marrow or from the blood, from a third-party donor (**allogeneic** transplant) or from the patient (**autologous** transplant). This definition further specifically includes all component parts of the procedure, including the HDC and/or HDR.

    Autologous bone marrow transplant specifically includes transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvest directly from the bone marrow, a procedure commonly known as peripheral stem cell transplant or rescue procedure.

  - Processing and/or storage of the stem cells after harvesting;

  - The administration of HDC and/or HDR, when this step is prescribed by the treating physician;

  - The infusion of the harvested stem cells; and

  - Hospitalization, observation and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts.

- **Related Expenses:** the cost associated with pre-transplant testing, chemotherapy or radiation therapy associated with transplant procedures, harvest and reinfusion of stem cells or bone marrow, drugs and medications (including those administered to mobilize stem cells for transplants), inpatient hospitalization and outpatient services.

Covered Transplants

The following transplants are eligible for coverage when they meet the BCBSAZ coverage criteria:

- Organ transplants – heart; heart-lung; lung (lobar, single and double lung); kidney; pancreas; kidney-pancreas; liver
- Small bowel; small bowel-multivisceral
- Corneal transplants
- Autologous islet cell transplantation (AICT)
- Allogeneic and autologous bone marrow/stem cell transplants

Benefits for allogeneic or autologous bone marrow transplants (including peripheral stem cell rescue (PSCR) procedures and/or HDC or HDR) are not available for treatment of all conditions, or at all stages of a condition, even if your provider may recommend such treatment.

Please note: Since medical research regarding the effectiveness of transplants or PSCR procedures is ongoing, BCBSAZ periodically reviews conditions to determine eligibility for benefits. You or your treating provider may obtain a list of the approved conditions and medical criteria for eligibility for benefits upon request.

Not all organ/ tissue/ bone marrow transplants/stem cell support procedures ("transplants") are covered, whether performed as independent procedures or in combination with other therapies, e.g., HDC and/or HDR. Upon receipt of a request for precertification for a transplant, BCBSAZ will undertake a review. **Only** the transplants and combination therapies deemed medically necessary and not investigational by BCBSAZ are eligible for coverage.

The term "transplant" as used in this benefit plan booklet includes related procedures and combination therapies (e.g., HDC and/or HDR) in conjunction with a transplant, and includes any drugs or devices used in conjunction with the transplant or procedure.

In addition to meeting the medical necessity criteria described in this benefit plan booklet, including the Technology Evaluation Center, BCBSAZ will also consider the following criteria in determining medical necessity:

- Scientific adequacy of clinical trials and research on the safety, efficacy and outcomes of the requested transplantation and its indications;
- Community standards and practice as determined by BCBSAZ; **and**
- Whether the proposed transplant is investigational, as described below.

In determining whether the proposed transplant is investigational, BCBSAZ will use the following criteria:

- The drug or device cannot be lawfully marketed without full (unrestricted) approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the proposed transplant/procedure is furnished; **or**
- The hospital or facility performing the transplant/procedure or providing the drug, device or medical treatment considers it experimental or investigational as indicated on such hospital or facility's patient consent form, or in its medical policies; **or**

- Published reports and articles in authoritative (peer reviewed) medical and scientific literature show that the prevailing opinion among experts regarding the drug, device, medical treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, appropriate patient selection, its efficacy, or its efficacy as compared with the standard treatment(s) for the diagnosis.

Covered Services

The following services, provided in connection with or in preparation for, the organ, tissue or bone marrow transplants or stem cell support procedures and combination therapies included within this benefit provision, are considered covered services when medically necessary, as defined above:

- Facility and professional services

- Drugs and supplies

- Air and ground transportation of a medical team to and from the site in the contiguous states of the United States for the procurement of tissue that is subsequently transplanted into you or your covered dependent

- Bone marrow search and procurement of a suitable bone marrow donor when a subscriber or eligible dependent is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center.

- Expenses incurred by a donor when both the donor and the recipient are covered by BCBSAZ. Both donor and recipient are responsible for deductible, coinsurance and/or copayment requirements unless and until BCBSAZ is notified that a BCBSAZ subscriber is a donor for a recipient who is also a BCBSAZ subscriber, at which time all covered donor related services following such notification will be processed under the recipient's benefit plan

- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ and the donor is not covered by BCBSAZ. Covered donor expenses include complications and medically necessary follow-up care related to the donation for up to six (6) months post transplant, as long as the recipient's BCBSAZ coverage remains in effect.

If coverage is requested for a transplant/PSCR procedure to treat a condition other than those on BCBSAZ's approved list, the request will be individually reviewed, as described above. If it is determined by BCBSAZ that the transplant is not medically necessary for the subscriber, or is otherwise excluded from coverage, coverage will be denied.

Benefits are <u>not</u> available for:

- Nonmyeloablative ("mini") or consecutive ("tandem") ABMT/stem cell rescue procedures, unless they otherwise meet BCBSAZ coverage criteria

- Expenses related to a non-covered transplant, including, but not limited to, pre-transplant testing, chemotherapy or radiation therapy, HDC or HDR associated with transplant procedures, harvest and reinfusion of stem cells or bone marrow, drugs and medications (including those administered to mobilize stem cells transplants), inpatient hospitalization and outpatient services.

- Expenses in relation to donation of an organ to a recipient who is not covered by BCBSAZ

FF. Transplant Travel and Lodging

Deductible and coinsurance are not applied to travel and lodging reimbursement.

As used in this benefit provision, the term "eligible BCBSAZ subscriber" means a subscriber who is receiving a covered solid organ, bone marrow or stem cell transplant that has been precertified by BCBSAZ. This Transplant Travel and Lodging benefit is only available to a subscriber receiving a transplant or a donor donating for a covered solid organ bone marrow or stem cell transplant.

When an eligible BCBSAZ subscriber must travel more than seventy-five (75) miles from his/her residence for a covered solid organ, bone marrow or stem cell transplant, coverage is available to reimburse the subscriber for documented transportation, lodging and food expenses while the subscriber must be at or in proximity to the facility.

This benefit is available while the subscriber is receiving medically necessary pre and post-operative treatments. In addition, this benefit is available when the subscriber must travel to the facility at which the transplant was performed for treatment of complications related to the covered transplant or for routine transplant follow-up care. This benefit is also available for travel related to covered follow-up care or treatment of complications for subscribers who received a transplant while covered by another carrier.

To the extent a donor is eligible for coverage under the provisions of the "*Transplant - Organ - Tissue - Bone Marrow Transplants and Stem Cell Procedures*" benefit, and if the donor must travel more than 75 miles from his/her home to donate for a solid organ, bone marrow or stem cell transplant, travel and lodging expenses are also covered for the donor, but accumulate toward the recipient subscriber's lifetime maximum travel and lodging benefit.

This Transplant Travel and Lodging benefit is not available for a transplant other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service.

Covered Expenses

Covered expenses include mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service in effect at the time of travel), **or** car rental charges, **or** bus, train or air fare, room charges from hotels/motels, hostels and meal expenses for the subscriber (when not an inpatient) and human caregiver(s).

A lifetime maximum of $10,000 per covered recipient subscriber who receives a covered solid organ, bone marrow or stem cell transplant(s) is provided at the rate of up to $200 per day **only** when covered services are received at a BCBSAZ contracted facility or a Blue Quality Centers for Transplants (BQCT) facility (see "*Contracted Providers*" below).

The daily maximum is an aggregate amount, not a per person amount, for the subscriber receiving a covered transplant and any and all human caregiver(s) accompanying the subscriber. The reimbursement will be calculated at $200 per day for the total number of travel and lodging days, but will not exceed actual covered expenses. The lifetime maximum includes travel and lodging expenses for covered treatment of complications, follow-up care, and donor expenses, as described above.

Contracted Providers:

This benefit may be used for covered services received within the state of Arizona when such services are rendered by a BCBSAZ contracted provider, as indicated in your provider directory and on the BCBSAZ Web site, www.azblue.com.

When covered services are received out-of-state, subscribers are eligible for the travel and lodging benefit if covered services are received at contracted providers, which include BQCT providers, or a provider that has a contract with the local Blue Cross and/or Blue Shield plan where services are rendered.

This benefit is subject to all exclusions and limitations outlined in this benefit plan. In addition, reimbursement is **not** available for:

- Travel and/or lodging related to evaluation, consultation or medical testing to determine if a subscriber is a candidate for transplantation.
- Travel and/or lodging related to or associated with non-covered transplant services and/or any follow-up care, including treatment of complications
- Ambulance transportation (ground or air) - see "*Ambulance Services*"
- Travel and lodging expenses for subscribers and/or human caregiver(s) when the subscriber (transplant recipient) does not travel more than 75 miles for an authorized transplant or transplant related services, including follow-up care and treatment of complications.
- Donor travel expenses, except as specifically described in this benefit provision.
- Alcoholic beverages, in-room movies, items from in-room mini-bars or refrigerators, laundry/dry cleaning/valet services, telephone or internet service charges, spa services, gym facilities, or other hotel/motel amenities.
- Vehicle maintenance and/or services (e.g., tires, brakes, oil change).
- Lodging and/or meals provided by friends or relatives of subscriber and/or human caregiver(s) are not eligible for reimbursement.
- Home modifications.

To request reimbursement of eligible transplant travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with original dated receipts to BCBSAZ at:

Attn: Transplant Travel Claim Processor
Mail Stop: A116
Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ 85002-3466

Please contact BCBSAZ at (800) 232-2345, extension 4051 to request Transplant Travel and Lodging claim forms.

GG. Urgent Care

Urgent care services are for conditions that require prompt medical attention, but are not emergencies, and therefore do not require treatment at an emergency room.

BCBSAZ has contracted with certain urgent care facilities to provide these services to its subscribers. These facilities are listed in your provider directory, or you can look on the BCBSAZ Web site at www.azblue.com. In the Web site provider directory, look under "*Urgent Care Centers*." When you use one of these facilities, you pay the per-visit copayment indicated on your schedule page, even when referred by a physician or other provider. After the copayment, covered services are paid at 100% of the BCBSAZ allowed amount.

If you obtain urgent care services at a provider who is not specifically listed as a BCBSAZ urgent care provider, you will be responsible for the applicable deductible and/or coinsurance listed on your schedule page. In addition, you may be responsible for paying the difference between non-contracted provider's billed charges and the BCBSAZ allowed amount.

HH. Vision Exams (Routine) and Eyewear Discounts

This benefit plan does not provide your routine vision benefits. Contact your group benefits administrator for information.

- **Pre-existing Conditions**

  A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) month period immediately preceding the subscriber's enrollment date. For purposes of determining a pre-existing condition and pre-existing condition waiting periods, enrollment date means the subscriber's effective date of coverage under this benefit plan or the first day of the group's eligibility waiting period, whichever is earliest.

  Coverage for services related to a pre-existing condition or complications related to the condition will not begin until twelve (12) consecutive months have elapsed from the subscriber's enrollment date. That waiting period may be shortened or eliminated by the amount of credit given for periods of prior creditable coverage. For prior coverage to apply toward this pre-existing condition waiting period you must not have any period of sixty-three (63) days or more (excluding the employer's group's eligibility waiting period) during which you were not covered under any creditable coverage. Creditable coverage includes the following:

  - Coverage provided under a group health plan (insured or self-insured)
  - An individual insurance policy
  - Medicare
  - Medicaid
  - A federal or state public health plan, including but not limited to, AHCCCS and public health plans provided by a foreign government.
  - TRICARE
  - A health benefits risk pool
  - The Peace Corps
  - A Bona Fide Association
  - Indian Health Services (IHS)
  - The Federal Employee Health Benefits Plan (FEHBP), or
  - The State Children's Health Insurance Program (SCHIP)

  Pregnancy is not considered a pre-existing condition. Newborns enrolled within thirty-one (31) days of birth will not be subject to this pre-existing condition waiting period. If you adopt a child or a child is placed for adoption with you, and you enroll him/her within thirty one (31) days of placement, he/she will not be subject to this pre-existing condition waiting period.

- **Non-Covered Services and Supplies**

  Some limitations and exclusions on certain benefits appear within the specific benefit provision. Expenses for services that exceed benefit limitations are not covered**. BCBSAZ contracted providers are permitted by the terms of their contract with BCBSAZ to charge you for non-covered services and supplies. We recommend that you check with the provider regarding the cost of non-covered services and supplies before you obtain them.**

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

- **Abortions** (including fetal and multi-fetal reductions) - non-spontaneous, medically-induced abortions (by surgical or non-surgical means) are not covered. This includes the following:

  - Termination of pregnancy for chromosomal and/or genetic abnormalities that do not affect the viability of the fetus. Non-viable means to a reasonable degree of medical probability, the fetus/newborn is not expected to live longer than thirty (30) days outside the womb. A fetus is not considered non-viable for purposes of this provision if a pregnancy is terminated for reasons other than as stated above, but at a stage of pregnancy too early for viability.

- Fetal and/or multi-fetal reductions, except when medically appropriate based on BCBSAZ's determination that the fetus(es) to be aborted is/will be non-viable as defined above. Fetal and/or multi-fetal reductions to generally increase the health outcome(s) by increasing the gestational age and/or birth weight of the remaining fetus(es) are expressly excluded.

- **Activity Therapy** - activity therapy, milieu therapy or any care primarily intended to assist an individual in the activities of daily living or for the comfort or convenience of the subscriber or family member, except as specifically set forth in this benefit plan.

- **Acupuncture**

- **Alternative Medicine** - non-traditional or alternative medical therapies, e.g., interventions, services or procedures not commonly accepted as part of allopathic or osteopathic curriculums practices; naturopathic and homeopathic medicine; diet therapies; nutritional or lifestyle therapies; aromatherapy.

- **Biofeedback** – biofeedback, neurofeedback and/or hypnotherapy.

- **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, or services related to employability.

- **Complications of Body Piercing/Tattooing** - complications of body piercing, implants (body art) and/or tattooing, e.g., the evaluation, treatment, removal, and/or repair of lacerations, infection, cellulitis, and keloids.

- **Complications of Non-Covered Benefits** - complications, consequences, or after effects, whether immediate or delayed, that arise from any condition, service, or supply that is not covered under this benefit plan, whether the condition, service or supply occurred or was used prior to or during the time the subscriber was covered by BCBSAZ.

- **Cosmetic Services** - surgery, procedures, treatment, and office visits and/or consultations and other services for cosmetic purposes. "Cosmetic" means surgery, procedures, or treatment and other services performed primarily to enhance or improve appearance, even if such services will improve emotional, psychological or mental condition or function. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy, in accordance with state and/or federal law.

- **Counseling** - counseling/behavioral modification services (except as may be available from the behavioral services administrator).

- **Court-Ordered Services** - court-ordered testing, treatment or therapy, unless such services are otherwise covered under this benefit plan as determined by BCBSAZ.

- **Custodial Care** - any health services and other related services that are for the comfort or convenience of the subscriber or family member, or do not seek to cure, or are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition (except as covered under "*Home Infusion/ Medication Administration Therapy"*) or other self care, or are provided when acute care is not required, or do not require continued administration by licensed skilled medical personnel, e.g., LPN, RN, licensed therapist. See "*Home Health Services*."

- **Dental** - dental or orthodontic services or supplies, whether inpatient or outpatient; placement or replacement of crowns, bridges or implants; any fixed dental reconstruction of the teeth; orthodontics; extractions of teeth; dentures, and procedures associated with the fitting of dentures; vestibuloplasty; and surgical orthodontics, except as otherwise specifically provided in this benefit plan.

- **Dietary/Nutritional Supplements** - all dietary, caloric and nutritional supplements, e.g., specialized formulas for infants, children or adults or other special foods or diets, even if prescribed by a physician or other eligible provider, except as otherwise specifically provided under "*Medical Foods*."

- **Environmental Medicine** - services or supplies associated with environmental medicine or clinical ecology, defined as the diagnosis or treatment of environmental illness, e.g., chemical sensitivity(ies) or toxicity(ies) from past or continued exposure to atmospheric contaminants, pesticides, herbicides, or foods exposed to atmospheric or environmental contaminants.

- **Fees** - fees other than for medically appropriate in-person, direct patient treatment, tests, services, medications, supplies or equipment.

- **Fertility/Infertility Services** - services for retrieval, collection, fertilization, preservation, implantation or storage of sperm/eggs; services, drugs and procedures to improve or achieve fertility (ability to conceive) or to diagnose and treat infertility (inability to conceive), as determined by BCBSAZ.

- **Foot Care** - foot care involving trimming of nails, treatment of corns or calluses, flat feet, fallen arches, arch supports and weak feet, except when medically appropriate for diabetic or neurological involvement or peripheral vascular disease of the foot or lower leg (below the knee).

- **Genetic/Chromosome Testing and Screening** – genetic/chromosomal testing of an asymptomatic or unaffected individual or an individual not displaying signs or symptoms of a suspected or specific inherited disorder.

- **Government Services** - services for injuries received in the line of duty and/or services covered by a governmental health care program or provided by a governmental hospital, clinic or other facility at no charge to the subscriber, except as otherwise required by law or unless the facility has been approved for payment by BCBSAZ.

- **Growth Hormone(s)** – growth hormone(s) except as determined medically necessary by BCBSAZ to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat Idiopathic Short Stature (ISS) is expressly excluded.

- **Hearing Services or Devices** - routine hearing exams, except for hearing screenings included in a physical exam (see *"Preventive Care - Mammography - Routine Physical Exams"),* hearing aid services and supplies, including external, semi-implantable middle ear, and implantable bone conduction hearing aids. Diagnostic hearing tests related to a medical condition identified by a physician are covered as any other service.

- **Investigational** - investigational treatments, procedures, equipment, drugs, devices, or supplies, as determined by BCBSAZ, except as specifically provided in "*Prescription Drugs for the Treatment of Cancer*" and "Cancer Clinical Trials" (see also *"Medically Necessary"*).

- **Lodging and Meals** - lodging and meals, except as described in "*Transplant Travel and Lodging*."

- **Medications Dispensed in a Physician's/Provider's Office** - prescription medications and over-the-counter medications, including pharmaceutical manufacturers' samples, dispensed to the patient in a physician's/provider's office by any mode of administration. This does not include eligible injectable drugs administered in the physician's office.

- **Non-Medically Necessary Services** - services that are not medically necessary as determined by BCBSAZ. **Please note**: BCBSAZ may not be able to determine medical necessity until after services are rendered.

- **Over-the-Counter Items** - any drug, medicine, device, equipment or supply (except for certain diabetic supplies and inhaler spacers, as described in *"Retail Pharmacy Benefit"*), that is lawfully obtainable without a prescription.

- **Personal Comfort Items** - services or devices intended primarily for assistance in daily living, socialization, personal comfort, convenience or other non-medical reasons for the subscriber or family member, whether inpatient or outpatient.

- **Screening Tests** - screening and/or diagnostic testing or treatment performed without a personal history of a specific diagnosis, and/or acute signs or symptoms, regardless of risk factors; screening and/or diagnostic testing deemed investigational by BCBSAZ, including full body scans, even if component parts of the scans are not investigational, except as specifically provided in this benefit plan.

- **Services For Which You Have No Legal Obligation to Pay.**

- **Services from Family Member(s)** - services that are provided by an eligible provider who is a member of your immediate family. "Immediate family" members are: your spouse, children, sister, brother, father and mother. When a provider is also the covered person, services rendered by that provider for him/herself are also excluded from coverage.

- **Services Not Requiring Licensed Professional** - services that do not have to be performed by a licensed professional, which you or an immediate family member or caregiver not compensated by BCBSAZ could provide after demonstrating proficiency at providing the service.

- **Services of Ineligible Providers** - inpatient or outpatient services at any facility or from any other health care provider, except those listed as eligible in this benefit plan (see "*Eligible Providers*").

- **Services or Supplies After Termination Date** - services or supplies rendered or delivered after this coverage terminates, except as expressly provided in this benefit plan.

- **Services or Supplies Prior to Effective Date** - services or supplies rendered or delivered prior to the effective date of this benefit plan.

- **Services or Supplies Related to or Associated with a Non-Covered Service or Supply.**

- **Services Without a Prescription** - services and supplies that are required by this benefit plan to have a prescription and are not prescribed by a physician or other provider licensed to prescribe.

- **Sexual Dysfunction** - evaluation and/or testing, diagnosis, treatment (surgical or non-surgical), or medication or devices for sexual dysfunction, regardless of the cause of the condition, including trauma and complications of medically necessary surgery or treatment.

- **Smoking Cessation** - smoking cessation programs, medications, aids or devices, (except as may be provided by the BSA).

- **Telephonic or Electronic Consultations**

- **Therapy Services** - therapy services, except as expressly provided in this benefit plan (see *"Physical Therapy – Occupational Therapy - Speech Therapy," "Cardiac and Pulmonary Rehabilitation," "Inpatient Extended Active Rehabilitation (EAR) Services*").

- **Training and Education** - training and education, except as expressly provided in this benefit plan (see "*Diabetes and Asthma Supplies and Disease Management"*).

- **Transplants** - transplants (organ, tissue, bone marrow/peripheral stem cell rescue procedures) not approved as a covered benefit by BCBSAZ; high dose chemotherapy, high-dose radiation, or other related services administered in conjunction with a non-covered transplant or expenses related to donation of an organ to a recipient who is not covered by BCBSAZ.

- **Transportation** - transport services or travel expenses, except as described in "*Ambulance Services*" and "*Transplant Travel and Lodging.*"

- **Transsexual -** transsexual treatment or surgery and/or any related services.

- **Treatment for behavioral/mental health conditions** in a non-acute facility (e.g., residential, skilled nursing).

- **Vision** - vision therapy; all types of refractive keratoplasties; any other procedures, treatments or devices for refractive correction; eyeglasses and contact lenses, the vision examination for prescribing and fitting of same and routine vision services and exams, except as specifically set forth in this benefit plan.

- **Vitamins** - vitamins or minerals except as specifically set forth in this benefit plan (see *"Retail Pharmacy Benefit"*).

- **Weight Loss/Gain** - weight loss/gain treatment, therapy or medications, including, but not limited to, Xenical® and Meridia®, except medically necessary, covered surgical procedures (see "*Physician Services*"). Medical treatment of complications of anorexia or bulimia are not excluded from coverage under this provision.

- **Workers' Compensation** - services for an illness or injury covered by Workers' Compensation or similar benefits, unless you are exempt from such coverage or have made a statutory opt-out election.

- **Benefit Plan**

  This benefit plan includes the benefit plan booklet and schedule page, any replacement benefit plan booklets, your ID card, and any amendments, riders or modifications to this benefit plan, including, but not limited to, any changes in deductible, coinsurance or copayment amounts.

  Benefits are subject to change upon notification to the group and to subscribers as may be required by law (see *"Benefit Plan Amendment"*).

- **Coordination of Benefits**

  Your Group Master Contract contains a coordination of benefits provision that prevents duplication of payments. Under the provision, if you are eligible for benefits under any other group health insurance, the combined benefit payments from all coverages will not exceed 100% of the billed charges. BCBSAZ's payment will not exceed 100% of the BCBSAZ allowed amount.

  Please note: BCBSAZ will periodically require from you information about other coverage you may have. If you fail to provide the information requested, this may result in delay or denial of your claims.

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

  - If the person is an inpatient on the day this benefit plan becomes effective and benefits are payable under the person's prior health care coverage for the inpatient stay, the prior health care coverage pays first

  - If the person who received care is covered as an active employee under one benefit plan, and as a dependent under another, the employee coverage pays first

  - If the person who receives care is covered as an active employee under one benefit plan and as an inactive employee under another, the coverage through active employment pays first

  - If the person who receives care is a dependent child, then the plan benefits of the parent whose birthday occurred earlier in a calendar year shall cover the child first

  - If both parents have the same birthday, the benefits of the plan that covered a parent longer shall cover a dependent child first

  - If one of the plans determines the order of benefits based upon the gender of a parent, and, as a result, the plans do not agree on the order of benefit determination, the plan with the gender rule shall determine the order of benefits

  - If the dependent child's parents are legally separated or divorced, then the following applies:

    - The coverage of the parent with custody pays first. If the parent with custody has remarried, the stepparent's coverage pays second. The coverage of the parent who does not have custody pays last.

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

    - If the parents have joint custody, then the plan benefits of the parent whose birthday occurred earlier in a calendar year shall cover the child first.

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

Please note: Under no circumstances are benefits coordinated for covered services provided by a retail pharmacy, including mail order services.

- **Non-Duplication of BCBSAZ Benefits**

  Where benefits for covered services are payable under this benefit plan and one or more other BCBSAZ group benefit plans, the rules described above in "*Coordination of Benefits*" will be used to determine which coverage pays first. Payment of the claim will be subject to **all** applicable deductibles, coinsurance and copayments, and the combined benefit payments will not exceed 100% of the BCBSAZ allowed amount.

  Where benefits for covered services are payable under this benefit plan and one or more BCBSAZ non-group contracts, benefits will be paid first under the non-group contract. Payment of the claim will be subject to all applicable deductibles, coinsurance and copayments, and the combined benefit payments will not exceed 100% of the BCBSAZ allowed amount. BCBSAZ does not coordinate benefits with non-group coverage provided by a carrier other than BCBSAZ.

  Please note: Under no circumstances are benefits coordinated for covered services provided by a retail pharmacy, including mail order services.

- **Definitions**

  - **"Dependents"** are the following: (1) the employee's spouse under a legally valid existing marriage; and/or (2) the employee's unmarried children or the unmarried children of his/her spouse. This includes natural children, legally adopted children, step-children, children placed for adoption, children under legal guardianship substantiated by a court order, and children who are entitled to coverage under a medical support order and/or; (3) the foster child that meets the following criteria: a child you are raising as your own; a child who lives in your home; a child who is dependent on you for support; a child for whom you have taken full parental responsibility and control (Subject to approval by BCBSAZ. Please obtain documentation from your benefit plan administrator). The child is **not** eligible if the child is: a child placed with you in your home by a social service agency which retains control of the child; or a child whose natural parent is in a position to exercise or share parental responsibility and control.

  - **"Disabled Dependent Child**" is a child who has reached age 19 (or 23, if a full-time student). A disabled dependent child may continue coverage under this benefit plan if the child is otherwise eligible for the benefit plan and meets all of the following criteria: (1) has been covered under this benefit plan up to the day he/she is no longer eligible for coverage based on the age limit(s) specified in this benefit plan; and (2) is continuously incapable of self-sustaining employment because of mental retardation, or mental or physical disability; and (3) is chiefly dependent upon the employee for maintenance and support.

    Medical reports, acceptable to BCBSAZ, must substantiate the incapacity and must be submitted by the employee within thirty-one (31) days of the date such disabled dependent child reaches age 19 (or 23 if a full-time student). The child's eligibility to continue this coverage is subject to periodic review by BCBSAZ. BCBSAZ uses the Social Security Administration medical criteria for determining disabilities as a guide when evaluating the extent of your dependent child's disability. Termination of the Group Master Contract or cessation of child's disability or dependency will terminate the child's coverage under this benefit plan.

  - **"Employee"/"Retiree"** refers to the person eligible for this benefit plan because of his/her employment relationship or former relationship to the group.

  - **"Group"** refers to the employer or other entity to which a Group Master Contract is issued under which the employee and/or dependents become entitled to health coverage. The Group Master Contract controls the administration of the group coverage and is on file with the employer. The coverage described in this booklet will terminate when the Group Master Contract terminates. It is

the responsibility of the group to notify subscribers in the event the Group Master Contract is terminated by the group or if the Group Master Contract is terminated for non-payment of premiums. BCBSAZ will notify subscribers if the Group Master Contract is terminated for any other reason.

- **"Open Enrollment"** is an annual period during which the employee and/or dependents are eligible to enroll for coverage or change benefit plan options. The benefit plan administrator will notify the employee if the group has established such an open enrollment period.

- **Eligibility Requirements**

  - **Employee** - An employee becomes eligible to enroll for coverage after meeting the group's eligibility requirements outlined in the Group Master Contract.

  - **Dependent Children** - Dependent children are eligible for dependent coverage until: (1) their 19th birthday, or (2) the 23rd birthday for a child who is otherwise eligible and is continuously attending an accredited institution as a full-time student. BCBSAZ may require verification of dependency and student status.

  - **Retirees** – Please see your benefit plan administrator to determine eligibility.

- **Effective Date of Coverage**

  - **Employee –** an employee's effective date of coverage will be either the date the employee becomes eligible to enroll or the first billing date after the employee becomes eligible to enroll as determined by the group, as long as the employee completes the application process within thirty-one (31) days of becoming eligible. See your schedule page for employee effective date.

  - **Dependent -** Dependent coverage can only be obtained if an eligible employee has enrolled for coverage. Eligible dependents will have the same effective date as the employee if they are included on the application at the time the employee first enrolls. If the employee and/or dependents do not enroll when first eligible, the employee and/or dependents may only apply for coverage at the group's annual open enrollment period, except as specifically described under *"Special Enrollment Provisions*" or if court-ordered. The effective date of coverage for an application made during an open enrollment period is the group's anniversary date following that open enrollment period.

  - **Spouse** - The effective date for a new spouse will be the date of marriage, as long as the employee completes an application within thirty-one (31) days of that date. If the application is not completed with thirty-one (31) days after the date of marriage, the spouse may not enroll until the next open enrollment period, unless he/she qualifies under "*Special Enrollment Provisions*."

  - **Newborn/Adopted Child/Child Placed for Adoption** - A child is automatically eligible for coverage for the first thirty-one (31) days after the date of birth, adoption or placement for adoption, so long as the parent or guardian covered under this benefit plan remains eligible for coverage during that period and the newborn or child adopted or placed for adoption is otherwise an eligible dependent under this benefit plan. To continue coverage for the child beyond the first thirty-one (31) days, you may need to enroll for family coverage within the 31-day time period and agree to pay any additional required premium for family coverage. Even if no additional premium is required (e.g., you already have family coverage), you may need to complete an application to add the child within thirty-one (31) days of birth, adoption, or placement for adoption to assure continuity of coverage.

  - **Other Children** - The effective date for a dependent child who is not a newborn child, adopted child or a child placed for adoption (as described above) shall be the date the child becomes an eligible dependent, as long as you complete an application to add the child within thirty-one (31) days of that date. If an application is not completed within thirty-one (31) days, the child may not enroll until the next open enrollment period, unless the child qualifies under "*Special Enrollment Provisions."*

  - **Retirees** – Please see your benefit plan administrator to determine effective dates of coverage.

- **Loss of Eligibility/Termination Date of Coverage**

  The date eligibility ends is not necessarily the date coverage ends under the benefit plan. Coverage for employees and dependents ends in accordance with the requirements of the Group Master Contract.

  Some groups have up to thirty-one (31) days to notify BCBSAZ that an employee has become ineligible. Until BCBSAZ receives notice and processes the termination of eligibility, benefits may be quoted, precertification given or claims paid that ultimately will be recouped from subscribers or providers, if it is later determined the subscriber(s) were ineligible on the date services were received. Such benefit quotations or precertifications become null and void, regardless of whether the employee has received notice of termination of eligibility from the group.

  Employee eligibility ends on the following days:

  - The end of the month in which the employee was entitled to receive compensation from the group for the employee's full-time employment, as defined in the Group Master Contract, and for which BCBSAZ has received premium.
  - The end of the month in which an approved leave of absence expires, if the employee fails to return to active full-time employment.
  - The date of death.

  Dependent eligibility ends on the following days:

  - The end of the month during which the divorce decree becomes final.
  - The end of the month in which the child turns age 19 and is not a full time student or does not qualify as a disabled dependent.
  - The end of the month in which the child between age 19 and 23 (not disabled) loses full-time student status.
  - The end of the month in which the child marries.
  - The end of the month in which the disability or dependency ceases for a child over age 19 (not a full-time student) or over age 23.
  - The end of the month in which a child covered by a medical support order is no longer eligible under the court order or administrative order.
  - The end of the month in which the employee's death occurs.

- **Termination Date of Coverage**

  An employee's and/or dependent's coverage will terminate on the **earlier** of the following:

  - The date the Group Master Contract terminates; **or**
  - The last day on which the employee or dependent is eligible for coverage (as described above) **or** the last day of the billing month when eligibility ends, as set forth in the Group Master Contract. The Group Master Contract controls whether coverage terminates on the date eligibility ends or the last day of the billing month when eligibility ends.

  Employees' and/or dependents' coverage ends no later than the date the Group Master Contract terminates.

When an employee's coverage terminates, coverage for all dependents also terminates. Subscribers may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Subscribers may also be eligible for individual portability coverage or may apply to BCBSAZ for an individual conversion contract.

BCBSAZ will issue a certificate of creditable coverage upon receipt of notice of the employee's termination. Subscribers may request a certificate of creditable coverage at anytime up to twenty-four (24) months after termination of coverage.

- **Special Enrollment Provisions**

  If an employee or dependent does not enroll when first eligible, the employee or dependent may enroll for coverage other than at open enrollment **if** he/she meets the following criteria:

  The employee/dependent at the time of the initial enrollment period was covered under a public or private health insurance policy or other health benefit plan and he/she lost coverage under the plan due to any of the following reasons, and the employee/dependent requests coverage by completing an application within thirty-one (31) days of the loss of other coverage:

  - Dependent's termination of employment
  - Dependent's termination of eligibility
  - Dependent's reduction in the number of hours of employment
  - Termination of the other plan's coverage
  - The death of an employed spouse
  - Legal separation or divorce
  - Exhaustion of COBRA
  - Termination of the employer's contribution toward the coverage
  - The person is employed by an employer that offers multiple health benefit plans and the person elects a different plan during an open enrollment
  - The person becomes a dependent of a covered person through marriage, birth, adoption or placement for adoption and BCBSAZ received a completed application no later than thirty-one (31) days after becoming a dependent.
  - Exhaustion of a lifetime maximum on all benefits under a plan
  - The person no longer resides, lives or works in the other plan's service area and no other group benefit plan is available to the person.

  If an employee is not a participant in the group's health plan when a special enrollment qualifying event occurs, the employee and dependents are eligible to enroll in the group health plan and are not considered late enrollees so long as BCBSAZ receives a completed application no later than thirty-one (31) days after the special enrollment qualifying event.

- **Leave of Absence**

  The group may continue coverage for subscribers during the time period which the employee is on a formal leave of absence. The group must continue to pay any premiums due during the leave of absence. Leave of absence coverage is the following:

  Unpaid Leave of Absence – Coverage terminates on the first day of the policy month following the unpaid leave.

  Paid Leave of Absence – Coverage will continue until the earlier of six months or the date you exhaust your paid leave (sick, vacation, sabbatical, personal).

  BCBSAZ agrees to continue coverage for subscribers during any leave of absence the group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993, and any amendments or successor provisions. If you return to active employment by the end of the leave of absence period, coverage under this benefit plan will continue for an employee and his/her dependents, so long as the group maintains coverage with BCBSAZ. If not, the employee will cease to be eligible, and coverage for the employee and dependent(s) will terminate as described in "*Termination of Coverage*."

- **Medical Support Orders**

  Coverage is available to a child of the employee 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 employee. The order must clearly specify the name and last known mailing address of the employee and each child covered by the order, and the time period to which the order applies.

  Following receipt of the above information from the group, BCBSAZ will add the child to the employee's coverage, subject to BCBSAZ's guidelines for adding dependent children, as outlined above. If the employee does not have family coverage, the employee is required to enroll for family coverage and pay the required premium.

- **Termination of Coverage**

  All benefits terminate when coverage terminates, except in the following circumstances:

  ♦ **Continuation of Coverage**

  Under federal law it is the group's responsibility, as plan administrator, to inform employees and dependents of the availability, terms and conditions of continuation of coverage available under COBRA.

  COBRA requires most employers who have twenty or more employees and sponsor a group health plan to offer employees and their covered dependents the opportunity for a temporary extension of health coverage (called “continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

  ♦ **Hospitalization**

  If a subscriber is an inpatient in an acute care hospital on the day coverage terminates, benefits for covered inpatient facility services delivered during that admission will be provided under this benefit plan. **Any professional services rendered during the stay but after the date of termination are not covered.** This hospital coverage does not apply to inpatient stays in long-term acute care, skilled nursing, extended active rehabilitation or behavioral health facilities.

  ♦ **Disability Extension of Benefits**

  BCBSAZ uses the medical criteria established by the Social Security Administration to determine total disability. Eligibility to continue coverage for a disabling condition is subject to periodic review by BCBSAZ.

  (1) Group Discontinuation: If you are totally disabled on the date that the group discontinues coverage through BCBSAZ, medical expense benefits will continue, **for the disabling condition only, for a period not to exceed twelve (12) months from the date of termination**. To ensure an orderly extension of benefits and timely processing of your claims, it is important to provide BCBSAZ with written notice of the disabling condition no later than thirty-one (31) days after such termination. You do not waive your right to extended benefits if you do not notify BCBSAZ; however, claims payments cannot be made until notice is received.

  When you provide notice, you will be required to also provide reports satisfactory to BCBSAZ that show the date of your termination, the condition that resulted in your becoming totally disabled, and that you have been totally disabled from that condition from the time of such termination. You are eligible for this extension of benefits whether covered as an active employee, the dependent of an active employee or a qualified COBRA beneficiary on the date the group discontinues coverage through BCBSAZ.

(2) Individual Termination: If you are totally disabled on the date your coverage as an active employee (or as the dependent of an active employee) terminates, medical expense benefits will continue, **for the disabling condition only, for a period not to exceed twelve (12) months from the date of termination**. You do not waive your right to extended benefits if you do not notify BCBSAZ; however, claims payment cannot be made until notice is received.

When you provide notice, you will also be required to provide reports satisfactory to BCBSAZ that show the date of your termination, the condition that resulted in your becoming totally disabled, and that you have been totally disabled from that condition from the time of such termination. If you are eligible for extension of benefits because of an individual termination as described above, and you elect continuation coverage under COBRA, the extension of benefits shall run concurrently with your continuation coverage under COBRA, until the 12-month extension of benefits period is exhausted. Because these provisions run concurrently, please contact your employer before making any changes to, or terminating, your COBRA continuation coverage.

- **Individual Portability Coverage**

You are eligible for certain individual coverage with no medical underwriting or pre-existing condition waiting periods if you meet **all** of the following criteria:

(1) You have eighteen (18) months of prior continuous creditable coverage; the most recent coverage must be with a group, government or church plan, **and**

(2) You are no longer eligible for a group plan, Medicare or Medicaid, **and**

(3) Coverage was not terminated for non-payment of premium or fraud, **and**

(4) You elected and exhausted COBRA continuation coverage (or other similar coverage) if this coverage was available to you, **and**

(5) You apply for individual portability coverage within sixty-three (63) days of the date your group (or COBRA) coverage ends.

Please contact BCBSAZ for information on individual portability coverage.

- **Conversion Coverage**

If this benefit plan terminates because the group changes its insurance carrier, you are not eligible for a conversion contract.
If your coverage under this benefit plan ends for any reason other than the group changing carriers and you maintain your permanent residence in Arizona, you may apply for an individual conversion contract offered by BCBSAZ.

You must apply in writing to BCBSAZ for a conversion contract within thirty-one (31) days of your termination from this benefit plan. You may also apply for conversion coverage when your continuation coverage under COBRA expires, provided the Group Master Contract is still in force.

- **Transfer Coverage**

If you cease to be a subscriber under this benefit plan (for any reason other than the group changing insurance carriers), and you move to an area served by another Blue Cross and/or Blue Shield plan, you may be eligible to enroll for transfer coverage with the BCBS plan serving your new address.

If you do not wish to enroll in the transfer coverage, you may be eligible for other BCBS plan policies. You will have to apply and meet medical underwriting requirements just like any other new customer. You may or may not receive pre-existing condition waiting period credit.

Other coverage options and their benefits and limitations are very different from this coverage. Policies that do not require a health history (such as conversion, transfer or portability coverage) or that do not have pre-existing condition limitations will have significantly higher premiums.

- **BCBSAZ Continuous Coverage Policy**

If you are terminating your BCBSAZ group coverage and you were covered under a BCBSAZ medically underwritten individual policy directly prior to your BCBSAZ group coverage, you may be eligible to return to BCBSAZ individual coverage without having to meet individual medical underwriting guidelines.

To return to individual coverage, you must be under age 65 and there can be no lapse in your BCBSAZ coverage. Before your group coverage terminates, please contact BCBSAZ Direct Pay Enrollment Services at (602) 864-4115 for more information.

Except as described in "*Termination of Coverage,*" this benefit plan excludes payment of benefits for services provided after termination.

- **BCBSAZ PPO and Participating Providers**

  All BCBSAZ BluePreferred (PPO) and Participating providers will file a claim for covered services for you. BCBSAZ's payment for covered services will be sent directly to the contracted provider.

- **Claim Forms**

  Medical and prescription drug claim forms are available from BCBSAZ by calling the Supply Line telephone number listed at the front of this booklet. A separate medical foods or transplant travel claim form is also available (see *"Medical Foods"* or *"Transplant Travel and Lodging"*).

- **Complete Claims**

  Before BCBSAZ can process a claim to determine whether the service is covered and before BCBSAZ can determine appropriate reimbursement, the claim must be complete. To be complete, a claim must include, at a minimum, the following information:

  - Subscriber name
  - Subscriber ID number
  - Date of service(s)
  - Name of provider
  - Provider ID number
  - Diagnosis code
  - Procedure code
  - Billed charges
  - Signature of provider who rendered services

  When any of this information is not included on the claim, processing the claim may be delayed. Even when all of the above information is on the claim form, it may be necessary to request medical records before BCBSAZ can make a coverage determination.

- **Concurrent Care Decisions**

  Benefits, such as home health services, may require that your provider submit a plan of care, and you then receive precertification for 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 twenty-four (24) hours prior to the expiration of an existing plan of care. A determination will be made as soon as possible in accordance with medical exigencies but no later than twenty-four (24) hours after receipt of the request. If that precertification is denied, you may appeal that denial in the same way you appeal any other coverage denial.

- **Explanation of Benefits (EOB) Form**

  An EOB shows the services billed, whether the services are covered or not covered, and how access fees, deductibles, copayments, coinsurance or benefit maximums were applied. After your claim is processed, BCBSAZ will send an EOB. Save the EOB for your personal records. BCBSAZ may charge a fee for duplication of claims records.

- **Initial Claim**

  If your claim is not filed properly or is missing information, you will be sent notification within five (5) days of receipt of the claim, unless it is missing so much information you cannot be identified as a subscriber covered by BCBSAZ. In that case, it will be returned to the person who submitted the claim.

  If the claim is complete and properly submitted, it will be processed according to the time periods described in this section.

- **Non-Contracted Providers**

  A non-contracted 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. Payment for covered services will be made to you and it is your responsibility to pay the provider. In certain limited situations, federal law may allow for payment to be made to other individuals covered under this benefit plan for covered services provided to them. In such a situation, it would be the responsibility of that individual to pay the provider. Remember, non-contracted providers may charge you for the difference between their billed charges and the BCBSAZ allowed amount (see *"Choosing a Provider"*).

- **Notice of Determination**

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

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

- **Pharmacy Claims**

  When you submit a prescription to either a retail or mail order pharmacy, you may submit a claim to BCBSAZ for such prescription in the following circumstances:

  - Coverage for the prescription was denied in whole or in part
  - You feel that you paid the wrong copayment or other cost-sharing amount for such prescription
  - You were required to pay other amounts you feel you are not required to pay
  - Other dispute or discrepancy regarding your prescription drug coverage

  When you submit a pharmacy claim, a notice will be sent within a reasonable time period, but not longer than thirty (30) days, from receipt of the claim. This notice is in the form of an Explanation of Benefits (EOB), described in your benefit plan booklet.

  If a decision on your claim cannot be made within thirty (30) days, the initial processing time may be extended fifteen (15) days. You will receive notice prior to the extension time period indicating why the extension is necessary and the date by which a determination can be expected. If the extension is necessary to obtain additional information, the extension notice will describe the information needed, and you or your provider will be given at least forty-five (45) days to submit the information.

- **Post-Service Claims**

  When you submit a claim for services that have already been rendered, or when precertification is not required, and your claim is denied, a notice will be sent within a reasonable time period but not longer than (thirty) 30 days from receipt of the claim. This notice is in the form of an Explanation of Benefits (EOB), described in this benefit plan booklet.

- **Pre-Service Claims**

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

  If more time is required to make a coverage determination, BCBSAZ has an additional fifteen (15) days in which to respond. You will receive notice prior to the extension time period indicating why the extension is necessary and the date by which a determination can be expected. If the extension is necessary to obtain additional information, the extension notice will describe the information needed, and you will be given at least forty-five (45) days to submit the information.

- **Providers Outside of Arizona – BlueCard**

  Some providers in other states will file a claim for services through the Blue Cross and/or Blue Shield plan in the state where services were delivered. In this case, payment for covered services will be made to the provider. If the provider does not file your claim, call the Customer Service telephone number at the front of this booklet for information concerning filing out-of state claims (see *"BlueCard Program").*

  Claims for covered services received outside the United States should be submitted through the "*BlueCard Program*." Please call (800) 810-BLUE (2583) and follow the instructions for care received outside the United States. An international claim submitted through the "*BlueCard Program*" will be translated (if necessary), and payment for covered services will be made to you or directly to the provider.

- **Time Limit for Claim Filing**

  BCBSAZ is not liable for payment unless claims for services are filed timely. The claim notice must include all information necessary for BCBSAZ to determine benefits and must be filed with BCBSAZ within one year from the date the covered services were provided (see *"Complete Claims"*).

- **Urgent Claims**

  IMPORTANT NOTE: Federal law defines an "urgent" medical situation as one where applying the time periods for handling non-urgent care determinations could seriously jeopardize the life or health of the subscriber or the ability of the person to regain maximum function, or, in the opinion of a physician with knowledge of the subscriber's medical condition, would subject the subscriber to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In BCBSAZ benefit plans, this is the way "emergency" is defined. BCBSAZ benefit plans do **not** require precertification or authorization in an emergency situation.

  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.

APPEAL AND GRIEVANCE PROCESS

Subscribers and their treating providers may participate in the appeal process, which is described in detail in the Health Coverage Appeal Information Packet, a separate document provided to you. You may request an additional copy of the Health Coverage Appeal Information Packet from BCBSAZ at any time by contacting the BCBSAZ Supply Line telephone number listed at the front of this booklet.

Below is a summary of those issues that can be appealed, and those that are not subject to the appeal process but can be reviewed through the BCBSAZ Grievance Process.

You Can Appeal the Following Decisions:

1. BCBSAZ does not approve a service that you have or your treating provider has requested, but that you have not yet received.
2. BCBSAZ does not pay for a service that you have already received.
3. BCBSAZ does not authorize a service or pay for a claim because it is not "medically necessary".
4. BCBSAZ does not authorize a service or pay for a claim because it is not covered under your insurance policy, and you believe it is covered.
5. BCBSAZ does not authorize a referral to a specialist.
6. Where preauthorization for a service is required by your benefit plan, BCBSAZ does not approve or deny your preauthorization request within ten business days.

Under Arizona Law, You Cannot Appeal the Following Decisions:

Although the items listed below are not appealable under state law, you and/or your authorized representative may have the right to appeal some of the following types of decisions under federal law or the right to submit a grievance through the BCBSAZ Grievance Process. Please consult the section entitled "Additional Federal Rights for Groups Plans" for additional information regarding your appeal rights under federal law and/or the section entitled "*Grievance Process.*"

1. You disagree with BCBSAZ's decision as to the amount of the BCBSAZ allowed amount.
2. You disagree with how BCBSAZ is coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how BCBSAZ has applied your claims to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with BCBSAZ's decision upon completion of a possible nondisclosure investigation.
6. You are dissatisfied with any rate increases you may receive under your insurance.
7. You believe BCBSAZ has violated any other parts of the Arizona Insurance Code.

Additional Federal Rights for Group Plans (Excluding Government Plans and Church Plans)

Levels 2 and 3 of Expedited Appeals and Standard Appeals and Level 2 of the Grievance Process are voluntary. If you choose to participate in Levels 2 or 3 of the Appeals Process or Level 2 of the Grievance Process, BCBSAZ will waive its right to assert that you have failed to exhaust administrative remedies. Any statute of limitations defense or other defenses based on timeliness will be stopped while your voluntary appeal or grievance is pending.

No fees or costs may be imposed upon you as part of any voluntary level of appeal or grievance. You also have the right to request the following information from BCBSAZ before deciding to submit your claim to Levels 2 & 3: (1) information about applicable rules of Levels 2 and 3, (2) your right to representation, (3) the process for selecting the decision maker, and (4) circumstances that may affect the impartiality of the decision maker, if any. If you wish to receive this information, please call or write to the following address and telephone number:

Dispute Resolution Coordinator
Formal Appeal
Mail Stop: A109
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85002-3466
Phone: (602) 864-5630
Fax: (602) 864-5858

You will have the opportunity to submit written comments, documents, or other information in support of your appeal or grievance, and you will have access to all documents that are relevant to your claim. Your appeal or grievance will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your appeal involves a medical judgment question, BCBSAZ will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, BCBSAZ will provide you with the identification of any medical expert whose advice was obtained on behalf of the plan in connection with your appeal.

These Appeal & Grievance rights are in addition to your rights to challenge BCBSAZ's decision in court, including, but not limited to bringing legal action under Section 503(A) of the Employee Retirement Income Security Act of 1974 (ERISA). You and your ERISA plan may have other voluntary alternative dispute resolution options in addition to the Appeals and Grievance Processes described in the benefit plan booklet, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office. You may also be able to obtain information from your group benefits administrator.

Levels of Appeal

There are two types of appeals: (1) Expedited Appeal for urgent matters, and (2) Standard Appeal. Each type of appeal has three levels of review. The Expedited Appeals operate similarly to Standard Appeals, except that Expedited Appeals are processed much faster because of the patient's condition.

Expedited Appeal (for urgently needed services you have not yet received)	**Standard Appeal** (for non-urgent services or denied claims)
Level 1 – Expedited Medical Review	Level 1 – Informal Reconsideration
Level 2 – Expedited Appeal	Level 2 – Formal Appeal
Level 3 – Expedited External Independent Review	Level 3 – External Independent Review

Expedited Appeal

1. Level 1 – Expedited Medical Review

The first level of Expedited Appeal is Expedited Medical Review, which is available only when BCBSAZ or the behavioral services administrator (BSA) denies a request for a covered service that has not yet been provided (a precertification request). Expedited Medical Review requires your physician to certify orally or in writing that proceeding with the Standard Appeal process (Informal Reconsideration, Formal Appeal and External Independent Review) could seriously jeopardize your life, health or ability to regain maximum function or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. BCBSAZ or the BSA must notify you of its decision regarding an Expedited Medical Review as soon as possible in accordance with medical exigencies, but no later than one (1) business day.

In the event of a three or four day holiday weekend, BCBSAZ will notify you of its decision as soon as possible in accordance with medical exigencies, but no later than 72 hours after we receive your appeal request. For this Level 1 appeal, issues related to services provided by the BSA are handled by the BSA. If a service is denied, the BSA will process the Expedited Medical Review.

2. Level 2 – Expedited Appeal

An Expedited Appeal is available when, following an Expedited Medical Review, BCBSAZ or the BSA affirms a denial of a request for a covered service not yet provided (precertification request). To request an Expedited Appeal, immediately following the Expedited Medical Review, your treating provider will be required to submit to BCBSAZ a written appeal regarding the denial of the requested service not yet provided. BCBSAZ will notify you of its decision regarding an Expedited Appeal within three (3) business days.

3. Level 3 – Expedited External Independent Review

You may request an Expedited External Independent Review if, at the Expedited Medical Review and Expedited Appeal level, BCBSAZ affirms a denial of a request for a covered service not yet provided (precertification request). For cases involving coverage issues, the Arizona Department of Insurance (ADOI) must issue a decision within two (2) business days. For cases involving issues of medical necessity, the ADOI will select an Independent Review Organization (IRO), which will have five (5) business days to issue a decision.

Standard Appeal

1. Level 1 – Informal Reconsideration

If you are not eligible to participate in the Expedited Appeal process and wish to appeal the denial of a request for a covered service not yet provided (precertification request) or a denial of a claim for a service already provided, you may request an Informal Reconsideration. BCBSAZ or the BSA must notify you of its decision within thirty (30) days.

For this Level 1 appeal, issues related to services provided by the BSA are handled by the BSA. If a service is denied, the BSA will provide you with information on the Level 1 process applicable to its services.

2. Level 2 – Formal Appeal

You may proceed to a Formal Appeal if a denial is upheld by BCBSAZ or the BSA at the Informal Reconsideration level. BCBSAZ must notify you of its decision within thirty (30) days for an appeal of a covered service not yet provided (precertification request) and sixty (60) days for an appeal of a claim for a service already provided.

3. Level 3 – External Independent Review

You are not responsible for the costs of any External Independent Review.

You may request an External Independent Review following an Informal Reconsideration and Formal Appeal. For appeals involving medical necessity issues, the ADOI must select an Independent Review Organization (IRO), which has twenty-one (21) days to issue a decision regarding your appeal. For cases involving coverage issues, the ADOI must issue a decision within fifteen (15) business days.

If the ADOI finds that your appeal involves a medical issue, or if the ADOI is unable to determine issues of coverage, it must submit your case to an IRO.

Grievance Process

If you cannot resolve one of the issues that are not subject to the appeal process, you may direct a complaint or reconsideration request to BCBSAZ. Your complaint or reconsideration request must be made to BCBSAZ within one (1) year of the occurrence. These time limits may be extended by BCBSAZ in its sole and absolute discretion for good cause. Examples of good cause include a death in the immediate family or serious illness of you or someone in your immediate family. Good cause does not include travel for any reason other than death or serious illness as noted.

BCBSAZ will then review the situation, including any new information brought to our attention. You will be notified of BCBSAZ's decision within thirty (30) days of receipt for preservice issues and within sixty (60) days of receipt for claims and other post service issues.

The 30 or 60-day limit may be extended if necessary and in accordance with applicable law, and you will be notified if for any reason the 30 or 60-day time period will not be met.

If you do not find BCBSAZ's decision satisfactory, you may send a written grievance to BCBSAZ. The grievance must be filed within sixty (60) days of receiving BCBSAZ's decision regarding your complaint or reconsideration request. The written grievance must state your reason for the grievance, including the reason for dissatisfaction with the initial decision, and any additional information for review.

BCBSAZ will review your grievance and you will be notified of BCBSAZ's final decision within sixty (60) days of the date BCBSAZ received your grievance.

- **Benefit Plan Amendment**

  There is no guarantee to continued benefits as outlined in this benefit plan. This benefit plan may be amended, and benefits may be added, deleted, or changed by BCBSAZ upon sixty (60) days' notice to the group, or as required to comply with state or federal laws. Please review and retain this benefit plan booklet, any replacement benefit plan booklets, all schedule pages, all riders, amendments and other communications concerning your coverage.

- **Billing Limitations and Exceptions**

  BCBSAZ network providers may not bill for the difference between the provider's billed charges and the BCBSAZ allowed amount, except as described below.

  In most situations, Arizona law prohibits BCBSAZ contracted providers from charging you more than the access fee, deductible, copayment or coinsurance amounts you are obligated to pay under your coverage agreement with BCBSAZ for covered services.

  When there is another source of payment such as a liability insurer or government payer, BCBSAZ contracted providers may be entitled to collect from the other source, or from proceeds received from the other source, any difference between the provider's customary charges and the BCBSAZ allowed amount, pursuant to A.R.S. §33-931.

  A.R.S. §33-931 may give providers medical lien rights independent of this contract 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 benefit booklet to your attorney.

- **BlueCard Program**

  When you obtain health care services through BlueCard outside the geographic area BCBSAZ serves, the amount you pay for covered services is calculated on the **lower** of:

  - The billed charges for your covered services, or
  - The negotiated price that the Blue Cross and/or Blue Shield Plan ("Host Plan") passes on to us.

    Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangement and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

    Statutes in a small number of states may require the Host Blue to use a basis for calculating subscriber liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate subscriber liability calculation methods that differ from the usual BlueCard method noted in the above paragraph or require a surcharge, BCBSAZ would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

- **Blue Cross and Blue Shield of Arizona**

  BCBSAZ is an independent licensee of the Blue Cross and Blue Shield Association. It is a non-profit corporation organized under the laws of the State of Arizona as a hospital, medical, dental and optometric services corporation and is authorized to operate a health care services organization as a line of business.

- **Blue Cross and Blue Shield Association**

  The subscriber hereby expressly acknowledges his/her understanding that the benefit plan constitutes a contract solely between the contract holder and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield plans, permitting BCBSAZ to use the Blue Cross and/or Blue Shield Service Mark(s) in the State of Arizona, and that BCBSAZ is not contracting as the agent of the Association.

  The subscriber further acknowledges and agrees that he/she has not entered into this contract based upon representations by any person other than BCBSAZ and that no person, entity or organization other than BCBSAZ shall be held accountable or liable to the subscriber for any of BCBSAZ's obligations to the subscriber created under this benefit plan. This paragraph shall not create any additional obligations whatsoever on the part of BCBSAZ other than those obligations created under other provisions of this benefit plan.

- **Broker Commissions**

  BCBSAZ sells its insurance and other health and dental coverage products either directly or through licensed insurance brokers, some of whom are BCBSAZ employees. Generally, BCBSAZ pays commissions and/or other incentives to selling brokers which is one of the costs factored into calculating premium amounts. For small groups (typically 2-99 eligible employees), BCBSAZ does not calculate premiums differently based upon whether a product is sold by a broker or sold by BCBSAZ directly. For large groups, the premium rate reflects the specific commission. Occasionally, a commission or other payment to a selling broker or consultant will not be paid by BCBSAZ and factored into the premium amount but will instead be paid directly by your employer to the broker and/or consultant.

- **Claim Editing Procedures**

  In order to process claims accurately, BCBSAZ utilizes a number of editing systems to verify benefits, eligibility, claims accuracy and compliance with BCBSAZ coding guidelines and medical policy. Claim edits are updated by BCBSAZ from time to time. Editing systems and clinically based claims coding software is utilized by BCBSAZ to process professional and outpatient facility claims for surgery, laboratory, radiology, maternity and dental services. BCBSAZ's editing software and systems are designed to identify the following: Procedure unbundling, separate billing for incidental services, mutually exclusive procedures, correct use of coding guidelines, patient's age and sex edits. The editing software is not used to audit the diagnosis code to change or modify the intensity of service of evaluation and management codes.

- **Confidentiality/Release of Information**

  BCBSAZ takes confidentiality very seriously and various processes are in place to safeguard sensitive or confidential information and to release such information in accordance with state and federal law.

  If you wish to authorize someone to have access to your information, please call the Customer Service Department and request a Confidential Information Release Form. Once BCBSAZ receives the completed form, it will release information to the person you have designated.

- **Court or Administrative Orders Concerning Dependent Children/Access to Information Concerning Dependent Children**

  When the contract holder is not the custodial parent of a child who is covered because of 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.

  Whether issues relate to a court or administrative order concerning coverage or simply access to information, BCBSAZ is not a party to domestic disputes. Such matters 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.

- **Disclaimer of Liability**

  All network providers are independent contractors and not employees, agents, or representatives of BCBSAZ. These independent providers have an agreement with BCBSAZ concerning reimbursement and administrative policies. Each provider exercises independent medical judgment. BCBSAZ's role is limited to administration of the benefits under this benefit plan. Your provider may recommend services or treatment not covered under this benefit plan. Whether to proceed with the service or procedure if benefits have been denied by BCBSAZ is an issue to be decided between you and your provider.

  Use of the terms "BluePreferred," "PPO," "Participating," "contracted" or "network" in describing any provider is not a statement as to the professional ability of the provider.

  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.

- **Discretionary Authority**

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

- **Government Health Care Programs**

  If you and/or your dependents are eligible for services by a government health care program other than Medicare (such as AHCCCS or Medicaid), in most cases this BCBSAZ benefit plan will be primary for covered services. It is important that you notify the government health care program of your BCBSAZ coverage so that claims payment can be coordinated.

  Where benefits for covered services are paid by Medicare as primary, this benefit plan will not duplicate those payments.

- **Legal Action**

  This benefit plan is governed by and construed and enforced in accordance with the laws of the state of Arizona and applicable federal law.

  Lawsuits against BCBSAZ

  BCBSAZ has an appeal program for resolving disputes with customers. BCBSAZ encourages you to use the appeal program prior to filing a lawsuit, as issues can often be resolved when further information is provided to BCBSAZ through the appeal process.

In accordance with Arizona law, before a subscriber may file a lawsuit pursuant to Arizona's Health Care Insurer Liability Act, the subscriber must first **either** complete all available levels of appeal according to the BCBSAZ appeal process, or provide **written notice** to BCBSAZ **at least thirty (30) days prior to 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.

Completion of all applicable levels of appeal is required before bringing a lawsuit **other than** a suit filed pursuant to the Health Care Insurer Liability Act. Failure to complete 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.

Lawsuits by BCBSAZ

Occasionally, BCBSAZ is presented with an opportunity to join class action lawsuits, where third party payors (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 subscribers, 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/entity.

- **Non-Assignability of Benefits**

  The benefits of this benefit plan are not assignable. You may not assign or transfer the rights to receive any portion of your benefits to any person or entity, either through power of attorney or outright assignment.

- **Notices to Subscribers**

  Generally, all notices and correspondence dealing with claims are sent to the employee by ordinary mail to the last address in BCBSAZ's enrollment records, or may be sent electronically, or both. The employee is responsible for notifying BCBSAZ of any change of name or address.

- **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 of services, depending on to whom payment was made, 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 non-covered services.**

- **Prescription Drug Rebates**

  BCBSAZ enters into contracts with pharmaceutical manufacturers to receive rebate payments based on the volume and/or market share of pharmaceutical products utilized by BCBSAZ subscribers. These rebate contracts are subject to renegotiation and/or termination from time to time at BCBSAZ's sole discretion. BCBSAZ's rebate contracts with pharmaceutical manufacturers generally work as follows: BCBSAZ submits data regarding utilization of specific drug(s) to the pharmaceutical manufacturer. The

pharmaceutical manufacturer compares the data to the utilization level and/or market share required by the applicable rebate contract. If the utilization and/or market share meets the requirements of the rebate contract, the manufacturer issues a rebate payment to BCBSAZ after receipt of the data. As utilization and/or market share increases, the amount of the rebate payable to BCBSAZ may increase.

Rebates may be paid on drugs that are covered under the BCBSAZ retail pharmacy benefit. The BCBSAZ Pharmacy and Therapeutics (P&T) Committee decides which drugs to place on which levels of the tiered pharmacy benefit. The P& T Committee is comprised of pharmacists, BCBSAZ employees and other members as needed. The community physician members of the P&T Committee are not informed of potential rebate contracts or rebate payments when deciding which drugs to place on which levels of the tiered pharmacy benefit. Certain BCBSAZ employees are aware of the potential rebate contracts or rebate payments. The P&T Committee decisions are not binding and can be overridden by BCBSAZ.

The rebates BCBSAZ receives are not reimbursable to you or your employer. BCBSAZ retains the rebates as part of its overall compensation pursuant to its contract with your employer. You acknowledge and agree BCBSAZ will retain any and all rebates. The rebates reduce BCBSAZ's costs and assist in limiting premium increases.

Rebates received by BCBSAZ may result in the overall cost of a particular drug falling below the amount you pay for such drug pursuant to the coverage described in this benefit plan. Other discount programs offered by a pharmacy may result in members of the public paying a lower cost for some drugs than you pay under this benefit plan

- **Provider and Third Party Administrator Reimbursement Arrangements**

  BCBSAZ has negotiated varied reimbursement methods with network providers. BCBSAZ network providers have generally agreed to accept the lesser of billed charges or the BCBSAZ fee schedule, including any contractual arrangements. The BCBSAZ fee schedule for professional services is referred to as the Prevailing Fee. The BCBSAZ fee schedule for inpatient services is referred to as the Diagnosis Related Grouping (DRG). A DRG is a category of diagnoses or procedures used to reimburse hospitals specific dollar amounts depending on the category of reason for admission (diagnosis) or treatment (procedure). Some institutional providers are paid on a per diem (per day) basis.

  For certain benefits, BCBSAZ contracts with a behavioral services administrator (BSA) for certain outpatient behavioral and mental health services. BCBSAZ pays a capitated amount per member per month to the BSA.

- **Release of Records**

  Subject to Arizona or federal law, the subscriber agrees that BCBSAZ may obtain any and all records or information relating to his/her health, condition, treatment, prior health insurance claims, or health benefit programs. This information may be obtained from any provider or insurance company.

  BCBSAZ reserves the right to reject or suspend a claim based on lack of medical information or records (see *"Complete Claims").*

- **Rescission of Coverage**

  Coverage for any person ineligible to be on the benefit plan as described in the Group Master Contract will be rescinded, that is, as never having been in effect. Premiums paid for the coverage for the ineligible person will be refunded; minus any claims paid for that person. BCBSAZ is entitled to recover claim payments that exceed the amount of premium paid. Such rescission does not affect the coverage of those persons on the benefit plan who remain eligible for coverage.

  A subscriber's eligibility to enroll in the group's health plan is not based on the subscriber's health status. An omission or misrepresentation of health information in your application for group coverage is not a basis for rescission of your group coverage.

- **Statement of ERISA Rights**

  (Does Not Apply to Government Plans, Church Plans or Other Non-ERISA Qualified Plans)

  As a subscriber to a group health insurance benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

  Please Note: For purposes of ERISA, your employer is the "Plan Administrator."

  ERISA provides that all subscribers shall be entitled to:

  - **Receive information about your plan and benefits**

    Under ERISA, you are entitled to examine, without charge, at the plan administrator's office and other locations, such as worksites and union halls, all documents governing the plan that are available from the Plan Administrator. Upon written request to the Plan Administrator, you may obtain copies of the plan documents. The Plan Administrator may make a reasonable charge for the copies.

  - **Continue group health plan coverage**

    COBRA is the abbreviation for a federal law that regulates continuation of health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. Unless you have an agreement with your employer to pay your COBRA premiums, you or your dependents will be responsible for full payment of the premium to continue coverage under your group plan. Review your benefit plan booklet and talk to your benefits administrator about your COBRA continuation coverage rights.

  - **Receive credit for pre-existing condition waiting periods**

    If you have creditable coverage from one health plan, you may receive credit toward meeting the preexisting condition waiting period of another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance carrier when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, and when your COBRA continuation coverage ends, if you request such a certificate before losing coverage, or if you request it within 24 months of losing your coverage.

    Without evidence of creditable coverage, you may be subject to a pre-existing condition waiting period of 11 months from your effective date (or 18 months, if you are a late enrollee in your group plan).

  - **Prudent actions by plan fiduciaries**

    In addition to creating certain rights for group subscribers, ERISA also imposes certain duties on the "plan fiduciaries," those responsible for administration of the health plan. The plan fiduciaries have a duty to operate the plan prudently and in the interest of you and other subscribers.

  - **Enforce your rights**

    No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

    If your claim for a benefit is denied in whole or in part, you have a right to know why it was denied, obtain copies of documents related to the decision (at no charge), and appeal any denial, all within the time periods required by ERISA.

- **Your Right to Information**

  You have the right to inspect and copy your information and records that BCBSAZ maintains, with some limited exceptions required by law. This right is described in the Notice of Privacy Practices provided to you at the time of enrollment and available by request from BCBSAZ.

  Please note: 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.

INDEX

GROUP SUBSCRIBERS

PLEASE PRINT CLEARLY

- ❒ ADDRESS CHANGE
- ❒ DIRECTORY REQUEST
- ❒ MAIL ORDER PHARMACY FORM (Walgreen's Healthcare Plus)

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone Number: _____

ID Number: _____ **Group** _____

Dear Customer:

As a BCBSAZ subscriber we have made it convenient for you to change your name, address or phone number by using any of the following methods. First, you can complete the information requested above and return this form either by faxing to (602) 864-4041 or mailing to the address listed below. Secondly, you can call customer service during regular business hours 8:00 a.m, to 4:30 p.m., Monday through Friday. In the metro Phoenix area please call (602) 864-4115, all others please call (800) 232-2345, extension 4115. Lastly, you can make your changes online. First you must register with our BlueNet suite of services. Simply go to www.azblue.com, choose **Member**, then **Register Here**.

If you would like to receive an updated provider directory or a Walgreen's mail order form, please complete the information requested above and mail to the address listed below or call our automated supply line. In the metro Phoenix area please call (602) 995-6960, all others please call (800) 232-2345, extension 6960. Please allow three weeks for delivery.

Please mail this form to: Attn: Enrollment Services
MS A102
Blue Cross Blue Shield of Arizona
PO Box 13466
Phoenix, AZ 85002-3466

ENROLLMENT SERVICES DEPARTMENT
BLUE CROSS BLUE SHIELD OF ARIZONA

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