

**Northern Arizona Public Employee Benefit Trust (NAPEBT)
PPO HSA Plus Benefit Plan**

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

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

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

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

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

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

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

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

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

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BCBSAZ CUSTOMER SERVICE INFORMATION

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

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

Claims and benefits information	Search for providers
Track deductible, if applicable to your plan	Compare hospitals
Update account information	Review Medical Coverage Guidelines
Verify enrollment status	HealthyBlue® - tools for a healthier life
Order ID cards	

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

BCBSAZ Customer Service (benefit questions or claim information)

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

Maricopa County	(602) 864-4400
Pima County	(520) 745-1883
Statewide	(800) 232-2345

Send all correspondence to this address unless otherwise indicated below:

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

Claims

Mail new claims to:

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

Claims for transplant travel and lodging:

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

Claims for services received on a cruise ship:

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

Customer Walk-In Office Locations

Phoenix (main office)	2444 W. Las Palmaritas Drive, 85021-4883 (2 blocks north of Northern Avenue between the Black Canyon Freeway (I-17) and 23rd Avenue)
Tucson	5285 E. Williams Circle, Suite 1000, 85711- 7411 (East on Broadway Road, right on S. Williams Circle, left on E. Williams Circle)
Flagstaff	1500 E. Cedar Avenue, Suite 56, 86004 -1643 (Intersection of Cedar Avenue and West Street)

Provider Network Status

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

BCBSAZ Other Information**BlueCard® Program**

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

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

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

Care Management and Disease Management Support Line

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

Continuity of Care Requests

(877) My-HBlue or (877) 694-2583

Hearing Impaired (TDD) (Claim information)

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

Medical Appeals and Grievances

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

Chiropractic Appeals and Grievances

American Specialty Health Networks, Inc. (800) 678-9133
Attn: Appeals Coordinator Fax: (619) 209-6237
P.O. Box 509001
San Diego, CA 92150-9001

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

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

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

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

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

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

Precertification (your doctor must contact BCBSAZ)

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

Precertification Denial Appeals

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

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

Requests for Transplant Travel and Lodging Claim Forms

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

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

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

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

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

DEFINITIONS

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

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

The allowed amount is calculated as follows:

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

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

“BCBSAZ Fee Schedules” mean proprietary schedules of provider fees compiled by BCBSAZ. BCBSAZ develops proprietary schedules of fees based on annual reviews of information from numerous sources, including, but not limited to: Medicare fee schedules from the Centers for Medicare and Medicaid Services (CMS), BCBSAZ’s historical claims experience, pricing information that may be available to BCBSAZ, information and comments from providers and negotiated contractual adjustments with providers.

"BCBSAZ" or "We" means Blue Cross Blue Shield of Arizona when acting as the issuer of insurance coverage or as the administrator of a group benefit plan.

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

BCBSAZ is a non-profit corporation organized under the laws of the State of Arizona as a hospital, medical, dental and optometric services corporation and is authorized to operate a health care services organization as a line of business.

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

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

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

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

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

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

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

"Cosmetic" means surgery, procedures or treatment and other services performed primarily to enhance or improve appearance, including but not limited to, those surgeries, procedures, treatments and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological or mental condition or function.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UNDERSTANDING THE BASICS

You have enrolled in PPO HSA Plus, a high deductible health plan that can be used with a health savings account (HSA). You must satisfy certain criteria to be eligible to open a health savings account. Enrolling in PPO HSA Plus does not automatically qualify you to open an HSA. Check with your tax or legal advisor regarding whether you satisfy these criteria.

Your Responsibilities

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

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

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

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

Review your explanation of benefits (EOB) documents, other claims-related information, and available claims history. Notify BCBSAZ of any discrepancies or inconsistencies between amounts shown and amounts you actually paid, or in amounts credited toward your deductible or out-of-pocket maximum. This will help to avoid any adverse tax consequences to your high deductible health plan and health savings account.

BCBSAZ ID Card

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

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

Benefit Maximums

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

All benefit maximums are included in the applicable benefit description.

Coverage Changes

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

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

Covered Services

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

- a benefit of this plan;
- medically necessary as determined by BCBSAZ;
- not excluded;
- not experimental or investigational as determined by BCBSAZ;
- precertified where precertification is required;
- provided while this benefit plan is in effect and while the person claiming benefits is eligible for benefits;
- **and**
- rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ.

Experimental or Investigational Services

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

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

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

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

Health Savings Account (HSA)

An HSA is a tax-exempt trust or custodial account that is used with a qualified high deductible health plan. A member uses the funds in the HSA to pay for qualified medical expenses and provide savings for the future. This PPO HSA Plus plan is designed to work in conjunction with an HSA that you separately establish with a qualified financial institution.

BCBSAZ is not an HSA trustee or custodian. You cannot set up an HSA with BCBSAZ. BCBSAZ does not make any contributions to the HSA.

Federal and state regulations governing HSAs are subject to change. BCBSAZ does not render tax, investment or legal advice. Please contact your tax or legal advisor for more information about health savings accounts.

Medically Necessary

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

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

- Is consistent with the diagnosis or treatment of a symptom, illness, disease or injury;
- Is not primarily for the convenience of a member or a provider;

- Is the most appropriate site, supply or service level that can safely be provided; **and**
- Meets BCBSAZ's medical necessity guidelines and criteria in effect when the service is precertified or rendered. If no such guidelines or criteria are available, BCBSAZ will base its decision on the judgment and expertise of a BCBSAZ medical professional or medical consultant retained by BCBSAZ.

Medical Necessity Guidelines and Criteria

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

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

BCBSAZ may contract with a chiropractic services administrator, which may also make medical necessity determinations based on its own medical necessity criteria, which are also available to you on request.

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

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

Provider Eligibility and Network Status

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

Schedule Page

BCBSAZ gives you a schedule page that lists the persons covered; applicable copays, access fees, coinsurance percentages, deductible amounts, other cost-sharing amounts; your effective date of coverage; and other important information. Please keep your current schedule page with your benefit book.

MEMBER COST-SHARING

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

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

Access Fee

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

Balance Bill

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

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

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

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

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for covered services each calendar year (January through December) before the benefit plan begins to pay for covered services. The deductible applies to every covered service unless the specific benefit section says it does not apply. Covered services provided under this benefit plan and covered prescription expenses provided through Caremark apply towards meeting the calendar-year deductible(s).

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

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

The family deductible must be met on a family policy before the plan will pay for covered services for any individuals covered under that policy (except preventive care).

Coinsurance

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

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

Covered prescription expenses received through Caremark apply towards meeting the out-of-pocket maximum.

Out-of-Pocket Maximum (Individual and Family)

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

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

If you have family coverage, there is an out-of-pocket maximum for your family; amounts applied to each member's out-of-pocket maximum also apply to the family out-of-pocket maximum.

The family maximum is applied in the same way as the individual maximum described above and is subject to the same rules.

Precertification Charges

You must make sure that your provider obtains precertification from BCBSAZ for any service that requires it. Otherwise, you are subject to a precertification charge or complete loss of your benefit, depending on the plan. Applicable precertification charges are shown on your schedule page.

BCBSAZ will send your provider a letter, with a copy to you, to confirm that BCBSAZ has precertified a service. If you are not sure whether your service needs precertification or if your provider has precertified your service, you can contact BCBSAZ customer service at the number listed on your ID card or the front of this book.

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

PROVIDERS

Eligible Providers

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

Eligible providers include the following:

Professional	Facility Ancillary
<ul style="list-style-type: none"> • Certified Nurse First Assist (CRNFA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Doctor of chiropractic (D.C.) • Doctor of dental surgery (D.D.S.) • Doctor of medical dentistry (D.M.D.) • Doctor of medicine (M.D.) • Doctor of optometry (O.D.) • Doctor of osteopathy (D.O.) • Doctor of podiatry (D.P.M.) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner • Licensed professional counselor • Physician Assistant (PA) • Psychologist (Ph.D., Ed.D. and Psy.D.) • Perfusionist • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational or physical therapist • Surgical Assist (SA) • Surgical Technician (ST) 	<ul style="list-style-type: none"> • Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long Term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Rehabilitation Treatment Centers (substance abuse centers) • Skilled Nursing Facility • Specialty Laboratory • Sleep Lab • Urgent Care

Choosing a Provider

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

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

In-Network Providers (Contracted)

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

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

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

Out-of-Network Providers (Contracted and Noncontracted)

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

- **Participating-Only Providers**

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

- **Noncontracted Providers**

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

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

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

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

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

Provider Status and Payment – Summary Table

Provider contract status	Network status and applicable cost share	Provider required to file claim on member’s behalf	Accept BCBSAZ Allowed Amount¹ and do not Balance Bill	Payee for Reimbursement
Providers contracted with BCBSAZ	In-network ²	Yes	Yes	BCBSAZ reimburses the provider the allowed amount, less any member cost-share
Providers contracted with another Blue Cross or Blue Shield Plan (“Host Blue”) as PPO providers	In-network ²	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the provider the allowed amount less any member cost-share

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

¹ See "Definitions" section for basis of allowed amount computation. For non-emergency services from out-of-state noncontracted providers, the allowed amount is based on the lesser of the provider's billed charges or the BCBSAZ fee schedule.

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

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

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

Differences in Financial Responsibility

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

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

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

Locating an In-Network Provider

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

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

Precertifications for Out-of-Network Providers

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

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

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

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

New Members	Current Members
<p>A new member may continue an active course of treatment with an out-of-network Arizona physician during the transitional period after the member's effective date if:</p> <p>The member has:</p> <ol style="list-style-type: none"> 1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of coverage; or 2. Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; and 	<p>A current member may continue an active course of treatment with an out-of-network Arizona physician if BCBSAZ terminates the physician from the network for reasons other than medical incompetence or unprofessional conduct if:</p> <p>The member has:</p> <ol style="list-style-type: none"> 1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of the physician's termination; or 2. Entered the third trimester of pregnancy on the effective date of the physician's termination, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; and
<p>The member's physician agrees in writing to do all of the following:</p> <ol style="list-style-type: none"> 1. Accept the BCBSAZ allowed amount applicable to covered services as if provided by an in-network physician, subject to the deductible, coinsurance and copay requirements of this benefit plan; 2. Provide BCBSAZ with any necessary medical information related to your care; and 3. Comply with BCBSAZ's policies and procedures, as applicable, including precertification, network referral, claims processing, quality assurance and utilization review. 	

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

Out-of-Area Services

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

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

BlueCard Program

Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for fulfilling BCBSAZ's contractual obligations.

However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

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

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

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

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

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

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

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

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

Negotiated (non-BlueCard Program) National Account Arrangements

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

BlueCard Outside the United States (BlueCard Worldwide)

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

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

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

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

- **Inpatient Services**

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

- **Outpatient Services**

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

Services Received on Cruise Ships

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

PRECERTIFICATION

Precertification

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

Services (Including Medications) Requiring Precertification

You must have your provider obtain precertification before you receive the following services or medications:

- Inpatient admissions - including hospital, long-term acute care, detoxification, skilled nursing facility, behavioral health, extended active rehabilitation and dental (emergency and maternity admissions do not require precertification)
- Inpatient dental services or procedures
- Certain medications covered under the “Home Health/Home Infusion” benefit. The current list of specific medications that require precertification is available at www.azblue.com and is subject to change at any time without prior notice.
- Organ, tissue or bone marrow transplants and stem cell procedures
- Requests for services by an out-of-network provider for the in-network cost-share
- Services directly associated with a cancer clinical trial
- Behavioral therapy services for treatment of autism spectrum disorders

Precertification is required regardless of the provider’s network status.

Notwithstanding any other language in this benefit book, BCBSAZ may change the list of services that require precertification at any time. You will receive a notice of any changes to the list of services that require precertification.

If Required Precertification is Not Obtained

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

The benefit description will tell you whether you will be subject to a precertification charge or denial of benefits if you fail to obtain required precertification.

Prescription Medication Exception

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

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

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

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

How to Obtain Precertification

Ask your provider to contact BCBSAZ for precertification before you receive services. Your provider must contact BCBSAZ because he or she has the information and medical records we need to make a benefit determination. BCBSAZ will rely on information supplied by your provider. If that information is inaccurate or incomplete it may affect the ultimate disposition of your claim.

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

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

Precertification of in-network cost-share for services provided by an out-of-network provider is a process separate from precertification of services. If you want an out-of-network provider to render services that require precertification and you also want to be eligible for the in-network cost-share, you must ensure that your provider makes two separate precertification requests: one for the service itself and one for use of the out-of-network provider. The benefit descriptions in this book refer only to your obligation to obtain precertification for the service.

If BCBSAZ precertifies you for the in-network cost-share, your services will be subject to the in-network cost-share. **You will still be responsible for any balance bill.**

Remember you are responsible for making sure your provider obtains precertification as required.

If BCBSAZ Precertifies Your Service

- If BCBSAZ precertifies you for services from an out-of-network provider at the in-network cost-share, you are responsible for the provider's balance bill in addition to any applicable deductible, coinsurance, copays and access fees.
- Precertification is not a pre-approval or a guarantee of payment. Precertification made in error by BCBSAZ is not a waiver of BCBSAZ's right to deny payment for noncovered services.
- You and your provider will receive a letter explaining the scope of the precertification.

If BCBSAZ Denies Your Precertification Request

If BCBSAZ denies your precertification request, you or your provider may appeal. Information on where to file an appeal is in the BCBSAZ customer service section at the front of this book.

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

DESCRIPTION OF BENEFITS

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

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

- a benefit of this plan;
- medically necessary as determined by BCBSAZ;
- not excluded;
- not experimental or investigational as determined by BCBSAZ;
- precertified if precertification is required;
- provided while this benefit plan is in effect and while the person claiming benefits is an eligible member;
- **and**
- rendered by an eligible provider acting within the provider’s scope of practice, as determined by BCBSAZ.

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

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

Benefits are listed in alphabetical order:

A. AMBULANCE SERVICES

Precertification: Not required.

Your Cost-Share: You pay deductible and in-network coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum.

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

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

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

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

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

Behavioral and Mental Health Services (Outpatient Facility and Professional Services):

Precertification: Not required.

Your Cost-Share: You pay deductible and 50 percent coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider’s network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Description: Non-emergency outpatient behavioral and mental health services which include psychotherapy, outpatient therapy services for chemical dependency or substance abuse, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, electroconvulsive therapy (ECT), and counseling for personal and family problems.

Benefit Limitations: Benefits for outpatient behavioral and mental health services are limited to a maximum of fifty-two (52) visits per member, per calendar year. Visits to both in- and out-of-network providers count toward the fifty-two (52) visit limit. Covered electroconvulsive therapy (ECT) services are not subject to the fifty-two (52) visit limit.

Behavioral and Mental Health Services (Inpatient):

Precertification: Required for non-emergency inpatient behavioral and mental health admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Maximum: There is a maximum of two (2) admissions, up to a combined total of thirty (30) days per member, per calendar year.

Benefit Description: Inpatient facility and professional behavioral and mental health services are covered. Benefits are available for inpatient behavioral and mental health services that meet all the following criteria:

- The inpatient program is provided in a facility licensed to provide an inpatient level of care;
- The facility designated medical director is a psychiatrist or physician with behavioral or mental health work experience, and is in charge of the medical services at the facility;
- A behavioral or mental health medical practitioner is present at the facility or on-call at all times to admit to the inpatient program and respond to the needs of patients;
- The facility's license requires 24/7 nursing coverage;
- The facility has sufficient behavioral or mental health professional staff to provide appropriate treatment; and
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

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

Behavioral and Mental Health Services (Emergency Room Services):

Precertification: Not required.

Your Cost-Share: You pay the emergency room access fee per member, per provider, per day, deductible and in-network coinsurance for each emergency room visit. Your access fee, deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. If you are admitted to the hospital, the access fee is waived and cost-sharing for inpatient behavioral and mental health admissions applies.

Benefit Description: Benefits are available for emergency behavioral and mental health services.

Behavioral Therapy Services For The Treatment Of Autism Spectrum Disorder

Precertification: Required. If you fail to obtain precertification, behavioral therapy services for the treatment of autism spectrum disorder will not be covered.

Your Cost-Share: You pay deductible and 50 percent coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit-Specific Definitions:

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

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

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

The limit of fifty-two (52) outpatient visits per member, per calendar year, does not apply to services covered under this benefit.

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

- Activity therapy, milieu therapy and any care primarily intended to assist an individual in the activities of daily living
- Biofeedback and hypnotherapy
- Development of a learning plan and treatment and education for learning disabilities (such as reading and arithmetic disorders)
- IQ testing
- Lifestyle education and management services
- Neurofeedback
- Neuropsychological and cognitive testing
- Partial hospitalization
- Inpatient and outpatient facility charges for services provided by the following facilities are not covered: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes. Inpatient and outpatient facility charges for services provided by residential treatment facilities are not covered except for very limited situations based upon BCBSAZ medical necessity criteria. All other inpatient and outpatient services provided by residential treatment facilities are not covered.

C. CANCER CLINICAL TRIALS

Precertification: Required for services directly associated with a cancer clinical trial. Precertification will be issued in accordance with the requirements of Arizona law, regardless of whether the clinical trial would otherwise be considered investigational. See specific benefit provisions for precertification charges.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider’s network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Description: Benefits are available for covered services directly associated with a cancer clinical trial conducted in Arizona and meeting all requirements specified by Arizona law. You or your provider may request a copy of these requirements from BCBSAZ customer service.

Benefits are limited to those services eligible for coverage under this plan that would be required if you received standard, non-investigational treatment. If you have any questions about whether a particular service will be covered, please contact BCBSAZ customer service.

You or your provider must inform BCBSAZ that you are enrolled in a cancer clinical trial, that the trial meets the requirements of Arizona law, and that the services to be rendered are directly associated with the trial. Otherwise, BCBSAZ will administer your benefits according to the other terms of your benefit plan, which may result in a denial of benefits.

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

Benefit-Specific Exclusions:

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

D. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

Precertification: Not required.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider’s network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

E. CATARACT SURGERY

Precertification: Required for inpatient cataract surgery. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: For cataract surgery and any associated services, you pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider’s network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum. In addition, you pay any amounts above the \$250 maximum per member, per six (6) month period, for eyeglasses or contact lenses.

Benefit Description: Benefits are available for the removal of cataracts. This includes the placement of a single intraocular lens at the time of the cataract removal. Following surgery, benefits are available for eyeglasses or external contact lenses, up to a \$250 maximum per member, per six (6) month period. The eyeglasses or external contact lenses must be prescribed and purchased within six (6) months of the surgery.

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

F. CHIROPRACTIC SERVICES

Precertification: Not required.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider’s network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Maximum: You have a combined in- and out-of-network maximum of twelve (12) visits per member, per calendar year. All covered services provided by a chiropractor apply toward meeting the twelve (12) visit maximum, including, but not limited to, physical therapy services.

Benefit Description: Benefits are available for chiropractic services.

Benefit-Specific Exclusions:

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

G. DENTAL SERVICES BENEFIT

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

1. Dental Accident Services

Precertification: Not required.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

A sound tooth is a tooth that is:

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

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

Covered Services:

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

Benefit-Specific Exclusions:

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

2. Dental Services Required for Medical Procedures

Precertification: Required for non-emergency inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

Benefits are available for the following:

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

Benefit-Specific Exclusions:

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

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

Precertification: Required for non-emergency inpatient admissions. If you fail to obtain precertification, these services will not be covered.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

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

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

Precertification: Not required.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will

depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

1. Durable Medical Equipment (DME)

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

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

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

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

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

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

2. Medical Supplies

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

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

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

3. Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

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

- ◆ therapeutic shoes (depth inlay or custom-molded) along with inserts, for individuals with diabetes; or
- ◆ covered in accordance with BCBSAZ medical necessity criteria.

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

Benefit-Specific Exclusion: Prosthetic appliances and orthotics exceeding one unit or one pair, as applicable, per member, per calendar year.

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

- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, breast pumps, car seats, cushions, disposable hygienic items, dressing aids and devices, elastic/support stockings (except TED hose), elevators, exercise equipment, foot stools, grab bars, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs and vehicle or home modifications.
- Items used primarily for assistance in daily living, socialization, personal comfort, convenience or other non-medical reasons
- Strollers of any kind
- Tilt or inversion tables or suspension devices
- Supplies used by a provider during office treatments
- Wig(s), when hair loss results from male or female-pattern baldness or natural or premature aging

I. EDUCATION AND TRAINING

Precertification: Not required.

Your Cost-Share: See descriptions under subheadings.

1. Diabetes and Asthma Education and Training

Your Cost-Share: You pay deductible and in-network coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum.

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

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

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

2. Nutritional Counseling and Training

Your Cost-Share: Deductible and coinsurance are waived for services from an in-network provider. You pay deductible and out-of-network coinsurance for services from an out-of-network provider. Your deductible and coinsurance payments count toward satisfaction of the out-of-

pocket maximum. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Maximum: Benefits are available for a maximum of three (3) nutritional counseling and training visits per member, per calendar year.

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

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

J. EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)

Precertification: Not required.

Your Cost-Share: You pay an emergency room access fee per member, per provider, per day, plus deductible and in-network coinsurance for emergency professional and facility charges. Your access fee, deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The emergency room access fee is waived if you are admitted to the hospital.

For all non-emergency services following the emergency treatment and stabilization, you pay applicable deductible, coinsurance, and access fees. The cost-share amount will depend on the provider's network status. If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

Teletrauma Services:

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

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

K. EOSINOPHILIC GASTROINTESTINAL DISORDER

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and 25 percent of the Cost of amino-acid based formula ("Formula") for the first \$20,000 of coverage. You pay applicable deductible and 80 percent of the Cost of Formula for all amounts that exceed \$20,000. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum.

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

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

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

L. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Precertification: Required for inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Description: Benefits are available for surgical and medical methods of contraception, which include implantable or injectable methods requiring surgical or medical administration by a provider. Other methods of contraception may be covered under another benefit of this plan.

M. HOME HEALTH AND HOME INFUSION - MEDICATION ADMINISTRATION THERAPY

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

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Maximum: Home health and home infusion medication administration services are available for up to a maximum of three two-hour visits per member, per day.

Benefit Description: Benefits are available for the following home health and home infusion medication administration therapy services:

- Home Infusion Medication Administration Therapy, including:
 - ◆ Blood and blood components
 - ◆ Hydration therapy
 - ◆ Intravenous catheter care
 - ◆ Intravenous, intramuscular or subcutaneous administration of medication
 - ◆ Specialty injectable medications, as defined by BCBSAZ
 - ◆ Total parenteral nutrition
- Enteral nutrition (tube feeding) when it is the sole source of nutrition. Sole source of nutrition is defined as the inability to orally receive more than 30 percent of daily caloric needs. Home health visits will be covered only for the purpose of instructing the member or caregiver (not compensated by BCBSAZ) to initiate and terminate the feeding, unless the member or caregiver cannot perform these tasks. If the member or caregiver cannot perform the tasks or no caregiver is available, BCBSAZ will continue to cover home health visits.

Home health and home infusion medication administration therapy services must meet the following criteria:

- A licensed home health agency must provide the services;
- A physician or registered nurse practitioner must order the services pursuant to a specific plan of home treatment for recovery from an illness or injury;
- Services must be provided in the member's residence;
- The member or primary caregiver (not compensated by BCBSAZ) must agree to participate in the home plan of care by learning the techniques and performing the procedures, for transition of care to the member or primary caregiver;
- The physician or registered nurse practitioner must regularly review the appropriateness of the services ("regularly" means at least every thirty (30) days or more frequently if appropriate under the treatment plan); **and**

- The services must be for skilled nursing care, which is required to be provided by a licensed practical nurse (L.P.N.) or a registered nurse (R.N.) or another eligible provider.

Benefit-Specific Exclusions:

- Continuous home health services or shift nursing that exceeds a two-hour visit, including 24-hour continuous nursing care
- Custodial Care
- Home health and home infusion medication administration in excess of three two-hour visits per day
- Home health and home infusion medication administration therapy services when the member or caregiver (not compensated by BCBSAZ) has demonstrated proficiency in providing the service

N. HOSPICE SERVICES

Precertification: Required for inpatient admissions not related to hospice services. Not required for inpatient hospice admissions. If you fail to obtain required precertification, you will be responsible for a precertification charge, or inpatient services will not be covered, depending on the type of admission.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider’s network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

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

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

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

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

Benefits are available for the following:

- ***Continuous Home Care:*** 24-hour skilled care provided by an RN or LPN during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- ***Inpatient Acute Care:*** Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- ***Respite Care:*** Admission of the member to an approved facility for up to five (5) days to provide rest to the member’s family or primary caregiver; respite care is available once every twenty-one (21) days
- ***Routine Care:*** Intermittent visits provided by a member of the hospice team

O. INPATIENT DETOXIFICATION

Precertification: Required for non-emergency admissions. If you fail to obtain precertification for a non-emergency admission, you will be responsible for a precertification charge.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

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

P. INPATIENT HOSPITAL

Precertification: Required prior to all elective or scheduled inpatient admissions. If you fail to obtain precertification for elective or scheduled inpatient admissions, you will be responsible for a precertification charge.

Your Cost-Share: You pay deductible and applicable coinsurance for all inpatient admissions. You pay an access fee for all bariatric surgeries, in addition to deductible and applicable coinsurance. The access fee applies toward the professional charges for bariatric surgery. Your deductible, coinsurance and access fee payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

Benefit Description:

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

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

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

Precertification: Required. If you fail to obtain precertification for an EAR admission, the services will not be covered.

Your Cost-Share:

In-Network: You pay deductible and in-network coinsurance for the first 60 days. You pay deductible and 50 percent coinsurance for the second 60 days. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum.

Out-of-Network: You pay deductible and out-of-network coinsurance for the first 60 days. You pay deductible and 50 percent coinsurance for the second 60 days. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Maximum: 120 days of EAR services per member, per calendar year.

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

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

Benefit-Specific Exclusions:

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

R. LONG-TERM ACUTE CARE (INPATIENT)

Precertification: Required. If you fail to obtain precertification for a long-term acute care admission, those services will not be covered.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Maximum: Plan coverage is limited to three hundred sixty-five (365) days of long-term acute care per member. If you have questions about the benefit maximum, contact BCBSAZ customer service at the number listed at the front of this book.

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

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

S. MATERNITY

Precertification: Not required

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

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

Benefit Description:

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

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

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

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

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

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

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

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

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

T. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and 50 percent of the Cost of Medical Foods for the first \$5,000 of coverage. You pay applicable deductible and 80 percent of the Cost for all amounts that exceed \$5,000. Your deductible and 50 percent and 80 percent coinsurance payments count toward satisfaction of the out-of-pocket maximum.

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

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

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

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

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

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

Benefit-Specific Exclusions:

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

Claim submission for Medical Foods

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

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

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

Medical Foods also may be covered under another benefit of this plan.

U. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Precertification: Not required.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider’s network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

V. OUTPATIENT SERVICES

Precertification: Not required.

Your Cost-Share: You pay deductible and applicable coinsurance. You pay an access fee for all bariatric surgeries, in addition to deductible and applicable coinsurance. The access fee applies toward the professional charges for bariatric surgery. Your deductible, coinsurance, and access fee payments count toward satisfaction of the out-of-pocket maximum. Your cost-share will vary depending on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

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

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

Precertification: Not required.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Maximum: PT provided by a chiropractor counts towards the 12 visit chiropractic limit.

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

Benefit-Specific Exclusions:

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

X. PHYSICIAN SERVICES

Precertification: Not required.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you

also pay the balance bill, which does not count toward the out-of-pocket maximum. If you receive preventive services from a physician, your applicable cost-share may be waived, as described in the "Preventive Services" section of this benefit book.

Benefit Description: Benefits are available for the following:

- General surgical procedures (including assistance at surgery) provided outside a physician's office. Only certain surgical assistants are eligible providers. Call BCBSAZ customer service at the numbers listed in the front of this book to verify that the surgical assistant chosen by your physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your physician are in-network providers.
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics)
- Inpatient medical visits
- Second surgical opinions

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

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

Y. POST-MASTECTOMY SERVICES

Precertification: Required for inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage, as described above under "Benefit Description," will be provided in a manner determined in consultation between the attending physician and the member being treated. These benefits are provided subject to the same deductibles and coinsurance generally applicable to other medical and surgical benefits provided under this plan, as described above in "Your Cost-Share" and in the schedule page for this benefit plan. If you would like more information on WHCRA benefits, call BCBSAZ customer service at the number listed in the front of this benefit book.

Z. PREGNANCY, TERMINATION

Precertification: Required for inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

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

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

AA. PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER

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

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

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

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

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

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

BB. PRESCRIPTION MEDICATIONS OBTAINED FROM A RETAIL OR MAIL ORDER PHARMACY

This benefit plan does not provide retail and/or mail order pharmacy benefits. Contact your group benefit administrator for information.

CC. PREVENTIVE SERVICES

Precertification: Not required.

Your Cost-Share:

In-Network:

Deductible and coinsurance are waived for preventive services (including routine physicals), regardless of the location where services are provided, if:

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

Out-of-Network:

Mammography Services: Deductible is waived. You pay out-of-network coinsurance.

All Other Preventive Services (except routine physicals): You pay deductible and out-of-network coinsurance.

If you receive preventive services from a noncontracted provider, you pay the balance bill. See the cost-share for “Nutritional Counseling and Training” under “*Education and Training*” for the cost-shares applicable to these preventive services.

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

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

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

- Preventive physical examination, i.e. routine physical examination, including the following services when done for screening purposes only:
 - ◆ resting electrocardiogram (EKG)
 - ◆ lung function test (spirometry)
 - ◆ vision and hearing screening (this may include newborn audiological evaluation in the hospital)
 - ◆ fecal occult blood test
 - ◆ general health laboratory panel (bilirubin, calcium, carbon dioxide, chloride, creatinine, alkaline phosphatase, potassium, total protein, sodium, ALT, SGPT, AST, SGOT, BUN, TSH)
 - ◆ thyroid function testing (TSH)
 - ◆ complete blood count (CBC)
 - ◆ lipid panel (cholesterol panel and triglycerides)
 - ◆ fasting glucose (blood sugar)
 - ◆ urinalysis
 - ◆ blood lead
 - ◆ sexually transmitted disease (STD) testing
 - ◆ prostate specific antigen (PSA)
 - ◆ TB testing
- Screening for abdominal aortic aneurysm for men ages 65 to 75 who have ever smoked
- Routine gynecologic exam including Pap test and other cervical cancer screening test
- Mammogram
- Bone density testing for osteoporosis
- Screening sigmoidoscopy or colonoscopy
- Routine immunizations and immunizations for foreign travel, as determined by BCBSAZ
- Behavioral intervention to promote breast-feeding for women
- Depression screening for members age 18 and older
- Screening for major depressive disorders for members ages 12 through 18
- Routine screening for iron deficiency anemia for asymptomatic pregnant women
- Counseling and behavioral interventions to promote sustained weight loss for obese adults
- Tobacco cessation counseling and augmented pregnancy counseling for members who use tobacco
- Newborn screenings as required by Arizona and federal law
- Vision screenings for children under age 5
- Alcohol misuse screening and behavioral counseling interventions for pregnant women
- Screening for asymptomatic bacteriuria for pregnant women at 12-16 weeks gestation or at first prenatal visit, if later
- Screening for Hepatitis B virus infection for pregnant women at their first prenatal visit

- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Repeated antibody testing for unsensitized Rh(D)-negative pregnant women at 24-28 weeks gestation, unless the biological father is known to be Rh(D) negative
- Smoking cessation devices, as prescribed

Benefit-Specific Exclusions:

- Except for nutritional counseling and training any service or test not specifically listed in this benefit description, such as chest X-rays, will not be covered when performed for preventive or screening purposes
- Routine physicals provided by an out-of-network provider

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

DD. RECONSTRUCTIVE SURGERY AND SERVICES

Precertification: Required for inpatient admissions. If you fail to obtain precertification for covered inpatient reconstructive surgery and services, you will be responsible for a precertification charge.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

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

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

EE. SKILLED NURSING FACILITY (SNF)

Precertification: Required. If you fail to obtain precertification for a SNF admission, the services will not be covered.

Your Cost-Share:

In-Network: You pay deductible and in-network coinsurance for the first 90 days. You pay deductible and 50 percent coinsurance for the second 90 days. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum.

Out-of-Network: You pay deductible and out-of-network coinsurance for the first 90 days. You pay deductible and 50 percent coinsurance for the second 90 days. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. If you receive skilled nursing facility services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

Benefit Maximum: 180 days of SNF services per member, per calendar year.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share

obligation will change to match your level of care. If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.

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

Benefit-Specific Exclusion: Custodial Care

FF. SPECIALTY SELF-INJECTABLE MEDICATIONS

This benefit plan does not provide specialty self-injectable medication benefits. Contact your group benefit administrator for information.

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

Precertification: Required prior to any organ, tissue or bone marrow transplant or stem cell procedure. If you fail to obtain precertification, the services will not be covered.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

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

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

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

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

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

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

- Inpatient and outpatient facility and professional services
- Air and ground transportation of a medical team to and from the site in the contiguous states of the United States to obtain tissue that is subsequently transplanted into a member

- Bone marrow search and procurement of a suitable bone marrow donor when a member is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
- Chemotherapy or radiation therapy associated with transplant procedures
- Harvest and reinfusion of stem cells or bone marrow
- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ. Covered donor expenses include complications and medically necessary follow-up care related to the donation for up to six (6) months post transplant, as long as the recipient's BCBSAZ coverage remains in effect.
- Pre-transplant testing and services

Benefit-Specific Exclusions:

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

HH. TRANSPLANT TRAVEL AND LODGING

Precertification: Not required.

Your Cost-Share: You pay deductible and in-network coinsurance. Your deductible and coinsurance payments count toward your out-of-pocket maximum.

Benefit Maximum: Plan maximum of \$10,000 per covered member. Covered expenses incurred by a donor, recipient or caregiver accumulate toward the member's \$10,000 plan maximum.

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

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

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

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

Benefit-Specific Exclusions:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of \$200 per day per covered member
- All travel and lodging expenses in excess of the \$10,000 plan maximum per covered member
- Ambulance transportation (ground or air)
- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with noncovered transplant services or any follow-up care, including treatment of complications
- Expenses for travel or lodging related to evaluation, consultation or medical testing to determine if a member is a candidate for transplantation
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Travel and lodging expenses for transplants other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service
- Travel and lodging expenses for members, donors or caregivers when the member, donor or caregiver does not travel more than seventy-five (75) miles for an authorized transplant or transplant related services, including follow-up care and treatment of complications
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement

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

II. URGENT CARE

Precertification: Not required.

Your Cost-Share: You pay deductible and applicable coinsurance. Your deductible and coinsurance payments count toward satisfaction of the out-of-pocket maximum. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill, which does not count toward the out-of-pocket maximum.

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

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

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

JJ. VISION EXAMS (ROUTINE)

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

WHAT IS NOT COVERED

Pre-existing Conditions

A waiting period may apply for coverage of pre-existing conditions for members age 19 and older. 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 member's enrollment date. For purposes of determining a pre-existing condition and pre-existing condition waiting periods, enrollment date means the member'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 member'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.

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

Abortions – Non-spontaneous, medically-induced abortions (by surgical or non-surgical means), except as stated in this plan

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

Acupuncture

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

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

Biofeedback and hypnotherapy

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

Certain Types of Facility Charges – Inpatient and outpatient facility charges for treatment provided by the following facilities are not covered: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes. Inpatient and outpatient facility charges for services provided by residential treatment facilities are not covered except for certain very limited situations based upon BCBSAZ medical necessity criteria. All other inpatient and outpatient services provided by residential treatment facilities are not covered.

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

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

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

Computer Speech Training, Therapy Programs and Devices

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

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

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

Custodial Care

Dental – Except as stated in this plan, dental and orthodontic services; placement or replacement of crowns, bridges or implants; any fixed dental reconstruction of the teeth; orthodontics; extractions of teeth; dentures and procedures associated with the fitting of dentures; vestibuloplasty and surgical orthodontics

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

Expenses for services that exceed benefit limitations

Experimental or Investigational Services

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

Fees – Fees for concierge medicine services

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

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

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

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

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

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

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

Hearing Services and Devices – Routine hearing exams, except for hearing screenings included in a physical exam covered under the “Preventive Services” benefit; and 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.

Lifestyle education and management services

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

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

Manipulation of the Spine Under Anesthesia

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

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

Medications – Medications which are:

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

Medications Dispensed in Certain Settings – Prescription medications given to the member, for the member’s future use, by any person or entity that is not a licensed pharmacy, home health agency, specialty pharmacy or hospital emergency room

Neurofeedback

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

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

Personal Comfort Services – Services intended primarily for assistance in daily living, socialization, personal comfort, convenience and other non-medical reasons

Retail and/or Mail Order Prescription Medications

Reversal of Sterilization

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

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

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

Services from a Family Member – Services delivered by an eligible provider who is a member of your immediate family. “Immediate family” members are: parents, siblings, children, stepparents, stepchildren, spouses, grandparents, grandchildren and any of the preceding individuals related to the member by

marriage. When a provider is also the covered person, services rendered by that provider for himself or herself are also excluded from coverage.

Services from Ineligible Providers

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

Services Prior to Effective Date

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

Services Provided by a Proficient Substitute for a Professional Caregiver – Services that would otherwise require a licensed professional or home health aide, but which are rendered by a proficient family member or other caregiver who is not compensated by BCBSAZ. "Proficient family member or caregiver" means an individual who has been trained to deliver a home health or other service needed by a member, such as tube feeding or change of dressing and has demonstrated proficiency in providing the service.

Services Related to or Associated with Noncovered Services

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

Sexual Dysfunction – Services for sexual dysfunction, regardless of the cause and all medications for the treatment of sexual dysfunction

Smoking Cessation – Smoking cessation programs, medications, aids and devices, except as stated in this plan

Specialty Self-Injectable Medications

Spinal Decompression or Vertebral Axial Decompression Therapy

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

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

Therapy services, except as stated in this plan

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

Transplants and Related Services Not Precertified by BCBSAZ

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

Transsexual Treatment, Surgery, Medications and Related Services

Vision – Routine vision exams, except for preventive vision screenings for members under age 5; vision therapy; all types of refractive keratoplasties; any other procedures, treatments and devices for refractive correction; eyeglasses, contact lenses and other eyewear; vision examinations for fitting of eyeglasses and contact lenses, except as stated in this plan

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

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

CLAIMS INFORMATION

Filing Claims

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

Time Limit for Claim Filing

A complete claim, as described below, must be filed within one year from the date of service. BCBSAZ may deny payment of any claim that is not filed within one year from the date of service.

Claim Forms

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

Complete Claims

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

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

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

Medical Records and Other Information Needed to Process a Claim

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

Explanation of Benefits (EOB) Form

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

Concurrent Care Decisions

BCBSAZ may require that your provider submit a plan of care; you may 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. BCBSAZ will make a determination 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.

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).

Time Period for Claim Decisions:

Post-Service Claims

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

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

Pre-Service Claims

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

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

Urgent Claims

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

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

Adjustments to Out-of-Pocket Costs and Impact on Health Savings Accounts

Sometimes members may have adjustments in their actual incurred expenses for services—adjustments of which BCBSAZ is unaware. (For example, a provider may choose to discount all patients’ cost-share by 2% if the patient pays cash on the day of service. Or, a member may have a discount coupon for the member’s

share of the cost of a drug.) If your out-of-pocket costs are reduced after your provider submits a claim, you must tell BCBSAZ about the reduction so BCBSAZ can properly credit amounts to your deductible and out-of-pocket maximum. If you do not tell us about these adjustments, it could result in inaccurate accumulations and jeopardize your status as an individual eligible for a health savings account.

PLAN ADMINISTRATION

Coordination of Benefits

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

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

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

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

Non-Duplication of Benefits

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

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

Definitions Related to Eligibility and Administration

“**Dependents**” are any of the following individuals: Spouse, Dependent Child (ren), Domestic Partner or children of a Domestic Partner who have completed all required formalities for enrollment for coverage under the plan and is actually covered by the Plan, as those terms are defined in this document. See the definition of Dependent Child/Children, Domestic Partner, Spouse and Domestic Partner Child/Children.

Dependent Child/Children: (see also the definition of Domestic Partner Child)

- A. A Dependent Child is any of the Employee’s or Retiree’s children listed below who are under the age of 26 (whether married or unmarried):
- **natural child**; or
 - **stepchild** (proof of relationship and age may be required); or
 - **legally adopted child**, or child Placed for adoption with the Employee or Retiree; (proof of adoption or placement for adoption may be requested); or
 - **child** for whom the Employee or Retiree has **legal guardianship** sustained by a court order (proof of guardianship may be requested); or
 - **foster child** who meets the following criteria: a child the Participant is raising as their own, or a child who lives in their home, or a child who is chiefly Dependent on them for support, or a child for whom they have taken parental responsibility and control. A foster child is not eligible if a child is temporarily living in the Participant’s home or is a child placed with the Participant in their 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 (proof of foster child status may be requested); or
 - **a child named in a Qualified Medical Child Support Order (QMCSO)** is also an eligible Dependent under this plan.
- B. **Disabled Adult Child:** An unmarried Dependent Child (as defined above) age 26 or older may continue coverage under the medical plan if the child is otherwise eligible for the benefit Plan and meets **all** of the following criteria: is permanently and totally disabled with a disability that existed prior to the attainment of the Plan’s age limit and is chiefly Dependent upon the Employee or Retiree for maintenance and support (meaning the child is claimed as a dependent on the participant’s tax return for each plan year for which coverage is provided). The Plan may require initial and periodic proof of disability.
- C. **It is the Participant’s obligation to inform the Plan promptly if any of the requirements set out in this definition of a Dependent Child are NOT met with respect to any Child for whom coverage is sought or is being provided.**
- D. With the exception of a Dependent Child who is permanently and totally disabled, coverage will terminate for the Child at the end of the month in which that Child reaches his or her 26th birthday or no longer meets the eligibility requirements of the Plan. See also the termination provisions for Dependent Children listed in the **Loss of Eligibility** section later in this chapter.
- E. The following individuals are not eligible under the Plan: a spouse of a Dependent Child (e.g. employee/retiree’s son-in-law or daughter-in-law).

Coverage of a Dependent Child ends at the end of month in which that child:

- reaches his or her 26th birthday (unless is a disabled adult child), **or**
- no longer meets the eligibility requirements of the Plan; **or**
- is no longer disabled or dependency ceases for a disabled dependent child over age 26; **or**
- is no longer eligible for coverage under a medical support order or administrative order; **or**
- the end of the month in which the Employee/Retiree’s death occurs or as provided in the Group Master Contract
- the date the plan is discontinued

“**Domestic Partner**”: An individual who is the same or opposite sex as the eligible Employee. Domestic Partner coverage is only available for Employees of the following employers: Coconino County, Coconino County Regional Accommodation School District #99, City of Flagstaff and Flagstaff Housing Authority (FHA).

“Children of a Domestic Partner”: If a Domestic Partner is enrolled, the Employee may also apply for coverage for the Domestic Partner’s child/children who meet the requirements set out below:

- A.** A Domestic Partner’s Child is any of the Domestic Partner’s Children under the age of 26 (whether married or unmarried):
- **natural child**; or
 - **stepchild** (proof of relationship and age may be required); or
 - **legally adopted child**, or child Placed for adoption with the Domestic Partner; (proof of adoption or placement for adoption may be requested); or
 - **child** for whom the Domestic Partner has **legal guardianship** under a court order (proof of guardianship may be requested); or
 - **foster child** who meets the following criteria: a child the Domestic Partner is raising as their own, or a child who lives in the Domestic Partner home, or a child who is chiefly Dependent on the Domestic Partner for support, or a child for whom the Domestic Partner has taken parental responsibility and control. A foster child is not eligible if a child is temporarily living in the Domestic Partner’s home or a child is placed with the Domestic Partner in their 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 (proof of foster child status may be requested); or
 - **a child named in a Qualified Medical Child Support Order (QMCSO)** is also an eligible Dependent under this plan.
- B. Disabled Adult Child:** An unmarried Dependent Child (as defined above) age 26 or older may continue under the medical plan if the child is otherwise eligible for the benefit Plan and meets all of the following criteria: is permanently and totally disabled with a disability that existed prior to the attainment of the Plan’s age limit and is chiefly dependent upon the Domestic Partner for maintenance and support (meaning the child is claimed as a dependent on the participant’s tax return for each plan year for which coverage is provided). The Plan may require initial and periodic proof of disability.
- C. It is the Participant’s obligation to inform the Plan promptly if any of the requirements set out in this definition of a Domestic Partner or Domestic Partner’s Child are NOT met with respect to any person for whom coverage is sought or is being provided.**
- D.** With the exception of a Dependent Child who is permanently and totally disabled, coverage will terminate for the Child of a Domestic Partner at the end of the month in which that Child reaches his or her 26th birthday or no longer meets the eligibility requirements of the Plan. See also the termination provisions for Dependent Children listed in the **Loss of Eligibility** section later in this chapter. Note that if the Domestic Partner loses benefits under the Plan the Children of a Domestic Partner also lose coverage.
- E.** The following individuals are not eligible under the Plan: a spouse of a Dependent Child of a Domestic Partner (e.g. employee/retiree/Domestic Partner’s son-in-law or daughter-in-law).

Coverage of a Domestic Partner ends in accordance with the termination provisions outlined in the **Loss of Eligibility** section later in this chapter.

Coverage of a Domestic Partner’s Dependent Child ends at the end of the month in which that child:

- reaches his or her 26th birthday (unless is a disabled adult child), **or**
- no longer meets the eligibility requirements of the Plan; **or**
- is no longer disabled or dependency ceases for a disabled dependent child over age 26; **or**
- is no longer eligible for coverage under a medical support order or administrative order; **or**
- the end of the month in which the Employee/Retiree/Domestic Partner’s death occurs or as provided in the Group Master Contract
- the date the plan is discontinued

Note that if the Domestic Partner loses benefits under the Plan the children of a Domestic Partner also lose coverage.

“Domestic Partnership Criteria” (City of Flagstaff and FHA):

A Domestic Partner is defined as a person of the same or opposite gender who:

- Is not a benefit eligible Employee with another NAPEBT employer;
- Has signed jointly with the subscriber, (an active Employee) a notarized affidavit of such Domestic Partner relationship;
- Shares the Employee’s permanent residence;
- Has resided with the Employee continuously and is expected to continue to reside with the Employee indefinitely;
- Has not signed a declaration or Affidavit of Qualified Domestic Partnership with any other person within the last twelve (12) months;
- Is financially interdependent with the Employee in at least two (2) of the following ways:
 - ◆ Holding one or more credit or bank accounts jointly;
 - ◆ Owning or leasing your permanent residence as joint tenants;
 - ◆ Naming your partner as a beneficiary of your life insurance or your will and being named by your partner as a beneficiary or their life insurance or will;
 - ◆ Each agreeing in writing to assume financial responsibility for the welfare of the other (i.e., durable power of attorney);
- Is no less than 18 years of age and is not a blood relative;
- Is not legally married to or legally separated from another person; and
- Both persons are capable of consenting to the Domestic Partnership.

To terminate a Domestic Partner’s coverage, the Employee must complete a “Termination Statement of Domestic Partnership” form within 31 days of the event. Once a Domestic Partnership is terminated another Affidavit of Domestic Partnership cannot be filed until twelve (12) months after a Termination Statement of Domestic Partnership has been filed with the applicable Human Resource Department.

A Domestic Partner and the child of a Domestic Partner may enroll only during Initial Enrollment or during the Open Enrollment period. Coverage of the Domestic Partner or child of a Domestic Partner will become effective the first of the month after the Plan receives a qualified, approved and notarized Domestic Partner Affidavit and/or after a 12 month waiting period.

“Domestic Partnership Criteria” (Coconino County and Coconino County Regional Accommodation School District):

A Domestic Partner is defined as a person of the same or opposite gender who:

- shares a permanent residence with the Employee and has resided with the Employee continuously for at least 12 consecutive months before filing an application for benefits and is expected to continue to reside with the Employee indefinitely as evidenced by completion of the County’s affidavit of Domestic Partnership ; **and**
- has not signed a declaration or affidavit of Domestic Partnership with any other person and has not had another Domestic Partner within the 12 months prior to filing an application for benefits; **and**
- does not have any other Domestic Partner or spouse of the same or opposite sex; **and**
- is not currently married to anyone or legally separated from anyone else; **and**
- is not a blood relative any closer than would prohibit marriage in Arizona; **and**
- was mentally competent to consent to contract when the Domestic Partnership began; **and**
- is not acting under fraud or duress in accepting benefits; **and**

- is at least 18 years of age; **and**
- is financially interdependent in at least three of the following ways (supporting documents are required to be submitted):
 - ◆ having a joint mortgage, joint property tax identification, or joint tenancy on a residential lease;
 - ◆ holding one or more credit or bank accounts jointly, such as a checking account in both names;
 - ◆ assuming joint liabilities (such as a utility bill);
 - ◆ having joint ownership of significant property, such as real estate, a vehicle, or a boat;
 - ◆ naming the partner as beneficiary on the Employee's life insurance, under the Employee's will, or Employee's retirement annuities and being named by the partner as beneficiary of the partner's life insurance, under the partner's will, or the partner's retirement annuities;
 - ◆ each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney.

To terminate a Domestic Partner's coverage the Employee must complete a "Notice of Termination of Domestic Partnership" form within 31 days of the event. Once a Domestic Partnership is terminated another Affidavit of Domestic Partnership cannot be filed until twelve (12) months after a Termination Statement of Domestic Partnership has been filed with the Human Resource Department.

A Domestic Partner and the child of a Domestic Partner may enroll at the same times that are permitted for Employees and coverage becomes effective at the same times as with Employees.

A Domestic Partner can be removed from coverage under the Plan at any time. Once coverage is dropped the Domestic Partner and child of a Domestic Partner can only be re-enrolled at the next Open enrollment period.

"Employee is a person employed by a participating employer of NAPEBT, who is on the payroll of a participating employer of NAPEBT and is eligible to enroll for coverage under the Plan. An Employee does not refer to leased employees and independent contractors. An Employee is also the Contractholder under this plan.

"Group" refers to the employer or other entity to which a Group Master Contract is issued and under which the Employee/Retiree and Dependents become entitled to health coverage.

"Group Master Contract" refers to the agreement between the group and BCBSAZ. The Group Master Contract controls the administration of the group coverage and is on file with the group. The coverage described in this book will terminate when the Group Master Contract terminates. The group is responsible to notify members if the group terminates the Group Master Contract or if the Group Master Contract is terminated for non-payment of premiums. BCBSAZ will notify members if the Group Master Contract is terminated for any other reason.

"Open Enrollment Period" is an annual period during which the Employee/Retiree and Dependents are eligible to enroll for coverage or change benefit plan options. The benefit plan administrator will notify the Employee/Retiree if the group has established such an open enrollment period. Employee/Retirees and Dependents can change benefit plans only during an open enrollment period, except as set forth in this benefit book.

"Retiree" is a person who was employed by a participating employer of NAPEBT and meets criteria to be eligible for coverage under this benefit plan.

Eligibility Requirements

- **Dependent Children** – See above for eligibility requirements for Dependent Children.
- **Disabled Adult Child** – See above for eligibility requirements for Disabled Adult Child.
- **Employee/Retiree** – An Employee/Retiree becomes eligible to enroll for coverage after meeting the group's eligibility requirements outlined in the Group Master Contract.
- **Retiree** – Please see your benefit plan administrator to determine eligibility requirements for a Retiree and his/her eligible Dependents.

Effective Date of Coverage

- **Employee/Retiree** – An Employee/Retiree's effective date of coverage will be either the date the Employee/Retiree becomes eligible to enroll or the first billing date after the Employee/Retiree becomes eligible to enroll as determined by the Group, as long as the Employee/Retiree completes the application process within thirty-one (31) days of becoming eligible. See your schedule page for Employee/Retiree effective date.
- **Dependent** – Dependent coverage is available only if an eligible Employee/Retiree has enrolled for coverage. Eligible Dependents will have the same effective date as the Employee/Retiree if they are included on the application at the time the Employee/Retiree first enrolls. If the Employee/Retiree and/or Dependents do not enroll when first eligible, the Employee/Retiree and/or Dependents may only apply for coverage at the group's annual open enrollment period, except as stated in "*Special Enrollment Provisions*" or if court-ordered. The effective date of coverage for an application made during an open enrollment period is the group's anniversary date following that open enrollment period.
- **Spouse** – The effective date for a new spouse will generally become effective on the date of marriage, as long as the Employee/Retiree completes an application within thirty-one (31) days of that date; otherwise, the spouse may not enroll until the next open enrollment period, unless he or she qualifies under "*Special Enrollment Provisions*."
- **Domestic Partner** – See above for effective date for Domestic Partners.
- **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 and the newborn child or child adopted or placed for adoption is otherwise an eligible dependent under this benefit plan. BCBSAZ will continue coverage for the child after the thirty-one (31) day period if the Employee/Retiree submits the appropriate enrollment documentation to the Group within the first thirty-one (31) days after the date of birth, adoption or placement for adoption and BCBSAZ receives notice from the Group that the child will continue to be enrolled in this benefit plan. No claims incurred beyond the first thirty-one (31) days following birth, adoption or placement for adoption will be processed unless the child continues to be enrolled in this benefit plan after the first thirty-one (31) days. If the parent or guardian covered under this benefit plan does not enroll the child within thirty-one (31) days following the date of birth, adoption or placement for adoption, the child's coverage will be terminated.

Contact Membership Services at the number listed in the front of this benefit plan book to receive a BCBSAZ adoption packet.

- **Other Children** – The effective date for a Dependent Child who is not a newborn child, adopted child or a child placed for adoption (as described above) shall be the date the child becomes an eligible Dependent Child, as long as the Employee/Retiree completes an application to add the child within thirty-one (31) days of that date. If an application is not completed within thirty-one (31) days, the child may not enroll until the next open enrollment period, unless the child qualifies under "*Special Enrollment Provisions*."
- **Retiree** – Please see your benefit plan administrator to determine effective dates of coverage for a Retiree and his/her eligible Dependents.

Loss of Eligibility

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

NAPEBT has up to sixty (60) days to notify BCBSAZ that an Employee/Retiree or Dependent has become ineligible. Until BCBSAZ receives notice and processes the termination of eligibility, BCBSAZ may quote benefits, give precertification or pay claims (that ultimately will be recouped from members or providers, if it is later determined the member was ineligible on the date services were received). Such benefit quotations or precertifications become null and void, regardless of whether NAPEBT has notified the Employee/Retiree that eligibility terminated.

Employee/Retiree eligibility ends on the following days:

- The end of the month in which the Employee/Retiree was entitled to receive benefits in accordance with the NAPEBT plan eligibility rules.
- The end of the month in which an approved leave of absence expires, if the Employee fails to return to active employment.
- The date of death.

Dependent spouse eligibility ends on the following days:

- the end of the month in which the divorce decree is final; or
- the end of the month in which the Employee/Retiree's death occurs or as provided in the Group Master Contract.

Retiree eligibility:

Please see your benefit plan administrator for information regarding loss of Retiree's eligibility and termination dates of coverage and the dates for a Retiree's Dependents.

When Coverage Ends (Termination of Coverage)

WHEN COVERAGE ENDS	WHOSE COVERAGE ENDS				
	EM- PLOY- EE	RETIREE*	DEPEN- DENT (SPOUSE AND CHILD)	DOM- ESTIC PART- NER	CHILD OF A DOM- ESTIC PARTNER
On the last day of the month in which the Employee's employment ends	✓		✓	✓	✓
On the last day of the month in which the Retiree's coverage ends		✓	✓	✓	✓
On the last day of the month in which THE Employee or Spouse enter the Armed Forces (the military) on full-time active duty (except the County – please see NAPEBT's Administrative Manual for more information.)	✓		✓	✓	✓
On the last day of the month in which you are no longer eligible to participate in the Plan	✓	✓	✓	✓	✓
On the last day of the month in which you cease to make any contributions required for your coverage	✓	✓	✓	✓	✓
The date the Plan is discontinued	✓	✓	✓	✓	✓
The date of the Employee's or Retiree's death** (Dependents have coverage through the end of the month in which the Employee dies; however see the special provision for extension of coverage for a surviving spouse/dependent child in this Eligibility chapter)	✓	✓	✓	✓	✓
(For all NAPEBT Employers except the County's dental, vision, and life insurance coverage) the earlier of the last day of the month <u>prior to</u> the month in which the Retiree or disabled Employee becomes entitled (eligible and enrolled) in Medicare Part A or B.		✓			
The date the Retiree becomes 65 years of age (<i>except for the County, where if retired prior to July 1, 2011: then eligible for Medical until the earlier of Medicare entitlement or age 65; eligible for Dental and Vision (indefinitely) and Life Insurance eligible to age 70. If retired on or after July 1, 2011: then eligible for Medical until the earlier of Medicare entitlement or age 65; eligible for Dental and Vision to age 65 and Life Insurance eligible to age 70.</i>)		✓			
The expiration of the period of coverage stated in the QMCSO.			✓		✓
For a Surviving Lawful Spouse and Surviving Dependents of a deceased law enforcement officer, coverage ends on the earliest of the following: <ul style="list-style-type: none"> • the last day of the month in which the surviving lawful Spouse and Dependents are no longer eligible to participate in the Plan (includes circumstances in which: (1) the 12 months of coverage for the surviving lawful Spouse and Dependents is exhausted; and (2) the surviving Dependents no longer meet the definition of Dependent Child(ren) as provided in the Definitions chapter of this document); or • the date the surviving lawful Spouse and surviving Dependents cease to make the contributions required for coverage; or • the date the Plan is discontinued. 			✓		

Employee/Retirees' and/or Dependents' coverage ends no later than the date the Group Master Contract terminates.

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

Special Enrollment Provisions

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

- The person requests coverage under this benefit plan by completing an application within sixty (60) days of either of the following:
 - ◆ The person loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP); **or**
 - ◆ The person receives notice that he or she is eligible for a CHIP premium assistance subsidy; **or**
- At the time of the initial enrollment period, the Employee or Dependent: (1) was covered under a public **or** private health insurance policy or other health benefit plan; (2) lost coverage under the other policy or plan for one or more of the reasons listed below, as applicable to the individual seeking coverage; and (3) requests coverage under this benefit plan by completing an application within thirty-one (31) days:
 - ◆ of loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of Employee to pay premiums on a timely basis or termination of the other coverage for cause); **or**
 - ◆ of termination of Employer contributions toward that other coverage (an Employer's reduction but not cessation of contributions does not trigger a Mid Year Change of Status right); **or**
 - ◆ the health insurance was provided under COBRA Continuation Coverage, and the COBRA coverage was "**Exhausted**"; **or**
 - ◆ of moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other Plan; **or**
 - ◆ of the other Plan ceasing to offer to a group of similarly situation individuals; **or**
 - ◆ of the loss of Dependent status under the other Plan's terms; **or**
 - ◆ of the termination of a benefit package option under the other Plan, unless substitute coverage offered; **or**
 - ◆ of the loss of eligibility due to reaching the lifetime benefit maximum on all medical Plan benefits under the other medical Plan. (For Mid Year Change of Status that arises from reaching a lifetime benefit maximum on all medical Plan benefits, an individual will be allowed to request Mid Year Change of Status in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all medical Plan benefits.
- BCBSAZ receives an application from one of the following persons seeking coverage under this benefit plan, within thirty-one days of one of the following qualifying events, as applicable to the individual seeking coverage:
 - ◆ The person becomes a Dependent of an Employee/Retiree or Employee/Retiree's spouse through marriage, birth, adoption or placement for adoption.
 - ◆ The person exhausts a lifetime maximum on all benefits under the other policy or plan (qualifying event is denial of a claim due to operation of a lifetime maximum).
 - ◆ 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.

Leave of Absence

Please see your group benefits administrator for information regarding coverage during a leave of absence.

BCBSAZ will also continue coverage for members during any leave of absence the group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 and any amendments or successor provisions. If the Employee/Retiree returns to active employment by the end of the leave of absence period, coverage under this benefit plan will continue for the Employee/Retiree and covered Dependents, so long as the group maintains coverage with BCBSAZ. If not, the Employee/Retiree will cease to be eligible and coverage for the Employee/Retiree and Dependent(s) will terminate as described in "*Termination of Coverage.*"

Medical Support Orders

Coverage is available to a child of the Employee/Retiree in accordance with any court order or administrative order issued by a court of competent jurisdiction that requires the Employee/Retiree to provide health benefits coverage for such child.

The order must clearly specify the name of the Employee/Retiree, the name and birth date of each child covered by the order and the time period to which the order applies.

Following receipt of the above information from the group, BCBSAZ will add the child to the Employee/Retiree's coverage, subject to the guidelines for adding Dependent Children as outlined above. If the Employee/Retiree does not have family coverage, the Employee/Retiree is required to enroll for family coverage and pay any additional required premium.

Termination of Coverage

Benefits After Termination

Except as described below, you have no coverage on and after the date coverage ends, regardless of the reason for termination. **There is one exception.** If a member is an inpatient in an acute care hospital on the day coverage ends, benefits for covered inpatient facility services delivered during that admission will be provided under this plan. **Any professional services rendered during the stay, but after the date of termination, are not covered.** This exception for continued coverage does not apply to inpatient stays in long-term acute care, skilled nursing, extended active rehabilitation or behavioral health facilities.

Certificates of Creditable Coverage

When your coverage ends, BCBSAZ will send you a certificate that shows the period you were covered under this plan. If you do not receive your certificate within thirty (30) days of your termination, you may request a certificate by contacting BCBSAZ Membership Services at any time up to twenty-four (24) months after your coverage ends.

Continuation of Coverage

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

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

Continuation of coverage is available when an Employee is absent from employment by reason of service in the uniformed services, as defined by applicable federal law. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Disability Extension of Benefits

BCBSAZ determines total disability in its sole and absolute discretion and will provide a copy of the criteria used to make this decision upon request. Eligibility to continue coverage for a disabling condition is subject to periodic review by BCBSAZ.

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

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

- **Individual Termination:** If you are totally disabled on the date your coverage 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, BCBSAZ cannot pay claims until notice is received.

When you provide notice, you will also be required to provide reports satisfactory to BCBSAZ that show the date of your termination, the condition that resulted in you becoming totally disabled and that you have been totally disabled from that condition from the time of such termination.

If you are eligible for an extension of benefits because of an individual termination as described above and you elect continuation coverage under COBRA, the extension of benefits shall run concurrently with your continuation coverage under COBRA, until the 12-month extension of benefits period is exhausted. Because these provisions run concurrently, please contact your employer before making any changes to or terminating your COBRA continuation coverage.

Individual Portability Coverage

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

- You have eighteen (18) months of prior continuous creditable coverage; the most recent coverage must be with a group, government or church plan, **and**
- You are no longer eligible for a group plan, Medicare or Medicaid, **and**
- Coverage was not terminated for non-payment of premium or fraud, **and**
- You elected and exhausted COBRA continuation coverage (or other similar coverage) if this coverage was available to you, **and**
- You apply for individual portability coverage within sixty-three (63) days of the date your group (or COBRA) coverage ends.

Please contact BCBSAZ for information on individual portability coverage.

Conversion Coverage

If this benefit plan terminates because the group changes its insurance plan, you are not eligible for a conversion contract.

If your coverage under this benefit plan ends for any reason other than the group changing insurance plans and you maintain your permanent residence in Arizona, you may apply for an individual conversion contract offered by BCBSAZ.

BCBSAZ must receive your written application 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

Each Blue Cross and Blue Shield (BCBS) plan is required to offer a transfer policy to members of other BCBS plans who are under age 65.

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

Transfer coverage available to you from the other BCBS plan may be very different from the coverage under this plan. You may have to apply and meet medical underwriting requirements just like any other new member. You may or may not receive credit for pre-existing condition waiting periods. Policies that do not require medical underwriting or that do not have pre-existing condition limitations may have significantly higher premiums and deductibles.

If you do not wish to enroll in the transfer coverage, you may be eligible for other policies issued by other BCBS plans.

BCBSAZ Continuous Coverage Policy

If you are terminating your BCBSAZ group coverage and you were covered under a BCBSAZ medically underwritten individual policy immediately prior to your BCBSAZ group coverage, you may be eligible to return to similar 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 Membership Services at the numbers listed in the front of this book.

Benefit-Specific Eligibility

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

- If a transplant recipient is covered under this plan and the donor is not a member, the donor may be eligible for limited benefits (see benefit descriptions for Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures and Transplant Travel and Lodging).
- If a non-member is pregnant with a baby that is to be adopted by a BCBSAZ member of this plan, the non-member may be eligible for maternity benefits under the following circumstances:
 - ◆ The child is adopted by a BCBSAZ member within one year of birth;
 - ◆ The member is legally obligated to pay the costs of birth; **and**
 - ◆ The member notified BCBSAZ that a court has certified the member as acceptable to adopt within 60 days of the court order or the effective date of this plan, whichever occurs later.

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

GENERAL PROVISIONS

Appeal and Grievance Process

Members may participate in BCBSAZ's appeals and grievances processes, which are described in detail in the Health Coverage Appeal Information Packet, a separate document provided to you with this booklet. You may ask BCBSAZ for another copy of the Health Coverage Appeal Information Packet at any time by submitting a request through www.azblue.com or by calling the BCBSAZ Supply Line telephone number listed in the front of this booklet.

You do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ. To appeal a denial of precertification for urgently needed services you have not yet received, please call the BCBSAZ Precertification Denial Appeals telephone number listed in the front of this booklet.

Billing Limitations and Exceptions

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

A.R.S. § 33-931 may give providers medical lien rights independent of this benefit plan or any contract with BCBSAZ. BCBSAZ is not a party to any collection dispute that may arise under the provisions of A.R.S. § 33-931.

Blue Cross and Blue Shield Association

You hereby expressly acknowledge and agree to the following:

- i. This benefit plan constitutes a contract between the group and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSAZ to use the Blue Cross and/or Blue Shield service marks in the State of Arizona;
- ii. BCBSAZ is not contracting as the agent of the Association;
- iii. In accepting the benefits of this plan, you are not relying on any representations by the Association or any other Blue Cross or Blue Shield plan, other than BCBSAZ; **and**
- iv. You will not seek to hold the Association or any Blue Cross and Blue Shield plan other than BCBSAZ, accountable or liable for BCBSAZ's obligations herein.

Broker Commissions

BCBSAZ sells health and dental coverage products either directly or through independent licensed insurance brokers. Commission payments to brokers are one of the costs factored into premiums, but BCBSAZ's premium calculation is not based on whether a product is sold directly or by a broker. BCBSAZ generally pays a commission to the broker of record or legal assignee designated by the broker until the insurance contract is terminated, the group terminates its relationship with the broker and notifies BCBSAZ or the broker becomes ineligible for receipt of commissions. Brokers are required under their agreement with BCBSAZ to provide information on commission rates with BCBSAZ.

Claim Editing Procedures

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

Confidentiality and Release of Information

BCBSAZ takes confidentiality very seriously. We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with state and federal law. If you wish to authorize someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from www.azblue.com or call BCBSAZ customer service and request a hard copy of the CIRF form.

Court or Administrative Orders Concerning Dependent Children

When a member is not the custodial parent of a child, but is required by a court or administrative order to provide health benefits to that child, BCBSAZ will provide benefit information to the custodial parent, permit the custodial parent to submit claims for the child and make payments directly to the custodial parent, provider or state agency as applicable.

Access to Information Concerning Dependent Children

BCBSAZ is not a party to domestic disputes. Parental disputes over dependent coverage and information must be resolved between the parents of the dependent child. Under Arizona law, both parents have equal rights of access to information about their children, unless there is a court order denying such access. Absent a copy of such order and subject to the confidentiality provisions described above, BCBSAZ provides equal parental access to information.

Discretionary Authority

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

Provider Treatment Decisions and Disclaimer of Liability

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

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

Lawsuits against BCBSAZ

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

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

Attn: Legal Department
Mail Stop: C300
Blue Cross Blue Shield of Arizona, Inc.
8220 N. 23rd Avenue
Phoenix, AZ 85021-4872

Failure to comply with these provisions may result in dismissal of the lawsuit.

A member must complete all applicable levels of appeal before bringing a lawsuit other than a suit filed pursuant to the Health Care Insurer Liability Act. Failure to complete the mandatory levels of the appeal process may result in dismissal of the lawsuit for failure to exhaust BCBSAZ's administrative remedies.

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

Legal Action and Applicable Law

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

This benefit book and the contract between BCBSAZ and the sponsor of your group health plan were issued in Arizona to a group headquartered in Arizona. The only state law governing the benefit book and the contract is the law of the state of Arizona. This benefit plan may not provide all benefits required by other state laws.

Jurisdiction and Venue

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

Lawsuits by BCBSAZ

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

Non-Assignability of Benefits

The benefits contained in this plan are not assignable. You may not assign or transfer by any means the rights to receive any portion of your benefits to any person or entity.

Medicaid Reimbursement

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

Member Notices and Communications

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

Payments Made in Error

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

Plan Amendment

There is no guarantee of continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted or changed upon notice to the group and/or Employee/Retiree or as required to comply with state or federal laws. Some mandated benefits or other plan provisions may be required or

unavailable based on the size of the employer group. At the time of renewal, if your group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available. Please review and retain this book, any replacement books, all schedule pages, all riders and amendments and other communications concerning your coverage.

Retroactive Changes

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

Provider Contractual Arrangements

The BCBSAZ allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors such as type and location of provider and other relevant information. For that reason, BCBSAZ network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate.

Release of Records

Subject to Arizona or federal law, the member agrees that BCBSAZ may obtain, from any provider, insurance company or third party, all records or information relating to the member's health, condition, treatment, prior health insurance claims or health benefit program.

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. In-network providers generally cannot charge you for providing BCBSAZ with health records needed to process claims, grievances or appeals. Out-of-network providers have no contractual obligation to provide records to BCBSAZ free of charge. If you receive services from an out-of-network provider who charges for record preparation, costs or copies, you will need to make arrangements with your provider to obtain any records required by BCBSAZ and pay any applicable fees.

Statement of ERISA Rights

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

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

For purposes of ERISA, your employer is the "Plan Administrator." BCBSAZ is not the Plan Administrator.

ERISA provides that all members shall be entitled to:

- **Receive information about your plan and benefits**
Under ERISA, you are entitled to examine, without charge, at the Plan Administrator's office and other locations, such as worksites and union halls, all documents governing the Plan that are available from the Plan Administrator, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Upon written request to the Plan Administrator, you may obtain copies of the Plan documents, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may charge you for the copies.
- **Continue group health plan coverage**
COBRA is the abbreviation for a federal law that regulates continuation of health care coverage for you, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Unless you have an agreement with your employer to pay your COBRA premiums, you or your dependents will be responsible for full payment of the premium to continue coverage under your group plan. Review your benefit book and talk to your benefits administrator about your COBRA continuation coverage rights.

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

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

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

- **Prudent actions by plan fiduciaries**

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

- **Enforce your rights**

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Third-Party Beneficiaries

The provisions of this benefit plan are only for the benefit of those covered under this plan. Except as may be expressly set forth in this book, no third party may seek to enforce or benefit from any provisions of this benefit plan.

Your Right to Information

You have the right to inspect and copy your information and records maintained by BCBSAZ, with some limited exceptions required by law. This right is described in the Notice of Privacy Practices provided to you at the time of enrollment and available by request from BCBSAZ. If you choose to review your medical records in person, BCBSAZ will require a reasonable amount of time to research and retrieve the records before scheduling a time with you to review the records.