PPO Actives

$600 Plan

Benefit Book

City of Phoenix

Group # 40000

Effective January 1, 2024

azblue.com

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

City of Phoenix
Preferred Provider Organization Actives Medical Certificate

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") to provide its employees with healthcare 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 Preferred Provider Organization (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 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 Medical Certificate describes the benefits for employees and their dependents that are eligible for and have elected coverage, under the PPO Medical Certificate. BCBSAZ may distribute a similar document 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 Medical Certificate 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 healthcare plan, benefits provided in this PPO plan may not include all benefits required for those healthcare plans which are not self-funded. Read this Medical Certificate carefully to understand the benefits and limitations of the PPO benefit plan.

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact BCBSAZ at one of the numbers on the back of your ID card.

MyBlue℠

BCBSAZ also makes information available at www.azblue.com, and you may wish to look there before calling. MyBlue 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 MyBlue account. After you register for MyBlue, you can*:

- View claims and benefits information
- Track deductible, if applicable to your plan
- Update account information
- Verify enrollment status
- Order ID cards
- Search for providers
- Compare hospitals

*Access to MyBlue links and services will vary based on benefit plan type.

BCBSAZ Customer Service

Customer Service phone numbers for your plan are on the back of your member ID card.

Hours:	Customer service hours are Monday through Friday, 6:00 a.m. to 6:00 p.m. MST (except holidays). All other services are available Monday through Friday, 8:00 a.m. to 4:30 p.m. MST (except holidays).
If you lose your ID card and need a replacement:	(602) 864-4400 (within the Phoenix Metro area) (800) 232-2345 (outside of Phoenix Metro)
Hearing Impaired (TTY):	(800) 770-8973, TTY: 711
For assistance in Spanish (en Español):	(602) 864-4884
Mailing Address:	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466

Benefits Administrator Contact Information

Telehealth Services Administrator (TSA):	Log in to MyBlue and click on the BlueCare Anywhere℠ link; download the BlueCare Anywhere app available on Google Play™ store or the App Store®; go to www.BlueCareAnywhereAZ.com; or call (844) 606-1612

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App Store is a service mark of Apple Inc., registered in the United States and other countries.

Claim Submissions

Mail new claims to:	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix, AZ 85062-2924
Mail claims for out-of-network services to:	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix, AZ 85062-2924
Claims for Transplant Travel and Lodging:	Attention: Transplant Travel Claim Processor, Mail Stop: A223, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
Claims for services received on a cruise ship:	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466

Disputes

Medical Appeals and Grievances:	Call the Customer Service number on the back of your ID card.
Prior Authorization Denial Appeals:	Call the Customer Service number on the back of your ID card.
Chiropractic Care Disputes:	Call the Chiropractic Care Customer Service number on the back of your ID card.

Social Media

Like us on Facebook: www.facebook.com/bcbsaz
Follow us on X: www.twitter.com/bcbsaz
Email complaints and concerns to socialcares@azblue.com

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 prior authorization charges. BCBSAZ uses the Allowed Amount to accumulate toward any out-of-pocket maximum that applies to the member's benefit plan. The Allowed Amount does not include any balance bills from noncontracted providers. The Allowed Amount is neither tied to, nor necessarily reflective of, the amounts providers in any given area usually charge for their services. The table below shows how BCBSAZ determines the Allowed Amount.

Type of Provider	Type of Claim	Basis for Allowed Amount
Providers contracted with BCBSAZ as plan network providers	Emergency and non-emergency	Lesser of the provider's billed charges or the applicable fee schedule, with adjustments for any negotiated contractual arrangements and certain *"Claims Editing Procedures and Pricing Guidelines."*
Providers contracted with a vendor	Emergency and non-emergency	Generally, the lesser of the provider's billed charges or the vendor's fee schedule, with adjustments for any negotiated contractual arrangements.
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue")	Emergency and non-emergency	Lesser of the provider's billed charges or the price the Host Blue plan has negotiated with the provider.
Noncontracted providers in Arizona, including providers contracted with another BCBSAZ network but not as a plan network provider for this benefit plan	Non-emergency	Lesser of the provider's billed charges or the applicable fee schedule, with adjustments for certain *"Claims Editing Procedures and Pricing Guidelines."*
Noncontracted providers (outside Arizona)	Non-emergency	Lesser of the provider's billed charges or the amount the Host Blue would pay the nonparticipating provider. In the event that the Host Blue has not established an amount it would pay the nonparticipating provider, the Allowed Amount is based on the applicable fee schedule, with adjustments for certain *"Claims Editing Procedures and Pricing Guidelines."*
Noncontracted ground ambulance providers, including providers contracted with another BCBSAZ network, but not contracted as a plan network provider for this benefit plan, in and outside Arizona	Emergency	The allowed amount is based upon the ambulance provider's billed charges.
Noncontracted providers in an in-network facility (in and outside Arizona)	Non-emergency and non-ancillary	The Qualifying Payment Amount, as defined by federal law, is the allowed amount. If you sign a consent for a noncontracted provider to perform services at an in-network facility, you are responsible for the difference between the Qualifying Payment Amount and the provider's billed charges.
Noncontracted providers, excluding air ambulance, in and outside Arizona	Emergency	The Qualifying Payment Amount, as defined by federal law, is the allowed amount.
Noncontracted air ambulance providers in and outside Arizona	Emergency and non-emergency	Lesser of the provider's billed charges or the applicable BCBSAZ fee schedule, with adjustments for certain *"Claims Editing Procedures and Pricing Guidelines."* The member's cost share will be based on the lesser of the provider's billed charges or the Qualifying Payment Amount, as defined by federal law.

"Ancillary Services" are services that include emergency medicine, anesthesiology, pathology, radiology, neonatology, certain laboratory services, or as otherwise required by law.

"BCBSAZ" or "We" means Blue Cross Blue Shield of Arizona, when acting as the issuer of insurance coverage or as the administrator of a group benefit plan. Within this Medical Certificate, "BCBSAZ" or "We" may also include contracted vendors, when a contracted vendor is performing functions on behalf of BCBSAZ.

Blue Cross Blue Shield of Arizona is an independent licensee of the Blue Cross and Blue Shield Association. BCBSAZ is a not-for-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 healthcare services organization as a line of business.

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

"Behavioral Health Benefits" means benefits for services to treat behavioral health conditions that are classified as behavioral health conditions based on generally recognized independent standards of current mental health, including the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or the most current version of the International Classification of Diseases (ICD).

"Billed Charges" means:
- For a provider that has a participation agreement governing the amount of reimbursement, the amount the provider routinely charges for a service;
- For a provider that has no participation agreement governing the amount of reimbursement, the lowest amount that the provider is willing to accept as payment for a service.

"Blue Distinction®" is a national designation awarded by Blue Cross and Blue Shield (BCBS) Plans to recognize providers that demonstrate expertise in delivering quality specialty care—safely, effectively, and cost-efficiently.

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

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

"Cost Share" means the member's financial obligation for a covered service. Depending on the plan type, Cost Share may include one or more of the following: access fee, balance bill, coinsurance, copay, deductible, and prior authorization charges.

"Custodial Care" means health services and other related services that meet any of the following criteria:
- Are for comfort or convenience;
- Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition, or other self care;
- Are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as a licensed practical nurse (LPN), registered nurse (RN), or licensed therapist; **or**
- Do not seek to cure.

"Diagnosis Related Grouping (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.

"Domiciliary Care" is a supervised living arrangement in a home-like environment for individuals who are unable to live independently and who need assistance with activities of daily living, such as bathing, dressing, and food preparation.

"Evidence-based Criteria" means medical, pharmaceutical, dental, and administrative criteria, which are based on industry-standard research and technology. These criteria help BCBSAZ determine whether a service, procedure, device, or drug meets the industry standard for medical necessity and/or is a covered benefit. Criteria may include prescription medication or service limitations. BCBSAZ ensures that Evidence-based Criteria is reviewed regularly and updated in response to changes and advancements in the healthcare industry. Decisions are based on the Evidence-based Criteria in effect at the time of service. You can obtain additional information by calling the Customer Service number on your ID card. BCBSAZ contracted vendor(s) may establish Evidence-based Criteria of their own for services the vendor provides or administers pursuant to the vendor's contract with BCBSAZ.

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

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

“Group Master Contract” means the legal agreement between the group and BCBSAZ.

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

“Medical Certificate,” “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 your summary of benefits and coverage (SBC), your application for coverage, any plan that is issued to replace this plan and any rider, amendment, or modification to this plan.

“Medical/Surgical Benefits” means benefits for services to treat medical conditions that are classified as medical/surgical based on generally recognized independent standards of current medical practice, including the most current version of the ICD.

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

“PCMH Providers” are providers who participate in BCBSAZ’s patient centered medical home (PCMH) program.

“Physician” for purposes of classifying benefits and member cost shares in this benefit plan, means a properly licensed MD, DO, DPM, or DC.

“Plan Network” means the network of providers contracted to provide services to members of this benefit plan. Plan Network providers are also referred to as in-network providers. See your SBC and ID card for the name of the Plan Network for this benefit plan.

“Primary Care Provider (PCP)” means a healthcare 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 Medical Certificate does not require you to have a PCP or to have a PCP authorize specialist referrals.

“Prior Authorization” is a review done by BCBSAZ to approve a service, treatment plan, doctor visit, or medication before you make the appointment or fill the prescription. Some services and medications require this review in order for the service or medication to be covered under your plan. If an out-of-network provider does not get a prior authorization from BCBSAZ for a service that requires it, you are subject to either a prior authorization charge or a complete loss of benefit. If you have to pay a prior authorization charge, it does not count toward the calendar-year deductible or out-of-pocket maximum.

“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. A Provider can be related to a member.

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

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

“Service” means a generic term referencing some type of healthcare treatment, test, procedure, supply, medication, technology, device, or equipment.

“Specialist” means either a physician or other healthcare professional who practices in a specific area other than those practiced by PCPs, or a properly licensed, certified, or registered individual healthcare provider whose practice is limited to rendering behavioral health services. For purposes of cost share, this definition of Specialist does not apply to dentists. BCBSAZ does not require you to obtain an authorization or referral to see a Specialist.

“Summary of Benefits and Coverage (SBC)” means a federally required document in a specified template with information on applicable access fees, coinsurance percentages, copays, deductible amounts, other cost-sharing amounts, benefits, exclusions, limitations, and other important information. BCBSAZ generally sends SBCs with member ID cards. Please keep your current SBC with your Medical Certificate.

“Telehealth Services Administrator (TSA)” means Amwell, an independent company contracted with BCBSAZ to provide contracted providers, an interactive web platform allowing members to interact with providers, and technical support for telehealth services (i.e., BlueCare Anywhere) covered under this plan.

“Telehealth Services from BlueCare Anywhere” means medical and behavioral health services provided online via video using a computer, tablet, smartphone, or other mobile device through the telehealth services administrator. BlueCare Anywhere is BCBSAZ’s telehealth service.

UNDERSTANDING THE BASICS

Your Responsibilities

Before you receive services:
- Check your provider's network status and know whether your provider is a plan network provider with BCBSAZ.
- Know how much cost share you will have to pay.
- Know the limits and exclusions on coverage.
- Know your coverage.
- Read your benefit materials.

After you receive services:
- Read your explanation of benefits (EOB) and monthly health statements.
- Tell BCBSAZ if you see any differences between the member cost share on your claims documents and what you actually paid.

BCBSAZ ID Card

Bring your ID card with you each time you seek healthcare services, and have your ID card available for reference when you contact BCBSAZ for information. BCBSAZ will mail you an ID card with basic information about your coverage:
- Cost-share amounts
- Identification numbers
- Important phone numbers and addresses
- Who is covered

Changes

You will be notified of any changes to this plan as required by law. You will be provided with 60 days advance written notice of material modifications to this plan.

Covered Services

To be covered, a service or item must be all of the following:
- A benefit of this plan;
- Approved when prior authorization is required;
- Medically or dentally necessary as determined by BCBSAZ or BCBSAZ's contracted vendor(s);
- Not excluded under any provision of this plan;
- Not experimental or investigational as determined by BCBSAZ or BCBSAZ's contracted vendor(s) (does not apply to covered services as part of an approved clinical trial);
- Provided while this Medical Certificate is in effect and while the person claiming benefits is eligible for benefits; **and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ or BCBSAZ's contracted vendor(s).

Experimental or Investigational Services

BCBSAZ, or BCBSAZ's contracted vendor, in its sole and absolute discretion, decides whether a service or item is experimental or investigational. A service or item is considered experimental or investigational unless it meets all of the following criteria:
- The improvement resulting from the service or item must be attainable outside the investigational setting;
- The scientific evidence must permit conclusions concerning the effect of the service or item on health outcomes;
- The service or item must be as beneficial as any established alternative;
- The service or item must have final approval from the appropriate governmental regulatory bodies (unless otherwise required by applicable law, final approval of a regulatory body does not, in and of itself, qualify a service or item for coverage) if applicable; **and**
- The service or item must improve the net health outcome.

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

- 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;
- The provider rendering the service or item documents that the service or item is experimental or investigational; **or**
- The service or item 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 or item is submitted for prior authorization or rendered.

Medically Necessary

BCBSAZ, or BCBSAZ's contracted vendor, in its sole and absolute discretion, decides whether a service is medically necessary based on the following definition. A medically necessary service is a service that meets all of the following requirements:

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

Medical Necessity Guidelines and Criteria

BCBSAZ uses evidence-based criteria to make medical necessity decisions. Call the Customer Service number on your ID card for additional information on evidence-based criteria. BCBSAZ contracts with vendors to administer some or all of the benefits covered under this plan. These contracted vendors make medical necessity determinations based on their own medical necessity criteria, which are also available to you on request.

Decisions about medical necessity may differ from your provider's opinion. A provider may prescribe, order, recommend, or approve a service that BCBSAZ decides is not medically necessary and therefore is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered. If you have an adverse determination, refer to the "*Explanation of Benefits (EOB) Form and Monthly Member Health Statement*" and the "*Appeal and Grievance Process*" sections. Also, not all medically necessary services are covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A service may be medically necessary and still excluded from coverage.

PROVIDERS

Know your provider's network and eligibility status before you receive services.

Provider Directory

The BCBSAZ provider directory is available online at www.azblue.com. If you do not have Internet access, would like to request a paper copy of the directory, or you have questions about a provider's network participation, call BCBSAZ Customer Service at the number on your ID card before you receive services.

Provider Eligibility and Network Status

To be eligible for coverage, a service must be rendered by an eligible individual provider acting within his or her scope of practice, and, when applicable, performed at an eligible facility that is licensed or certified for the type of procedure and services rendered.

Eligible Providers

Not all medical professionals are eligible providers. Eligible providers include the properly licensed, certified, or registered providers listed below, when acting within the scope of their practice and license. Scope of practice is determined by the regulatory oversight agency for each health profession. It means the procedures, actions, and processes that a licensed or certified medical professional is legally allowed to perform based on the individual's specific education and experience and demonstrated competency. For example, neurosurgery would not be within the scope of practice for a dentist.

Benefits may also be available from other healthcare professionals whose services are mandated by federal or Arizona 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. Not all eligible providers are contracted to participate in the plan network.

ELIGIBLE PROVIDER LIST	
Professional	**Facility Ancillary**
• Board Certified Applied Behavioral Analyst (BCABA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Certified Registered Nurse First Assist (CRNFA) • Doctor of chiropractic (DC) • Doctor of dental surgery (DDS) • Doctor of medical dentistry (DMD) • Doctor of medicine (MD) • Doctor of optometry (OD) • Doctor of osteopathy (DO) • Doctor of podiatry (DPM) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner (NP) • Licensed professional counselor • Perfusionist • Physician Assistant (PA) • Psychologist (PhD, EdD, and PsyD) • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational, or physical therapist • Surgical Assist (SA) • Surgical Technician (ST)	• Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long-term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Pain Management Clinic • Rehabilitation Treatment Center (inpatient substance use disorder treatment facility) • Skilled Nursing Facility • Sleep Lab • Specialty Laboratory • Sub-acute behavioral health facility (including residential treatment) • Urgent Care

Choosing a Provider

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

Network Status

In-Network Providers (Contracted)

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

Except for emergency services, if the provider submitting a laboratory, DME/medical supply, and/or air ambulance claim does not have a plan network contract with BCBSAZ (when the claim is submitted to BCBSAZ) or a PPO contract with the out-of-state Blue Cross and/or Blue Shield Plan to which the claim is submitted, the claim will be processed as an out-of-network claim**.** Members are responsible for out-of-network cost share and any applicable balance bill. See the *"Out-of-Network Providers"* section below.

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

- *Independent Clinical Laboratory:* Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the referring provider is located.
- *Durable Medical Equipment/Medical Supplies:* Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the member resides.
- *Air Ambulance:* Claims must be filed with the Blue Cross and/or Blue Shield plan in the state of the member pickup location.

In-network providers will file your claims with BCBSAZ or the applicable out-of-state Blue Cross and/or Blue Shield plan. The provider's contract generally prohibits the provider from charging more than the allowed amount for covered services. However, when there is another source of payment, such as liability insurance, all providers may be entitled to collect their balance bill from the other source, or from proceeds received from the other source. The provider's contract does allow the provider to charge you up to the provider's billed charges for noncovered services. We recommend that you discuss costs with the provider before you obtain noncovered services. BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan directly reimburse in-network providers for your benefit plan's portion of the allowed amount for covered services. You are responsible to pay your member cost share directly to the provider.

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

Locating an In-Network Provider: Check the plan network provider directory at www.azblue.com 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 an in-network provider, contact Customer Service at the number on your ID card.

Out-of-Network Providers (Contracted and Noncontracted)

Out-of-network providers are: (1) Providers who are contracted with BCBSAZ or a Host Blue plan as "Participating" only providers; (2) Providers who are contracted with BCBSAZ but do not have a plan network contract (such as BCBSAZ PPO-only providers); (3) Eligible providers who have no contract with BCBSAZ or a Host Blue plan (Noncontracted providers); (4) Providers who are contracted with Blue Cross Blue Shield Global® Core; and (5) Providers who submit a laboratory, DME/medical supply, or air ambulance claim to a Host Blue plan and do not have a PPO contract with that plan.

- *Participating-only Providers:* Participating-only providers are contracted with BCBSAZ or 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 plan with which they are contracted. Except for emergency services, and ancillary services provided in an in-network facility, if you receive covered services from a Participating-only provider, you will pay out-of-network cost share. However, you will not have to pay the balance bill because the provider is contracted.

- *Providers Contracted with BCBSAZ who are not in the Plan Network:* Some BCBSAZ providers are contracted with BCBSAZ for certain networks, but are not contracted as plan network providers. For

purposes of this benefit plan, they are considered noncontracted and will be treated like any other noncontracted provider described below. For example, BCBSAZ PPO-only providers are noncontracted providers. They may, but are not required to, submit your claims to BCBSAZ. Except for emergency services, and ancillary services provided in an in-network facility, if you receive covered services from a provider who is contracted with BCBSAZ, but not contracted as a plan network provider, you will pay out-of-network cost share. BCBSAZ will send any claim payments to you, and you are responsible to pay the provider. Because these providers are considered noncontracted, they may balance bill you like any other noncontracted provider.

- *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. Except for emergency services, and ancillary services provided in an in-network facility, if you receive covered services from an eligible noncontracted provider, you will pay out-of-network cost share 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.

  Except for claims covered by the No Surprises Act, or unless BCBSAZ agrees to pay the provider directly, BCBSAZ will send payment to you for whatever benefits are covered under your plan, and you will be responsible for paying the out-of-network provider.

- *Providers Contracted with Blue Cross Blue Shield Global® Core:* Providers who are contracted with Blue Cross Blue Shield Global Core are out-of-network providers. For covered services from these providers, you will pay out-of-network cost share (except for emergency services), plus the balance bill.

Provider Status and Payment – Summary Table
Subject to all terms and conditions noted in this section.

Provider Contract Status	Network Status and Applicable Cost Share	Provider Required to File Claim on Member's Behalf	Accept BCBSAZ Allowed Amount and Do Not Balance Bill	Payee for Reimbursement
Providers contracted with BCBSAZ as plan network providers*	In-network	Yes	Yes	BCBSAZ reimburses the provider the allowed amount, less any member cost share
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue") as PPO providers*	In-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the provider the allowed amount less any member cost share
Providers contracted with Host Blue as Participating only providers*	Out-of-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the provider the allowed amount less any member cost share
Providers contracted with Blue Cross Blue Shield Global Core	Out-of-network	Yes	No	Blue Cross Blue Shield Global Core reimburses the provider the allowed amount less any member cost share
Noncontracted providers for non-emergency or non-ancillary services rendered in an in-network facility in and outside Arizona, including providers who are contracted with BCBSAZ but not for your plan network (must be eligible providers)*	Out-of-network	No (provider may elect to do so as courtesy to member)	No. May charge up to full billed charges. Difference between billed charges and BCBSAZ member reimbursement may be substantial.	BCBSAZ reimburses the member or the provider the allowed amount, less any member cost share.

Noncontracted emergency service providers—in and outside Arizona (must be eligible providers)	Out-of-network	No (provider may elect to do so as a courtesy to member)	Yes. If the provider disputes the allowed amount, the provider must resolve the dispute with BCBSAZ directly.	BCBSAZ reimburses the provider the allowed amount, minus your cost share.

*Except as noted in this Medical Certificate

Sample Differences in Financial Responsibility Based on Provider Choice

The following example shows how out-of-pocket expenses can differ depending on the provider you choose. This example is provided for demonstration purposes only. Your savings may vary depending on your benefit plan and your chosen provider. In this example, the member has already satisfied the calendar-year deductible and has a 20% coinsurance for an in-network provider and 40% 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	This benefit plan pays:	$320	$240
		You pay:	$ 80 coinsurance amount	$160 coinsurance +$600 balance bill $760

Prior Authorization for Out-of-Network Providers

BCBSAZ does not guarantee that every specialist or facility will be in your plan 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 prior authorization for in-network cost share for services from an out-of-network provider. BCBSAZ will not issue prior authorization if we find that an in-network provider is available to treat you. The section on *"Prior Authorization"* explains how to make this request.

Continuing Care from an Out-of-Network Provider

You may be able to receive benefits at the in-network level for services provided by an out-of-network provider under the circumstances described below. Continuity of care benefits (explained below) are subject to all other applicable provisions (terms) of your benefit plan. To request continuity of care, call the Customer Service number on your ID card.

New Members

A new member may continue an active course of treatment with an out-of-network provider during the transitional period after the member's effective date if the member has:

- A life-threatening disease or condition, in which case the transitional period is not more than 30 days from the effective date of coverage; or
- Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered provider services for the delivery and any care related to the delivery for up to 6 weeks from the delivery date; **and**

The member's provider agrees, in writing, to:

- Accept the BCBSAZ allowed amount applicable to covered services as if provided by an in-network provider, subject to the cost-share requirements of this benefit plan;
- Provide BCBSAZ with any necessary medical information related to your care; **and**
- Comply with BCBSAZ's policies and procedures as applicable, including those surrounding prior authorization, network referrals, claims processing, quality assurance, and utilization review.

Current Members

If an in-network provider's contract with BCBSAZ is terminated or non-renewed (except for reasons of medical incompetence or unprofessional conduct) a member may continue an active course of treatment with that provider until the treatment is complete or for 90 days from the notice provided to the member, whichever is

shorter. This continuity of care timeframe extends through a new policy year period if the member remains enrolled in this benefit plan.

An active course of treatment means the member is:
- Determined to be terminally ill and is receiving treatment for such illness from such provider or facility;
- In the third trimester of pregnancy on the effective date of the provider's termination, in which case the transitional period includes the covered Provider services for the delivery and any care related to the delivery for up to six weeks from the delivery date;
- Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility;
- Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Undergoing a course of institutional or inpatient care from the provider or facility; **or**
- Undergoing a course of treatment for a serious and complex condition from the provider or facility.

The member's provider agrees, in writing, to:
- Accept the BCBSAZ allowed amount applicable to covered services as if provided by an in-network provider, subject to the cost-share requirements of this benefit plan;
- Provide BCBSAZ with any necessary medical information related to your care; **and**
- Comply with BCBSAZ's policies and procedures as applicable, including those surrounding prior authorization, network referrals, claims processing, quality assurance, and utilization review.

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

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

When you receive covered services outside BCBSAZ's service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:
- The billed charges for covered services; **or**
- The negotiated price that the Host Blue makes available to BCBSAZ.

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or under-estimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSAZ has used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

BlueCard Program

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

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

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

Nonparticipating Providers Outside BCBSAZ's Service Area

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

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

Blue Cross Blue Shield Global Core Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, 7 days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

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

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

- *Submitting a Blue Cross Blue Shield Global Core Claim*: When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSAZ, the Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, 7 days a week.

Services Received on Cruise Ships

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

PRIOR AUTHORIZATION

When Is Prior Authorization Required

Not all services or medications require prior authorization. Prior authorization is not required for emergency services or urgent care services. If it is required, your treating provider must obtain it on your behalf before rendering services. If prior authorization is not obtained for medications that require it, the medications will not be covered. Prior authorization may be required for services to be covered when provided in certain settings.

On the BCBSAZ website, you'll find a list of services that need prior authorization at azblue.com/individualsandfamilies/resources/forms and medications that need prior authorization at azblue.com/Pharmacy, or call the Customer Service number on your ID card. BCBSAZ may change the services that require prior authorization by posting a revised listing of medications and services at www.azblue.com.

How to Obtain Prior Authorization

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

Factors BCBSAZ Considers in Evaluating a Prior Authorization Request for Services or Medications

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

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

Prescription Medication Exception

If a covered medication requires prior authorization, but you must obtain the medication outside of BCBSAZ's prior authorization 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 treating provider request prior authorization on the next business day. Your claim for the medication will not be denied for lack of prior authorization, but all other exclusions and limitations of your plan will apply.

Prior Authorization for 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 for prior authorization for 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 provide prior authorization for in-network cost share for services from your out-of-network provider of choice.

Prior authorization for in-network cost share for services from an out-of-network provider is a process separate from prior authorization for services. If you want an out-of-network provider to render services that require prior authorization, and you also want to be eligible for the in-network cost share, you must ensure that your provider makes two separate prior authorization requests: one for the service itself and one for use of the out-of-network provider. If BCBSAZ provides you prior authorization for the in-network cost share, your services will be subject to the in-network cost share. You will still be responsible for any balance bill, plus your in-network cost share.

If BCBSAZ Provides Prior Authorization for Your Service

You and your provider will receive a letter explaining the scope of the prior authorization.

If BCBSAZ Denies Your Prior Authorization Request

Denial of prior authorization is an adverse benefit determination. As explained in the *"Notice of Determination"* section of this book, BCBSAZ will send you a notice explaining the reason for the denial, and your right to appeal the BCBSAZ decision. Information on where to file an appeal is in the BCBSAZ Appeal and Grievance Guidelines.

If your request for prior authorization 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 prior authorization.

If BCBSAZ denies your request for biomarker testing, go to www.azblue.com for information on how to request an exception.

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.

If you choose to pay a provider on a direct pay basis and submit a receipt to BCBSAZ, BCBSAZ will credit your deductibles and out-of-pocket maximums as required by applicable law. You must submit a receipt that includes the amount paid, the procedure and diagnosis codes for the services rendered, and a notation indicating direct payment. If you choose to pay a contracted provider for a covered service on a direct pay basis, the provider will not submit the claim to BCBSAZ for processing under this benefit plan.

Time Limit for Claim Filing

A complete claim, as described below, must be filed within 1 year from the date of service. Any claim not filed with all required content within the 1-year period is an untimely claim. BCBSAZ will deny untimely claims from contracted providers based on the terms of the provider's contract. BCBSAZ will deny untimely claims from members except for the following situations:

- Medicare or another carrier was the primary payer on a claim where BCBSAZ was secondary payer, and the delay was caused by the need to coordinate benefits with the primary payer.
- The member can show good cause for delay.
  Examples of good cause:
  - ♦ BCBSAZ gave the member wrong information about the filing date;
  - ♦ The member did not have legal capacity;
  - ♦ The member had an extended illness that prevented the member from filing the claim; **or**
  - ♦ Other similar situations outside the member's reasonable control.

Complete Claims

Claim forms are available from BCBSAZ. Go to the "Forms" section of the "Member" area of www.azblue.com or call the Customer Service number on your ID card. 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. 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

Medical and Dental Records and Other Information Needed to Process a Claim

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

Explanation of Benefits (EOB) Form and Monthly Member Health Statement

After your claim is processed, BCBSAZ and/or any contracted vendors that process claims will send you an EOB. Most EOBs are consolidated and sent to you in a monthly member health statement rather than as single EOBs. Your BCBSAZ EOBs also will be available through the member portal on www.azblue.com. An EOB shows services billed, whether the services are covered or not covered, the allowed amount, and the application of cost-sharing amounts. Carefully review your EOB for any discrepancies or inconsistencies with

the amounts your provider actually collects from you or bills to you. If you paid more cost share than required for a covered service, the provider will be responsible for refunding you. BCBSAZ and/or any contracted vendors will also send your in-network provider the information that appears on your EOB. Save the EOB for your personal records. BCBSAZ or any contracted vendor may charge a fee for duplication of claims records.

Notice of Determination

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

- 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),
- Reference the specific plan provision on which the determination is based, **and**
- 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 Medical Certificate).

Time Period for Claim Decisions

Post-Service Claims

Within 30 days of receiving your claim for a service that was already rendered, BCBSAZ will send you an EOB adjudicating the claim, or a notice that BCBSAZ has requested records needed to make a decision on your claim. If BCBSAZ cannot make a decision on your claim within 30 days, BCBSAZ may extend the initial processing time by 15 days by notifying you, within the initial 30-day period, of the need for an extension, the decision date, and any additional information that may be needed for the decision. You or your provider will have at least 45 days to submit any requested information.

Pre-Service Claims

When you request coverage for a service that has not yet been rendered (prior authorization), BCBSAZ will make a prior authorization decision within a reasonable time period considering the medical circumstances, but not later than 10 business days from receipt of the prior authorization request. If BCBSAZ requires more time to make a prior authorization decision, BCBSAZ may extend the time by an additional 15 days by notifying you, within the initial 10-day period of need for an extension, the expected decision date, and any additional information needed for the decision. You and your provider will have at least 45 days to submit any requested information.

Concurrent Care Decisions

BCBSAZ may require that your provider submit a plan of care. Based on that plan, BCBSAZ may provide prior authorization for a certain number of visits or services over a certain period of time. You may request prior authorization for additional periods of care. If your request involves urgent care and is made at least 24 hours prior to the expiration of the existing plan of care, BCBSAZ will make a determination as soon as possible in accordance with medical exigencies, but no later than 24 hours after receipt of the request. If your request is not made at least 24 hours prior to the expiration of the existing plan of care, BCBSAZ will make a determination as soon as possible in accordance with medical exigencies but no later than 72 hours after receipt of the request. If prior authorization is denied, you may appeal the denial in the same way you appeal any other coverage denial.

Urgent Requests for Prior Authorization

When your provider submits an urgent prior authorization request, a determination will be made as soon as possible, but no later than 72 hours after receipt of the request. Federal law defines an “urgent” medical situation as the following:

- 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**
- 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.

GENERAL PROVISIONS

Appeal and Grievance Process

Members may participate in BCBSAZ's appeal and grievance processes, which are described in detail in the BCBSAZ Appeal and Grievance Guidelines, a separate document provided to you. You do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ. You may obtain another copy of the BCBSAZ Appeal and Grievance Guidelines by visiting us at www.azblue.com or by calling Customer Service at the number on your ID card.

If you receive a bill from an out-of-network provider for services provided at an in-network facility and want to dispute the amount of the bill, you may be able to initiate a dispute resolution process defined under Arizona law. This process is not available for all balance bills. To initiate the dispute resolution process or to appeal a denial of prior authorization for urgently needed services you have not yet received, please call Customer Service at the number on your ID card.

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 Medical Certificate 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 ("Association"), an association of independent Blue Cross and Blue Shield Plans 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.

Claims Editing Procedures and Pricing Guidelines

BCBSAZ uses systems to verify benefits, eligibility, claims accuracy, and compliance with BCBSAZ coding and pricing guidelines and evidence-based criteria. BCBSAZ uses claims coding and editing logic to process claims and determine allowed amounts. BCBSAZ regularly updates its systems, claims and pricing guidelines and edits, and evidence-based criteria.

Confidentiality and Release of Information

We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with federal and state 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 Medical Certificate.

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 Medical Certificate. Your provider may recommend services or treatment not covered under this Medical Certificate. 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

There is an appeal process for resolving certain types of disputes with members. You are encouraged to use the appeal process before filing a lawsuit, as issues can often be resolved when you provide more information through the appeal process. By providing this notice BCBSAZ does not waive, but expressly reserves all applicable defenses available under federal and Arizona law.

Legal Action and Applicable Law

This contract is governed by, construed, and enforced in accordance with applicable federal law and the laws of the state of Arizona, without regard to conflict of laws principles. This Medical Certificate and the contract between BCBSAZ and the sponsor of your group health plan were issued in Arizona to a group headquartered in Arizona.

Any dispute arising directly or indirectly out of the plan must be resolved by binding arbitration to the fullest extent permitted by applicable law. You agree that neither class or collective claims, nor class action or collective action procedures, will be asserted in, or will apply to, any dispute that arises out of this benefit plan. You irrevocably and unconditionally waive, to the fullest extent permitted by applicable law, any right to a trial by jury in any dispute arising out of or relating to this benefit plan.

Jurisdiction and Venue: Jurisdiction and venue for any legal action or other proceeding that arises out of or relates to the contract or this Medical Certificate shall be in any court of competent jurisdiction in the state of Arizona.

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. This paragraph is not intended to limit or waive any claims BCBSAZ may have against any person or entity.

Non-Assignability of Benefits

Except as otherwise specified in this section, the benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to these benefits, or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against BCBSAZ and imposes no duty or obligation on BCBSAZ. If you receive Covered Services from an out-of-network Provider and wish to assign your payment to the Provider, you or the Provider may submit the

documents requesting assignment to BCBSAZ. BCBSAZ, at our sole discretion, will determine whether to honor the assignment and, if approved, remit any payment due directly to the Provider.

No Surprises Act

The federal "No Surprises Act" protects you from surprise balance bills from out-of-network providers in certain situations.

- **Emergencies:** When you receive emergency care from out-of-network providers, your financial responsibility will be determined in the same way as if you received the care from network providers. Also, out-of-network providers can't balance bill you for the difference between the allowed amount and the billed charge.
- **Non-emergency service at network facilities:** The same emergencies rule above applies if you receive services from out-of-network providers while you are at a network facility, such as a hospital or outpatient surgery center, unless the provider gives you a legally-required notice and you give consent in accordance with the law. If you give this consent, you will pay the out-of-network cost share and any balance bill, and the No Surprises Act dispute process won't apply.
- **Disputes:** If out-of-network Providers want to dispute the amount BCBSAZ pays them, they are required to resolve the dispute with us. As long as you pay your required cost-share amount, they can't collect any other amounts from you.

If you would like more information on the No Surprises Act, or if you feel that you have incorrectly received a balance bill, the federal government has created the following website:

www.cms.gov/nosurprises

You can also call (800) 985-3059.

To view a statement of Your Rights and Protections Against Surprise Medical Bills, go to www.azblue.com/individualsandfamilies/resources/forms. You can also call the number on the back of your ID card to have a copy of the statement mailed to you.

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 healthcare 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 Customer Service. 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:

- On delivery, if hand-delivered;
- If mailed, on the earlier of the day actually received by the member or 5 days after deposit in the U.S. mail, postage prepaid; **or**
- If transmitted electronically, on the earlier of the day of actual receipt or 24 hours after electronic transmission to the member's email address of record.

Payments Made in Error

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

Plan Amendment

There is no guarantee of continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted, or changed upon notice to the group and/or contract holder or as required to comply with federal or state laws. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the 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 SBCs, all riders and amendments, and other communications concerning your coverage.

Retroactive Changes

BCBSAZ with mutual agreement with the Plan Sponsor reserve the right to make certain retroactive amendments to this Medical Certificate, 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. For that reason, plan network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate. This means that your in-network cost share for a particular service can vary based on the network provider you choose, because not all providers have the same negotiated reimbursement rate for the same service. For information on your estimated cost share for a particular service, please call Customer Service at the number on your ID card. You will need to provide the name of the provider and the diagnosis and procedure code to receive an estimated cost share. The estimated cost share is only an estimate and the actual cost share may vary from the estimated cost share based on factors such as the services actually performed and the place where the services are actually rendered.

Release of Records

Subject to federal or Arizona 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. Failure to provide records needed to adjudicate a claim can result in denial of the claim.

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. In-network providers generally cannot charge you for providing BCBSAZ with health records. Noncontracted providers have no contractual obligation to provide records to BCBSAZ free of charge. If you receive services from a noncontracted provider who charges for record preparation or the cost of copies, you will need to arrange with your provider to obtain any records required by BCBSAZ and pay any applicable fees.

Rescission of Coverage

In the event of fraud or intentional misrepresentation of material fact, coverage for any person ineligible to be on the Medical Certificate as described in the group master contract will be rescinded, that is, as never having been in effect. Premiums paid for the coverage for the ineligible person will be refunded, minus any claims paid for that person. BCBSAZ is entitled to recover claim payments that exceed the amount of premium paid. Such rescission does not affect the coverage of those persons on the Medical Certificate who remain eligible for coverage.

BCBSAZ will give a 30-day written notice of its intent to rescind, during which time the person may protest the decision by writing to BCBSAZ at the address indicated in the notice and explaining why a rescission is not appropriate or allowable. A member's eligibility to enroll in the group's health plan is not based on the member's health status. An omission or misrepresentation of health information in your application for group coverage is not a basis for rescission of your group coverage.

Third-Party Beneficiaries

The provisions of this Medical Certificate 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 Medical Certificate.

Your Right to Information; Availability of Notice of Privacy Practices

You have the right to inspect and copy your information and records maintained by BCBSAZ, with some limited exceptions required by law. If you choose to review your medical records in person, BCBSAZ will require a reasonable amount of time to research and retrieve the records before scheduling a time with you to review the records.

The BCBSAZ "Notice of Privacy Practices" describes how BCBSAZ may use and disclose your information to administer your health plan. It also describes some of your individual rights and BCBSAZ's responsibilities under federal privacy regulations. BCBSAZ mails a copy of this Notice of Privacy Practices to your address shortly after you enroll for coverage with BCBSAZ. You can also view the "Notice of Privacy Practices" by visiting the BCBSAZ website, www.azblue.com, and clicking on the Legal link at the bottom of the home page. If you would like BCBSAZ to mail you another copy of the "Notice of Privacy Practices," please call the Customer Service number on your ID card, or call (602) 864-4400 or (800) 232-2345 to make your request.

Subrogation

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") that provides its employees and their dependents ("Participants") with healthcare coverage. BCBSAZ performs claims administration for the Plan and now also provides subrogation recovery services for the Plan as described in this section. Here is the way subrogation works. Sometimes you and/or your dependent ("you") require hospital and/or medical services due to an injury in an accident or due to a condition caused by another person's negligence. In such cases, the person causing the accident ("third party") is responsible for payment of your hospital and medical expenses. The Plan, who pays for your covered hospital and medical services, has the right to recover these payments from the third party or from you if you have recovered from the third party. When the Plan exercises its rights to be reimbursed, the process is known as subrogation, recovery and/or reimbursement ("subrogation").

During the subrogation process, BCBSAZ, on behalf of the Plan, will continue to pay your covered hospital and medical services on behalf of the Plan just as it always has. However, if a third party is legally obligated to pay for your expenses, the Plan will then exercise its rights to be reimbursed for 100% of what the Plan paid without any reduction for attorneys' fees and/or court costs and regardless of whether you were made whole. In addition, the Plan has first priority from any judgment, payment or settlement.

The Plan's rights apply to any settlement of a claim regardless of whether anyone has started litigation. Any right a Participant might have to be "made whole", (i.e., to be fully compensated for his/her injuries prior to any right the Plan has to recover its cost) is superseded by the Plan's subrogation rights. The Plan may subrogate against all money that you or anyone recovers regardless of the source of the money and regardless of where the money is located and/or regardless of how it is held. The Plan will also have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of recovery or settlement.

You must promptly execute and deliver any documents relating to settlement of claims, settlement negotiations or litigation when the Plan asks you to so the Plan can exercise its subrogation rights. Also, you or your legal representative must (1) promptly notify the Plan in writing of any settlement negotiations before you enter into any settlement agreement, (2) disclose to the Plan any amount recovered from any person or entity that may be liable and (3) not make any distributions of settlement or judgment proceeds without the Plan's prior written consent. No waiver, release of liability or other documents executed by you without such written notice to the Plan shall be binding upon the Plan.

MEMBER COST SHARING

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

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. Any amounts paid for balance bills do not count toward deductible, coinsurance, or the out-of-pocket maximum. Except for emergency services, and ancillary services provided in an in-network facility, 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.

Benefit Maximums

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

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for covered services each January through December before the Medical Certificate begins to pay for covered services. The deductible applies to every covered service unless the specific benefit section says it does not apply. The deductible is calculated based on the allowed amount. Amounts you pay for copays and access fees do not count toward the deductible.

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

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for certain covered services after meeting any applicable deductible. BCBSAZ subtracts any applicable prior authorization charges from the allowed amount before calculating coinsurance. Coinsurance applies to every covered service unless the specific benefit section says it does not apply. BCBSAZ normally calculates coinsurance based on the allowed amount. There is one exception. If a hospital provider's billed charges are less than the hospital's DRG reimbursement, BCBSAZ will calculate your coinsurance based on the lesser billed charge.

Copay

A copay is a specific dollar amount you must pay to the provider for some covered services. If a copay applies to a covered service, you must pay it when you receive services. Different services may have different copay amounts and are shown on your SBC. Usually, if a copay does not apply, you will pay applicable deductible and coinsurance.

Out-of-Pocket Maximum (Individual and Family)

An out-of-pocket maximum is the amount each member must pay each year before the plan begins paying 100% of the allowed amount on covered services, for the remainder of the calendar year. The payments listed

below do not count toward the out-of-pocket maximum. You must keep paying them even after you reach your out-of-pocket maximum:

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

If you have family coverage, there is an out-of-pocket maximum for your family. Amounts applied to each member's out-of-pocket maximum also apply to the family out-of-pocket maximum. The family maximum is applied in the same way as the individual maximum described above and is subject to the same rules. When the family has met its family out-of-pocket maximum, it also satisfies the out-of-pocket maximum requirements for all the individual members.

Prior Authorization Charges

You must make sure that your out-of-network provider obtains prior authorization from BCBSAZ for any service that requires it. If your out-of-network provider does not obtain required prior authorization from BCBSAZ, you are subject to a prior authorization charge or complete loss of your benefit. Applicable prior authorization charges are shown on your SBC. Amounts applied as prior authorization charges do not count toward the calendar-year deductible or out-of-pocket maximum.

DESCRIPTION OF BENEFITS

Please review this section for an explanation of covered services and benefit-specific limitations and exclusions. Also, be sure to review the information about covered services in *"Understanding the Basics"* and refer to *"What is Not Covered"* for general exclusions and limitations that apply to all benefits. BCBSAZ does not determine whether a service is covered under this Medical Certificate until after services are provided and BCBSAZ receives a complete claim describing the services actually rendered. The SBC sent with your member ID card shows the actual cost-share amounts for the cost-share types shown for each benefit, such as deductible amounts, copays, and coinsurance percentages.

A. ACUPUNCTURE SERVICES

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

Benefit Description: Benefits are only available if one of the following is met:

- Nausea and vomiting associated with pregnancy; **or**
- Nausea and vomiting associated with chemotherapy; **or**
- Postoperative dental pain, if the treatment of the dental condition was covered under the medical benefit; **or**
- Postoperative nausea and vomiting; **or**
- As an addition to standard therapy when conservative methods have failed for either of the following conditions:
  - Chronic headaches
  - Chronic pain (limited to osteoarthritis of the knee, chronic back and neck pain)

B. AMBULANCE SERVICES

Your Cost Share: Your cost share is waived.

Benefit Description: All factors for coverage are determined by BCBSAZ at its sole and absolute discretion. Benefits are available for:

- Air or water ambulance transportation to the nearest facility capable of providing appropriate treatment when the emergency, accident, or acute illness occurs in an area inaccessible by ground vehicles, or transport by ground ambulance would be harmful to the member's medical condition; or
- Ground ambulance transportation from the site of an emergency, accident, or acute illness to the nearest facility capable of providing appropriate treatment; **or**
- Interfacility ground, water, or air ambulance transfer for admission to a facility when the transferring facility is unable to provide the level of service required.

Benefit-Specific Exclusions:

- Air ambulance transfers to any facility that is not an acute care facility, such as a skilled nursing facility or an extended active rehabilitation facility.
- All other expenses for travel and transportation are not covered, except for the benefits described in *"Transplant or Gene Therapy Travel and Lodging."*

C. BEHAVIORAL HEALTH SERVICES (Includes Treatment for Mental Health, Chemical Dependency, or Substance Use Disorder)

C.1 Inpatient Hospital

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

Changing Types of Inpatient Care (applicable to C.1 and C.2 below): Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation, and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. If you are moving to a level of care that requires prior authorization, you will also need to obtain a new prior authorization for the different level of care.

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

Benefit-Specific Exclusions (applicable to C.1 and C.2 below):
- Domiciliary care
- Medications dispensed at the time of discharge from a hospital
- Respite care

C.2 Subacute Inpatient Behavioral Health Hospitalization (Including Residential Treatment)

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

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

Benefits are available for inpatient behavioral health services that meet all the following criteria:
- A physician or RN practitioner is present on the premises of the facility or on-call at all times;
- The facility has sufficient behavioral health professional staff to provide appropriate treatment;
- The facility has 24/7 onsite RN coverage;
- The facility is licensed to provide behavioral health services to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time;
- The facility's designated clinical director is a behavioral health professional and provides direction for the behavioral health services provided at the facility;
- The facility's designated medical director is a physician or RN practitioner and provides direction for physical health services provided at the facility; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

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

C.3 Behavioral Health Services (Outpatient Facility and Professional Services)

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

Benefit Description: Non-emergency outpatient behavioral health services are available in an individual, group, or structured group therapy program. Those services include psychotherapy, outpatient therapy for chemical dependency or substance use disorder, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, intensive outpatient services, counseling for personal and family problems, electroconvulsive therapy (ECT), and partial hospitalization.

C.4 Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder

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

Benefit-Specific Definitions: **"Autism Spectrum Disorder"** means autistic disorder, asperger's syndrome, or pervasive developmental disorder (not otherwise specified), as defined in current evidence-based criteria and referenced in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

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

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

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

Exception: Behavioral health services for minors that are otherwise covered under this section will not be denied solely on the basis that the services are provided in a school setting or are ordered by a court.

D. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

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

Benefit-Specific Maximum: There is a maximum benefit of 60 combined in- and out-of-network visits per member, per therapy type, per calendar year.

Benefit Description: Benefits are available for outpatient Phase 1 and 2 cardiac rehabilitation programs and pulmonary rehabilitation services.

E. CATARACT SURGERY AND KERATOCONUS

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

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

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

F. CHIROPRACTIC SERVICES

Your Cost Share:

In-Network: Your cost share is waived. For acupuncture services, your costs accumulate toward the deductible. See the "*Acupuncture Services*" section for benefits.

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

Benefit-Specific Maximum: There is a maximum combined in- and out-of-network benefit of 36 visits per member, per calendar year. Physical medicine performed by a chiropractor does apply to the chiropractic limit. This limit does not apply to claims submitted with a primary behavioral health diagnosis.

Benefit Description: Benefits are available for chiropractic services.

Benefit-Specific Exclusions:

- Maintenance or preventive treatment consisting of routine, long-term, or non-medically necessary care provided to prevent reoccurrences or to maintain the patient's current status
- Services after the 36 visit maximum has been reached

G. CLINICAL TRIALS

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

Benefit-Specific Definition: **"Approved Clinical Trial"** means a Phase 1, 2, 3, or 4 clinical trial conducted for the prevention, detection, or treatment of cancer or other life-threatening disease or condition and also approved or funded by at least one of the following:

- A panel of qualified, recognized clinical research experts within an Arizona academic health institution
- Food and Drug Administration (FDA) reviewed investigational new drug application
- The National Institutes of Health (NIH), including a NIH health cooperative group or center or a qualified research entity that meets the criteria established by NIH for grant eligibility
- The U.S. Department of Defense
- The U.S. Department of Veterans Affairs

Benefit Description: Benefits are available for covered services directly associated with an Approved Clinical Trial meeting all requirements specified by applicable federal and Arizona law. Benefits are limited to those services covered under this plan that would be required if you received standard, non-investigational treatment. Services may include laboratory, radiology, physician services, medical diagnostic, and/or surgical procedures.

For services associated with an Approved Clinical Trial to be covered, you or your provider must inform BCBSAZ that you are enrolled in a clinical trial, that the trial meets the requirements of applicable law, and that the services to be rendered are directly associated with the trial. Otherwise, BCBSAZ only covers clinical trials as required by law and will administer your benefits according to the other terms of your benefit plan, which may result in a denial of benefits. If you have any questions about whether a particular service is covered, please call Customer Service at the number on your ID card.

Benefit-Specific Exclusions:

- Any item, device or service that is the subject of the clinical study, or which is provided solely to meet the need for data collection and analysis
- Clinical trials not required by law to be covered
- Costs and services customarily paid for by government, biotechnical, pharmaceutical and device industry sources
- Costs related to clinical trials that do not meet the applicable requirements
- Costs to manage the clinical trial research
- Investigational medications (except as stated in *"Medications for the Treatment of*

Cancer") and devices
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services otherwise not covered under this plan

H. DENTAL SERVICES – MEDICAL

Not all dentists who are contracted with BCBSAZ are contracted to provide medical-related dental services. Call BCBSAZ Customer Service at the number on your ID card with questions.

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

H.1 Dental Accident Services

Benefit-Specific Definitions: **"Accidental Dental Injury"** is an accidental 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:
- Not in need of the treatment provided for any reason other than as the result of an Accidental Dental Injury;
- 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); or
- Whole or virgin; **and**
- Without current periodontal (tissue supporting the tooth) disease or current endodontal (tooth pulp or root) disease.

Benefit Description: Benefits are available only for the following services to repair or replace sound teeth damaged or lost by an Accidental Dental Injury:
- Extraction of teeth damaged as a result of Accidental Dental Injury
- Original placement of fixed or removable complete or partial dentures
- Original placement, repair, or replacement of crowns
- Original placement, repair, or replacement of veneers
- Orthodontic services directly related to a covered accidental injury
- Treatment for a fractured jaw

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

H.2 Dental Services Required for Medical Procedures

Benefit Description: Benefits are available for dental services required to perform the medical services listed in this benefit. These dental services may either be part of the medical procedure or may be performed in conjunction with and made medically necessary solely because of the medical procedure:
- Diagnostic services prior to planned organ or stem cell transplant 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
- Repair and replacement of fixed or removable complete or partial dentures
- Routine dental care
- Routine extractions

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

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

- Children 5 years or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office
- Dental extractions due to cancer related conditions
- Diabetes
- Heart problems
- Hemophilia
- Intellectual disability
- Malignant hypertension
- Other conditions that could increase the danger of anesthesia
- Probability of allergic reaction
- Senility or dementia
- Uncontrolled seizure disorder
- Unstable cardiovascular condition
- Other conditions for which these services are required by federal or state law to be covered

I. DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, AND PROSTHETIC APPLIANCES AND ORTHOTICS

Your Cost Share: You pay applicable deductible and coinsurance. Your cost share is waived for 1 FDA-approved manual or electric breast pump and breast pump supplies obtained from an in-or out-of-network provider per member, per calendar year. You still pay the balance bill for a breast pump and breast pump supplies obtained from a noncontracted provider. The cost-share amount will depend on the provider's network status. You also pay the balance bill for services provided by noncontracted providers.

Benefit-Specific Maximums:

- Benefits are limited to 1 unit or 1 pair of prosthetic appliances and orthotics per member, per calendar year.
- Benefits are limited to 1 breast pump and breast pump supplies per member, per calendar year, per Health Resources and Services Administration guidelines (see the "*Preventive Services*" section).
- Benefits are limited to $400 per member, per calendar year for wigs.

These limits do not apply to claims submitted with a primary behavioral health diagnosis.

I.1 Durable Medical Equipment (DME)

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

- Be designed for appropriate medical use in the home setting;
- Be specifically designed to improve or support the function of a body part; **and**
- Cannot be primarily useful to a person in the absence of an illness or injury.

Benefits are available for DME rental or purchase, as determined by BCBSAZ, and for DME repair or replacement, as determined by BCBSAZ, due to normal wear and tear caused by use of the item in accordance with the manufacturer's instructions or due to growth of a child. Benefits are limited to the allowed amount for the DME item base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded DME items may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusions:
- Charges for continued rental of a DME item after the purchase price is reached
- Repair costs that exceed the allowed amount 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

I.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 current evidence-based criteria
- Blood glucose monitors, including monitors for the legally blind and visually impaired
- Certain insulin pumps
- Cranial banding
- Ostomy and urinary catheter supplies
- Peak flow meters
- Supplies associated with oxygen or respiratory equipment
- Tubing for insulin pumps
- Volume nebulizers
- Other medical supplies required by federal or state law to be covered

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

Benefit-Specific Exclusion: Diabetic supplies, except for blood glucose monitors, and certain insulin pumps.

I.3 Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:
- Cochlear implants
- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- External and internal prosthetic devices, which are used as a replacement or substitute for a missing body part and are necessary for the support or function of a body part or for the alleviation or correction of illness, injury, or congenital defect. External prosthetic appliances shall include artificial arms and legs, wigs, hairpieces, and terminal devices such as a hand or hook. Wigs and hairpieces are covered:
  - For individuals diagnosed with alopecia (absence of hair) caused by chemotherapy, radiation therapy, or second- or third-degree burns;
  - For individuals diagnosed with a behavioral health condition; **and**
  - For individuals with any other condition for which coverage is required under federal or state law.
- Orthopedic shoes that are:
  - Attached to a brace; and
  - Covered in accordance with BCBSAZ medical necessity criteria; **and**
  - Depth inlay or custom-molded, along with inserts, for individuals with diabetes.
- Podiatric appliances, including foot orthotic devices and inserts (therapeutic shoes: including Depth Shoes or Custom-molded Shoes, as defined below) for prevention of complications associated with diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg. Custom-molded Shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and any of the following complications of diabetes involving the foot: for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment or pathological positioning of the foot and there is reasonable expectation of improvement; peripheral vascular disease (PVD); peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. Depth Shoes and Custom-molded Shoes are defined as follows:
  - **"Depth Shoes"** shall mean the shoe has a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded

or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of 3 widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.
    - ♦ **"Custom-molded Shoes"** shall mean constructed over a positive model of the member's foot; made from leather or other suitable material of equal quality; have removable inserts that can be altered or replaced as the member's condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.
- Other prosthetic appliances and orthotics required by federal or state law to be covered.

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

Benefit-Specific Exclusions for all DME, Medical Supplies, and Prosthetic Appliances and Orthotics:

- Biomechanical devices, which are any external devices operated through or in conjunction with nerve conduction or other electrical impulses
- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, corsets, cushions, dentures, diatherapy machines, disposable hygienic items, dressing aids and devices, elastic/support/compression stockings (except TED hose), elevators, exercise equipment, foot stools, garter belts, grab bars, health spas, hearing aid batteries, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, mineral baths, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas, and vehicle or home modifications.
- Diabetic supplies, except for blood glucose meters, insulin pumps and tubing for insulin pumps
- Hair transplants
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for help in daily living, socialization, personal comfort, convenience, or other nonmedical reasons
- Replacement of external prosthetic devices due to loss or theft
- Strollers of any kind
- Supplies used by a provider during office treatments
- Tilt or inversion tables or suspension devices
- Wigs and hair pieces for alopecia caused by anything other than chemotherapy, radiation therapy, second- or third-degree burns, or a behavioral health diagnosis

J. EDUCATION AND TRAINING

J.1 Diabetes and Asthma Education and Training

Your Cost Share: Your cost share is waived.

Benefit Description: Benefits are available for diabetes and asthma education and training from providers whose services are:

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

J.2 Nutritional Counseling and Training

Your Cost Share: Waived for services provided by in-network providers. You pay out-of-network deductible and coinsurance for services provided by out-of-network providers. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Maximum: Benefits are limited to 6 nutritional counseling and training visits per member, per calendar year.

Benefit Description: Benefits are available for nutritional counseling and training.

K. EMERGENCY SERVICES

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

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

Admission to the Hospital from the Emergency Room: You pay in-network deductible and coinsurance for facility and ancillary services related to the emergency, including facility and ancillary services provided while you were in the emergency room. You will also pay your cost-share for the inpatient admission and any professional services provided while you are an inpatient in the hospital. See the *"Physician Services"* and *"Inpatient Hospital"* sections of this Medical Certificate.

If You are Admitted for Observation or as an Outpatient: You pay in-network deductible and coinsurance for professional, facility, and ancillary services related to the emergency and provided after admission for observation or as an outpatient.

If you receive emergency services from a noncontracted facility or professional provider, BCBSAZ will base the allowed amount used to calculate your cost share on the Qualifying Payment Amount, as defined by federal law.

Benefit-Specific Definition: **"Emergency Medical Condition"** means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that failing to get immediate medical attention would result in serious jeopardy to the patient's life, health or ability to completely recover, serious impairment to a bodily function or part, or permanent disability.

Benefit Description: Benefits are available for services needed to treat an Emergency Medical Condition.

L. EOSINOPHILIC GASTROINTESTINAL DISORDER (EGID)

Your Cost Share: You pay applicable deductible and coinsurance for the Cost for Formula. The cost-share amount will depend on the provider's network status.

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

"Formula" is amino acid-based Formula.

Benefit Description: Benefits are available for Formula for members who are:
- At risk of mental or physical impairment if deprived of the Formula;
- Diagnosed with EGID; and
- Under the continuous supervision of a physician or a RN practitioner.

M. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Your Cost Share:

In-Network:

Implanted Devices: Your cost share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved female implanted contraceptive devices when the purpose of the procedure is contraception, as documented by your provider on the claim.

Sterilization Procedures: Your cost share is waived for professional and facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim. You pay in-network deductible and coinsurance for FDA-approved male sterilization procedures.

Hormonal Contraceptive Methods: Your cost share is waived for female oral contraceptives, patches, rings and contraceptive injections. See the *"Physician Services"* section for benefits.

Emergency Contraception: Your cost share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a physician or other provider. See the *"Physician Services"* section for benefits.

Barrier Contraceptive Methods: Your cost share is waived for diaphragms, cervical caps, cervical shields, condoms, sponges, and spermicides. See the *"Physician Services"* section for benefits.

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

Benefit Description: Benefits are available for FDA-approved contraceptive methods, devices, and sterilization procedures when prescribed by the member's provider. At least one contraceptive in each of the methods approved by the FDA is covered without cost share when obtained from an in-network provider.

For a list of covered contraceptives covered without cost share, see the "Guidance Regarding Preventive Medications" section on www.azblue.com, or call the Pharmacy Benefit Customer Service number on your ID card.

If your medication is not listed, you can ask for what is called an exception for waiver of cost share for a contraceptive medication or item you would get from an in-network pharmacy. This is a request that either you or your provider can make that, if approved, could mean you would not have to pay your normal cost share for this medication. To make this request, either you or your provider can call the Pharmacy Benefit Customer Service number on your ID card anytime, 24 hours a day, seven days a week, 365 days a year. There is no guarantee that BCBSAZ and/or the Pharmacy Benefit Manager (PBM) will okay an exception.

More information about contraceptives can be found on the FDA's website at www.fda.gov/consumers/free-publications-women/birth-control.

Benefit-Specific Exclusions:
- All prescription and over-the-counter contraceptive medications and devices for male members
- Except as stated in this benefit book, preventive services provided by an out-of-network provider

N. FERTILITY AND INFERTILITY SERVICES

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

Benefit Description: Benefits are available to diagnose or treat infertility.

Benefit-Specific Exclusions:
- Artificial insemination
- Costs associated with collection or storage of sperm or eggs
- Donor fees
- GIFT
- In-vitro fertilization
- Reversal of sterilization
- ZIFT

O. HEARING SERVICES

Your Cost Share:

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

Hearing Aids: You pay applicable deductible and coinsurance for hearing aids received from in- and out-of-network providers. The cost-share amount will depend on the provider's network status.

Benefit-Specific Maximum: There is a maximum benefit of 1 hearing aid (single purchase) per member, per ear, per every 2 years, including repair and replacement of existing hearing aids. This limit does not apply to claims for hearing services submitted with a primary behavioral health disorder diagnosis.

Benefit Description: Routine hearing exams (except hearing screenings performed as part of a routine well exam), Hearing Aids (including semi-implantable hearing devices), new or replacement Hearing Aids no longer under warranty, cleaning and repair of Hearing Aids, and dispensing fees for Hearing Aids.

Benefit Specific Exclusions:

- Additional warranties for hearing aids
- Assistive listening devices, including but not limited to, hearing aids that sync wirelessly with MP3 players, laptops, televisions and/or other wireless devices
- Batteries or battery replacement for hearing aids
- Direct audio input, Bluetooth capability or other additional features
- Disposable hearing aids
- Earmolds
- Replacement of lost, stolen or damaged hearing aids when the member has already met the benefit maximum of 1 hearing aid per member, per ear, per every 2 calendar years
- Follow-up visits in addition to the original hearing exam
- Return or exchange fees for hearing aids that are returned or exchanged

P. HOME HEALTH AND HOME INFUSION – MEDICATION ADMINISTRATION THERAPY

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

Benefit-Specific Definition: **"Sole Source of Nutrition"** is defined as the inability to orally receive more than 30% of daily caloric needs.

Benefit-Specific Maximum: Home health and home infusion medication administration services are available for up to a maximum of 3 two-hour visits per member, per day. The home health visit limit does not apply to home health services provided in lieu of hospitalization or hospital outpatient services, or to claims for home health services submitted with a primary behavioral health diagnosis.

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. 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 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
- Domiciliary 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
- Respite Care

Q. HOSPICE SERVICES

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

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

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

Benefit-Specific Maximum: Benefits are limited to a maximum of up to 5 days of respite care, once every 21-day period. This limit does not apply to claims for respite care services submitted with a primary behavioral health diagnosis.

Benefit Description: When a member elects to use the hospice benefit, it is in lieu of other medical benefits available under this plan, except for care unrelated to the terminal illness or related complications. The hospice agency determines the required level of care, which is subject to the medical necessity provisions of this benefit plan. Once the member selects the hospice benefit, the hospice agency coordinates all of the member's healthcare 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 LPN or RN 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
- Home health services
- Individual and family counseling provided by a psychologist, social worker, or family counselor
- *Inpatient Acute Care:* Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- Outpatient services
- *Respite Care:* Admission of the member to an approved facility to provide rest to the member's family or primary caregiver
- *Routine Care:* Intermittent visits provided by a member of the hospice team

R. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

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

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

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

S. INPATIENT HOSPITAL

Your Cost Share: You pay applicable deductible and coinsurance for all inpatient admissions, including bariatric surgeries. 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.

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

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

Benefit Description:

- Adjustments to bariatric surgery provided while the member was covered under another plan
- Blood transfusions, whole blood, blood components, and blood derivatives
- Diagnostic testing, including radiology, laboratory services, and biomarker testing
- Gender-affirming care
- General, spinal and caudal anesthetic provided in connection with a covered service
- In-network benefits are available for covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction Center
- Intensive care units and other special care units
- Medications, biologicals, and solutions
- Operating, recovery and treatment rooms, and equipment for covered services
- Radiation therapy or chemotherapy, except in conjunction with a noncovered transplant
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Other inpatient services required by federal or state law to be covered

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

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

Your Cost Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider during the 60 days of care, you also pay the balance bill.

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

Benefit-Specific Maximum: Benefits are limited to 60 combined days of EAR and SNF services per member, per calendar year, for services received from out-of-network providers. This limit does not apply to claims for EAR or SNF services submitted with a primary behavioral health diagnosis.

Benefit Description: Benefits are available for an intense therapy program which is provided in a facility licensed to provide EAR and/or SNF services and which meets the following criteria:

- A physician or RN practitioner is present on the premises of the facility or on-call at all times;
- Room and board in a semi-private room or a standard private room (not deluxe) is covered if the hospital only has private rooms or if a private room is medically necessary;
- Services must be for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time;
- Skilled nursing services must be provided by and under the supervision of qualified and licensed professionals, such as an LPN or RN, and provided at a level of complexity and sophistication requiring assessment, observation, monitoring, and/or teaching or training to achieve the medically desired outcome;
- The facility has 24/7 onsite RN coverage;
- The facility has sufficient professional staff to provide appropriate treatment;
- The facility's designated medical director is a physician or RN practitioner and provides direction for services provided at the facility; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

Benefit-Specific Exclusions:

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

U. LONG-TERM ACUTE CARE (INPATIENT)

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

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

Benefit Description: Benefits are available for specialized acute, medically complex care for patients who require extended hospitalization and treatment in a facility that is licensed to provide long-term acute care and which offers specialized treatment programs and aggressive clinical and therapeutic interventions. Room and board is only covered in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary.

Benefit-Specific Exclusions:

- Custodial care
- Domiciliary care
- Medications dispensed at the time of discharge from the facility
- Respite care

V. MATERNITY

Your Cost Share:

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

Outpatient Services:

In-Network: You pay a $10 copay for PCHM Providers, and for all other providers, you pay a $30 copay, which covers all prenatal visits, the physician's Global Charge and other physician office visits submitted with a primary diagnosis of maternity. If the amount of your copay changes during the course of your pregnancy, you will also pay the difference between the two copay amounts in addition to the original copay amount (even though you already paid the original copay amount). You pay in-network deductible and coinsurance for other covered maternity services.

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

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

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

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

Benefit-Specific Definition: **"Global Charge"** is a fee charged by the delivering provider that may include certain prenatal, delivery and postnatal services.

Benefit Description: Maternity benefits are available for covered services related to pregnancy. This includes certain screening tests such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases and others as determined by BCBSAZ. Certain tests, including some genetic screening, may not be covered. For a complete listing of covered prenatal screening, please call BCBSAZ Customer Service at the number on your ID card. Covered maternity services are available from birthing centers.

Maternity benefits are available for the expense incurred by a birth mother, including a surrogate, 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 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 Customer Service at the number on your ID card to receive a BCBSAZ adoption packet.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act: Under federal law, group health plans and health insurance issuers offering group health insurance coverage 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 healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours for the mother and

newborn child following a normal vaginal delivery or 96 hours for the mother and newborn child following a cesarean section delivery. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, call the Customer Service number on your ID card.

W. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Your Cost Share: You pay applicable deductible and coinsurance for the Cost for Medical Foods. The cost-share amount will depend on the provider's network status.

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

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

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

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

- Administered for the medical and nutritional management of a member who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation;
- Essential to the member's optimal growth, health and metabolic homeostasis;
- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an MD or DO physician or a RN practitioner;
- Processed or formulated to be deficient in 1 or more of the nutrients present in typical foodstuffs (metabolic formula only); **and**
- Processed or formulated to contain less than 1 gram of protein per unit of serving (modified low protein foods only).

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

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 MD or DO physician or RN practitioner
- Foods and formulas that do not require supervision by an MD or DO physician or a RN practitioner
- Food thickeners, baby food, or other regular grocery products
- Medical foods and formulas for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
- Nutrition for a diagnosis of anorexia
- Nutrition for nausea associated with mood disorder, end stage disease etc.
- Spices and flavorings
- Standard oral infant formula

Claims for Reimbursement: 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 RN practitioner;
- The amount paid for the Medical Foods;
- The dated receipt or other proof of purchase; **and**
- The name, telephone number, and address of the medical food supplier.

Medical Foods claim forms are available from BCBSAZ. Submit the completed Medical Foods claim form and the dated receipt to the address for claims submission at the front of this book. Medical Foods also may be covered under the *"Home Health and Home Infusion – Medication Administration Therapy Services"* benefit.

X. MEDICATIONS FOR THE TREATMENT OF CANCER

Your Cost Share: This Medical Certificate does *not* provide prescription medications for the treatment of cancer received through a *pharmacy* benefit. Contact your group benefit administrator for information.

You pay applicable deductible, coinsurance, and copays for medications received through your *medical* benefits. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: **"Off-label Prescription Medication"** means a medication that is FDA approved for treatment of a diagnosis, or condition other than the cancer diagnosis, or condition for which it is being prescribed, and which meets all requirements of Arizona law for mandated coverage of off label use. These requirements include, but are not limited to, scientific evidence that the drug has been recognized as safe and effective for the specific type of cancer for which it is being prescribed.

Benefit Description: Benefits are available, to the extent required by applicable state law, for off-label use of prescription medications and also for services directly associated with the administration of such medications. All other applicable benefit limitations and exclusions will apply to this benefit.

In administering claims for an Off-label Prescription Medication, BCBSAZ does not represent or warrant that the prescribed medication is safe or effective for the purpose for which your treating provider has prescribed the medication. Decisions regarding whether the medication is safe and effective for the type of cancer for which it has been prescribed and whether it is appropriate for you, are decisions to be made by your provider using his or her independent medical judgment. If the medication is subject to prior authorization, 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.

Y. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

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

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

Z. OUTPATIENT SERVICES

Your Cost Share: Outpatient services are often available in multiple settings and generally result in separate charges for professional and facility services. Your cost share will vary depending on the type of outpatient service, the location of the service, and the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill. You pay applicable deductible and coinsurance for all bariatric surgeries.

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

Your in-network cost share is waived for genetic tests to identify risks of colon cancer.

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

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

Benefit Description: Benefits are available for the following outpatient services and include, but are not limited to, any services that would be covered if performed as an inpatient service:

- Adjustments to bariatric surgery provided while the member was covered under another plan
- Allergy testing, antigen administration, and desensitization treatment
- Blood transfusions, whole blood, blood components, and blood derivatives
- Certain genetic tests to identify risks of colon cancer
- Diagnostic testing, including radiology, laboratory services, and biomarker testing
- Dialysis
- End-stage renal disease services
- Epidural and facet injections and radio frequency ablation for pain management
- Gender-affirming care
- Infusion/IV therapy in an outpatient setting
- In-network benefits are available for covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction Center.
- Maternity services provided in birthing centers
- Medications and the administration of medications in an outpatient setting
- Orthognathic treatment and surgery, including but not limited to dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)
- Outpatient and ambulatory cardiac testing, angiography, sleep testing (including sleep studies and polysomnography), and video EEG
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant
- Surgery and other invasive procedures
- Treatment of Temporomandibular Joint Disorders (TMJ)

AA. PHARMACY BENEFIT

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

BB. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST), AND COGNITIVE THERAPY (CT) SERVICES

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

Benefit-Specific Maximum: There is a maximum combined in- and out-of-network benefit of 60 PT, OT, ST and CT evaluations and visits per member, per calendar year. Prior authorization is required for visits exceeding the 60 visit limit for physical therapy, occupational therapy, speech therapy and cognitive therapy.

Benefit-Specific Definitions: **"Cognitive Therapy"** is treatment that focuses on present thinking, behavior, and communication, rather than on past experiences, and is oriented toward problem solving.

"Occupational Therapy" is treatment of neuromusculoskeletal dysfunction (injuries or disorders of the musculoskeletal system, such as muscles, tendons, ligaments, nerves, discs, and blood vessels) using specific tasks or goal-directed activities to improve functional performance.

"Physical Therapy" is treatment of disease or injury using therapeutic exercise and other measures to improve posture, locomotion, strength, endurance, balance, coordination, range of motion, flexibility, and ability to perform activities of daily living, and to help reduce pain.

"Speech Therapy" is treatment of communication impairment and swallowing disorders.

Benefit Description: Benefits are available for PT, OT, ST, and CT services related to a specific illness or injury and includes coverage for members diagnosed with autism spectrum disorder. Services performed by a chiropractor will accumulate to the chiropractic visit limit of 36 visits per member, per calendar year. See the *"Chiropractic Services"* for benefits.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration and home independence
- Any care for comfort and convenience
- Custodial care
- Domiciliary care
- Massage therapy
- Occupational therapy for any purpose other than training the member to perform the activities of daily living
- Phase 3 cardiac rehabilitation programs
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Strength training, cardiovascular endurance training, fitness programs, strengthening programs and other services designed primarily to improve or increase strength
- Work re-entry therapy, services, or programs

CC. PHYSICIAN SERVICES

Your Cost Share:

In-Network: You pay a $10 copay per member, per provider, per day for office, home and walk-in clinic visit services received from PCMH Providers. For all other in-network providers, you pay in-network deductible and coinsurance for office, home and walk-in clinic visits. If you receive preventive services during one of these visits, your cost share may be waived, as described in the *"Preventive Services"* section of this Medical Certificate.

You pay in-network deductible and coinsurance for non-preventive physician services provided in locations other than an office, home, or walk-in clinic, including but not limited to, inpatient and outpatient facilities. If you receive preventive physician services that are billed separately from inpatient or outpatient facility charges, your cost share for those services may be waived as described in the *"Preventive Services"* section of this Medical Certificate.

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

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

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

Benefit Description: Benefits are available for the following:

- Abortifacient medications for the abortions covered under this plan, including oral medications as described in current evidence-based criteria
- Allergy testing, antigen administration, and desensitization treatment
- Foot care, including trimming of nails or treatment of corns or calluses, when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg
- Gender-affirming care
- Certain genetic tests to identify risks of colon cancer
- Inpatient medical visits
- Medications and the administration of medications in a physician's office
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics) for the diagnosis and treatment of a sickness or injury

- Orthognathic treatment and surgery
- Second diagnostic surgical opinions
- Services for FDA-approved patches, rings, and contraceptive injections; FDA-approved diaphragms, cervical caps, cervical shields, condoms, sponges, and spermicides, and FDA-approved emergency contraception.
- Services for FDA-approved female sterilization procedures
- Services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices
- Services for FDA-approved female implanted contraceptive devices
- Sleep studies
- Surgical procedures (including assistance at surgery). Call Customer Service at the number on your ID card 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.
- Treatment of TMJ

The following circumstances may impact member cost share for physician services:
- If multiple surgical procedures are performed during a single operative session, the secondary procedures are usually reimbursed at reduced amounts. Noncontracted providers may bill the full amount for secondary, incidental or mutually exclusive procedures, in addition to the primary surgical procedure.
- You may receive services in a physician's office that incorporate services or supplies from a provider other than your physician. If the other provider submits a separate claim for those services or supplies, you will pay the cost share for the other provider plus the cost share for your office visit. Examples of services or supplies from another provider include DME from a medical supply company, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

DD. POST-MASTECTOMY SERVICES

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

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

Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving the mastectomy-related benefits described above under "Benefit Description," coverage will be provided in a manner determined in consultation between the attending physician and the member being treated. These benefits are subject to the same cost share generally applicable to other medical and surgical benefits provided under this plan, as described in the "Member Cost Share" section of your SBC. If you would like more information on WHCRA benefits, call BCBSAZ Customer Service at the number listed on your ID card.

EE. PREGNANCY, TERMINATION

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

Benefit Description: Benefits are available for abortions that meet the following requirements:
- The treating provider certifies in writing the abortion is medically necessary in order to save the life of the mother or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.

Benefits are also available for abortifacient medications for the abortions covered under this plan, including some oral medications, as described in current evidence-based criteria.

Benefit-Specific Exclusion: Abortions, except as stated in this benefit.

FF. PREVENTIVE SERVICES

Your Cost Share:

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

- You receive one of the services listed in the Benefit Description subsection of this Preventive Services section;
- The diagnosis code, procedure code, or the combination of procedure and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive; **and**
- The primary purpose of the visit at which you received services was for preventive care.

Out-of-Network

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

Routine Mammography Services: You have no coverage for routine mammography services received from out-of-network providers.

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

Benefit-Specific Maximum: Benefits are limited to 1 manual or electric (not hospital grade) breast pump and breast pump supplies per member, per calendar year. This limit does not apply to claims for Preventive Services submitted with a primary behavioral health diagnosis.

Benefit Description: Benefits are available at no charge when obtained from an in-network provider. Coverage is provided for the following services recommended by your provider and as appropriate for the member's age and gender, and as recommended by:

- Advisory Committee on Immunization Practices (ACIP) routine immunization recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html
- Health Resources and Services Administration (HRSA) guidelines for pediatric and adolescent preventive care and screening at https://mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html
- HRSA guidelines for women's healthcare services at www.hrsa.gov/womens-guidelines/index.html
- U.S. Preventive Services Task Force (USPSTF) A or B graded services at https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

Benefits are also specifically available at no charge when obtained from an in-network provider for the following services:

- Contraceptives and sterilization as described in the *"Family Planning (Contraceptives and Sterilization)"* section
- Mammograms for routine breast cancer screening
- Preexposure prophylaxis (PrEP) and related services for members at high risk for HIV
- Prostate specific antigen (PSA) testing and digital rectal examination (DRE) for members age 40 and older, or for members under age 40 who are at high risk due to:
  - Family history (such as multiple first-degree relatives diagnosed at an early age);
  - African-American race; **or**
  - Previous borderline PSA levels
- Well-baby/child care up to 47 months; childhood immunizations

Benefits will be provided for any other preventive service required by federal or state law. For questions about Preventive Services covered under this benefit, call Customer Service at the number on your ID card or log in to your MyBlue account on www.azblue.com for more preventive health information and links.

If a preventive service has been denied due to your gender on file with BCBSAZ, and you are undergoing or have undergone gender transition, please contact Customer Service at the number on your ID card for assistance. BCBSAZ covers all gender-specific Preventive Services that are deemed medically necessary for a member, as determined by the member's attending provider, without regard to the member's gender identity, gender assigned at birth, or gender that is on file with BCBSAZ.

Services or tests included 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 also are available through the *"Maternity"* benefit.

Benefit-Specific Exclusions:

- Abortifacient medications
- All prescription and over-the-counter contraceptive medications and devices for male members
- Except as stated in this benefit book, preventive services provided by an out-of-network provider

GG. RECONSTRUCTIVE SURGERY AND SERVICES

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

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

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

Benefit-Specific Exclusion: Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations, and other services for cosmetic purposes. This exclusion does not apply to:

- Breast reconstruction following a medically necessary mastectomy, to the extent required by federal and state law
- Medically necessary breast implant removal
- Other services required by federal or state law to be covered

HH. SPECIALTY MEDICATIONS

This Medical Certificate does not provide a specialty medication benefit. Contact your group benefit administrator for information.

Some specialty medications may be covered under the "Home Health and Home Infusion – Medication Administration Therapy" benefit.

II. TELEHEALTH SERVICES – BLUECARE ANYWHERE

Your Cost Share: Your cost share is waived.

Benefit Description: Remote medical and behavioral health consultations between a provider and a patient are offered by the TSA through BlueCare Anywhere, including:

- Counseling with a psychologist or other licensed therapist
- Medical consultations with a physician, physician's assistant, or nurse practitioner
- Psychiatry consultations with a psychiatrist

To use BlueCare Anywhere telehealth services, see the Customer Service section of this Medical Certificate for information on how to contact the TSA. After you connect with a provider, if he or she determines that your condition is not appropriate for telehealth services, the provider will suggest that you seek in-person treatment.

Benefit-Specific Exclusions:
- Emergency services
- Preventive services
- Services not provided through the TSA

JJ. TRANSPLANT OR GENE THERAPY TRAVEL AND LODGING

Your Cost Share: Waived.

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

Benefit-Specific Maximum: Benefits are limited to a maximum of $10,000 per member, per transplant or gene therapy treatment. Covered expenses incurred by a Caregiver or donor accumulate toward the member's $10,000 maximum.

Benefit Description: Transplant travel and lodging expenses are eligible for reimbursement during evaluation, transplant, post-transplant care, and complications directly related to the transplant. Reimbursement is available for transplant or gene therapy travel and lodging expenses when all the following criteria are met:
- BCBSAZ has given prior authorization for the service or, if BCBSAZ did not give prior authorization for the service, upon review we determine the service meets the requirements of this benefit plan;
- The distance from the member's, donor's, or caregiver's residence must be more than 60 miles from the facility;
- The expenses are incurred by the member, donor, or the member's Caregiver; **and**
- The expenses are for any of the following:
  - Meal expenses;
  - Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; bus; train or air fare; **and**
  - Room charges from hotels, motels, and hostels or apartment rental.

Benefit-Specific Exclusions:
- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or Internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of the benefit-specific maximum
- Ambulance transportation (ground or air)
- Caregiver salary, stipend, and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with services that do not qualify for coverage under this benefit plan
- 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 60 miles for authorized transplant- or gene therapy-related services
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement: To request reimbursement of eligible 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 is listed in the Customer Service section at the front of this book. To request a claim form, call the Customer Service number on your ID card.

KK. TRANSPLANTS – ORGAN – TISSUE – BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES

Your Cost Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill. If both a donor and a transplant recipient are covered by a BCBSAZ plan or a plan administered by BCBSAZ, the transplant recipient pays the cost share related to the transplant.

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: In-network benefits are available for covered transplant services from plan network providers, providers contracted with Host Blue plans, and Blue Distinction Centers for Transplants. The following transplants are eligible for coverage if they meet current evidence-based criteria:

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

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

- 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
- Inpatient and outpatient facility and professional services
- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ. Covered donor expenses include complications and follow-up care related to the donation for up to 6 months post-transplant, as long as the recipient's BCBSAZ coverage remains in effect
- Pre-transplant testing and services
- Procurement of an organ from a cadaver or live donor, including surgery to remove the organ; transportation, hospitalization, and surgery of a live donor

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 current evidence-based criteria

LL. URGENT CARE

Your Cost Share: You pay in-network deductible and coinsurance for services received from in- and out-of-network providers. If you receive services from a noncontracted provider, you also pay the balance bill. No matter what the circumstances, if you obtain Urgent Care services at a hospital or a hospital's on-site Urgent Care department, you will be responsible for the applicable emergency room cost share.

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

Benefit Description: Benefits are available for Urgent Care services. Providers contracted with the plan network as Urgent Care centers are listed on the BCBSAZ website at www.azblue.com under "Urgent Care Centers." Please be aware that the plan network includes some Providers, such as hospitals, that offer Urgent Care services, but which are not specifically contracted with the plan network as Urgent Care Providers. See *"Emergency Services"* for information about services you receive from certain providers, such as hospitals, that are not specifically contracted with the plan network as Urgent Care providers.

MM. VISION EXAMS (ROUTINE); EYEWEAR

Your Cost Share:

Vision Exams (Routine):

For Members Under Age 5: Applicable cost-share is waived for services from an in-network provider.

For Members Age 5 and Older: You pay a Routine Vision Exam copay for an exam by an in-network vision care provider.

If a medical condition is identified during your Routine Vision Exam, you will be responsible for the applicable cost share, as described in the *"Physician Services"* section of this book.

Eyewear:

For Members Under Age 19: Cost-share is waived. The Plan pays 100% of the allowed amount every 12 months for 1 pair of contact lenses and 1 pair of eyeglasses (frames, single lenses, bifocal lenses and trifocal lenses) provided by an in-network provider.

For Members Age 19 and Older: The Plan pays the following amounts every 12 months for 1 pair of eyeglasses and 1 pair of contact lenses. You pay the difference between the following amounts and the cost of the eyeglasses and/or contact lenses:

$20 per pair of single vision lenses
$30 per pair of bifocal lenses
$40 per pair of trifocal lenses
$30 per frame
$75 per pair of contact lenses (Dollar limit does not apply to contact lenses for the treatment of keratoconus or following cataract surgery)

Benefit-Specific Definition: A **"Routine Vision Exam"** is an exam generally performed to determine the need for corrective lenses.

Benefit-Specific Maximum: Benefits are limited to:
- 1 routine vision exam per member, per 12 month period
- 1 pair of eyeglasses per member, per 12 month period
- 1 pair of contact lenses per member, per 12 month period

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

Benefit-Specific Exclusions:
- Deluxe lens features
- Eye exams, eyeglasses, contact lenses and other eyewear services provided by out-of-network providers
- Lens upgrades
- Medical eye exams (such exams may be covered through another benefit of this plan)
- Office infection control charges
- Scratch resistant and UV coating
- Services not meeting accepted standards of optometric practice
- State or territorial taxes on vision services performed

WHAT IS NOT COVERED

Notwithstanding any other provision in this plan, no benefits will be paid for expenses associated with the following services. These exclusions do not apply to services that must be covered according to federal or state law:

Abortions, except as stated in this plan

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

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 benefit sections

Biofeedback

Blood Administration for the purpose of general improvement in physical condition

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

Care required by federal or state law to be supplied by a public school system or school district

Certain Types of Facility Charges – Inpatient and outpatient facility charges for treatment provided by group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes

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

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

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

Cosmetic Services and any Related Complications – Surgery and any related complications, procedures, treatment, office visits, consultations, and other services for cosmetic purposes. This exclusion does not apply to:

- Breast reconstruction following a medically necessary mastectomy
- Medically necessary breast implant removal
- Medically necessary surgery to improve or restore the impaired function of a body part or organ
- Surgery to correct a congenital defect

Cosmetics and health and beauty aids

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

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

Custodial Care

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

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

Domiciliary Care

Expenses for services that exceed benefit limitations

Experimental or Investigational Services or Items, except as stated in this plan

Fees that are –
- Associated with the collection or donation of blood or blood products
- Other than for medically necessary, in-person, direct member services, except as stated in this plan
- For concierge medicine services, **or**
- For direct primary care

Fertility and Infertility Services – Services to improve or achieve fertility (ability to conceive)

Flat Feet – Services for treatment of flat feet, weak feet, and fallen arches

Foot Care – Services for foot care, including trimming of nails or treatment of corns or calluses

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

GIFT, ZIFT, In-Vitro Fertilization, Artificial Insemination and Costs Associated with Collection or Storage of Sperm or Eggs

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

Growth Hormone – Growth hormone to treat idiopathic short stature (ISS)

Habilitation Services, except for certain limited services to treat autism spectrum disorder

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

Hypnotherapy

Inpatient or Outpatient Non-acute Long-term Care

Laboratory Services Provided Without an Order From an Eligible Provider

Lifestyle and work-related education and training, and management services

Lodging and Meals, except as stated in this plan

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

Manipulation of the Spine Under Anesthesia

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

Massage Therapy

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; or at garage sales, swap meets, and flea markets

Medications that 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 current evidence-based criteria
- Off-label, unlabeled, and orphan medications, except as stated in this plan
- Used to treat a condition not covered by BCBSAZ

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 home health agency or hospital emergency room

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

Neurofeedback

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

Non-Medical Ancillary Services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy

Orthoses and Orthotic Devices, except as stated in this plan

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

Payments for exclusions imposed by any certification requirement

Payments for services that are unlawful in the location where the service is performed at the time the expenses are incurred

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

Phase 3 Cardiac Rehabilitation

Prescription Medications Obtained from a Retail or Mail Order Pharmacy or Specialty Pharmacy

Private Duty Nursing

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

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

Respite Care, except as covered in the *"Hospice Services"* benefit

Reversal of Surgical Procedures, except as stated in current evidence-based criteria and other criteria as determined by BCBSAZ

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, or as required by law

Sensory Integration and Music Therapy

Service Animals and related costs, including but not limited to food, training and veterinary costs

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

Services for the administration of drugs that can be self-administered, except when medically necessary

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

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 Ineligible Providers (see *"Eligible Providers"* section of this book)

Services Paid for by Other Organizations or Those Required by Law to be Paid for by Other Organizations – Other organizations include, but are not limited to, the government, a school, and/or biotechnical, pharmaceutical, medical, or dental device industry organizations.

Services Prior to Member's Coverage Effective Date

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

Services 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 not related to organic disease and medications for the treatment of sexual dysfunction

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

Telehealth Services not provided by the TSA through BlueCare Anywhere

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

Therapy Services, except as stated in this plan

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

Training and Education, except as stated in this plan

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

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

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

Wigs and hairpieces, except as stated in this plan

Workers' Compensation – Services to treat illnesses and injuries that are:

- Covered by workers' compensation; **and**
- Expressly identified as workers' compensation claims when submitted to BCBSAZ.

This exclusion does not apply if the member has made a statutory opt-out election and/or is exempt from workers' compensation coverage.

PLAN ADMINISTRATION

Changes to Your Information

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

Notify BCBSAZ Customer Service and Plan Sponsor within thirty-one (31) days of when the following change(s) occur:

- A disabled dependent age twenty-six (26) or older who is no longer disabled
- Eligibility of you or your dependents for Arizona Health Care Cost Containment System (AHCCCS) or other Medicaid coverage during the term of this contract
- Eligibility of you or your dependents for basic health plan (BHP) coverage during the term of this contract
- Eligibility of you or your dependents for individual coverage purchased through a federal or state Exchange.
- Eligibility of you or your dependents for Medicare during the term of this contract
- Eligibility of you or your dependents for the Children's Health Insurance Program (CHIP) coverage during the term of this contract
- Individuals being added to the benefit plan: Spouse, newborns, adopted children, children placed for adoption, stepchildren
- Individuals removed from the benefit plan due to divorce or death
- Other medical coverage that you or your dependents add or lose, including any changes in benefits
- Your mailing address or phone number

Coordination of Benefits (COB)

If you have benefits under another group health plan, and the other group plan is the primary payer, then the combined benefit payments from all coverages cannot be more than the greater of the primary payer's or BCBSAZ's allowed amount. If your other group health insurance does not include a COB provision, the other group coverage pays first. If your other group health insurance provides for COB, the following rules will be used to determine which coverage will pay first:

- If the person who received care is covered as an active employee under one plan and as a dependent under another, the employee coverage pays first.
- If the person who received care is a dependent child, then the plan of the parent whose birthday occurred earlier in the calendar year covers the child first.
- If both parents have the same birthday, the benefits of the plan that has covered a parent longer covers the dependent child first.
- If the dependent child's parents are legally separated or divorced, the following applies:
  - ♦ 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, then the plan of the parent whose birthday occurred earlier in the calendar year pays first.
  - ♦ If a court decree specifies the parent who is financially responsible for the child's healthcare expenses, the specified parent's coverage pays first.
- If 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 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.

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"*).

If you have coverage under Medicare, Medicare guidelines will be used to determine the primary payer. If the provider accepts assignment from Medicare, the combined payments by Medicare and BCBSAZ will not exceed the Medicare allowed amount. If the provider does not accept assignment from Medicare the combined payments by Medicare and BCBSAZ will not exceed the provider's billed charges. If the provider opts-out of Medicare, BCBSAZ is the primary payer.

Non-Duplication of Benefits

If services are covered under this Medical Certificate and one or more other group benefit plans that are issued or administered by BCBSAZ, the rules described 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 Medical Certificate 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% 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 Plan Administration

- **"Dependents"** The term "Dependent(s)" means:

  1. An Employee's legally married spouse (does not include a spouse from whom the Employee is legally divorced[1], legally separated, or whose marriage has been legally annulled) or Qualified Domestic Partner (see definition herein); and

  2. Any child of an Employee who is
     - Less than twenty-six (26) years old;
     - Twenty-six (26) or more years old, primarily supported by the Employee and prior to age 26 has been determined to be incapable of self-sustaining employment by reason of mental or physical handicap.

     The term child means a child born to or legally adopted by you/your Qualified Domestic Partner, including any waiting period prior to the finalization of the child's adoption. It also means a stepchild, or the child of your Qualified Domestic Partner, or a child you/your Qualified Domestic Partner has either legal custody due to a court order or court-approved legal guardianship.

  3. A Qualified Domestic Partner and the child(ren) of the Qualified Domestic Partner are eligible to enroll for coverage as Dependents on the same basis as other eligible Dependents.

- **"Qualified Domestic Partner"** The term "Qualified Domestic Partner" means a person of the same or opposite gender who:

  1. Does not have any other Qualified Domestic Partnership, spouse, or spousal equivalent of the same or opposite sex;

  2. Has not signed a declaration or affidavit of Qualified Domestic Partnership with any other person within the last twelve (12) months;

  3. Has been approved for coverage by means of the City's Qualified Domestic Partnership (QDP) application and/or reverification process.

  The Qualified Domestic Partner may be covered under the City of Phoenix medical benefits[2] when the City of Phoenix Benefits Office has determined that all of the following conditions are met:

  1. The Qualified Domestic Partner is the only person meeting the policy's definition of Qualified Domestic Partner with respect to the Employee; **and**

  2. The Employee and the Qualified Domestic Partner furnish a notarized affidavit reflecting these requirements and agree to notify the City of Phoenix Benefits Office within thirty-one (31) days, if the requirements cease to be met using forms provided by the City of Phoenix Benefits Office.

[1] The date of a divorce is considered to be the date the judge files the signed order with the Clerk of the Court (such date will be stamped on the order by the Clerk).
[2] Continuation of medical coverage is not required under federal COBRA laws for Qualified Domestic Partners, but the City provides medical coverage under the same terms that apply to a married Employee's spouse.

Please find a Qualified Domestic Partner application packet online at employee.phoenix.gov/benefits under Forms and Docs.

- **"Children of a Qualified Domestic Partner"** are the children of the Qualified Domestic Partner, including natural children, legally adopted children, children placed for adoption, children under legal guardianship substantiated by a court order, and children who are entitled to coverage under a medical child support order.

- **"Disabled Dependent Child"** is a child who is already covered by the City's medical plan and who, within thirty-one (31) days of ceased coverage due to reaching age twenty-six (26), has made application for continued coverage due to disability. A Disabled Dependent Child may continue coverage if the child is otherwise eligible for coverage and meets all of the following criteria: (1) has been covered up to the day he/she is no longer eligible for coverage based on the age limit(s) specified in this Medical Certificate; and (2) is continuously incapable of self-sustaining employment due to a continuous physical or intellectual disability or condition as supported by current evidence-based criteria, on the date the dependent reaches age 26; and (3) is chiefly dependent upon the Employee for maintenance and support.

- **"Employee"** refers to the person eligible for coverage due to his/her employment relationship with the City of Phoenix.

- **"Group"** refers to the employer or other entity to which a Group Master Contract is issued under which the Employee and/or Dependents become entitled to medical coverage. The Group Master Contract controls the administration of the group coverage and is on file with the City of Phoenix. The coverage described in this Medical Certificate will terminate when the Group Master Contract terminates. It is the responsibility of the City of Phoenix to notify members in the event the Group Master Contract is terminated by the City of Phoenix or if the Group Master Contract is terminated for non-payment of premiums. BCBSAZ will notify members if the Group Master Contract is terminated for any other reason.

- **"Open Enrollment"** is an annual period during which the Employee and/or Dependents are eligible to enroll for coverage or change options. The City of Phoenix Benefits Office will notify the Employee when the City of Phoenix has established the annual open enrollment period.

Eligibility Requirements

- **Children** – Children, including children of a domestic partner who meets the domestic partnership eligibility criteria, are eligible for Dependent coverage through the end of month in which they reach age twenty-six (26).

- **Contract Holder** – A Contract Holder becomes eligible to enroll for coverage after meeting the group's eligibility requirements outlined in the City's 125 Plan Document.

- **Disabled Dependent Child -** A child who has reached age twenty-six (26) may continue coverage as an eligible dependent under this plan if the child is otherwise eligible for the plan and meets all of the following criteria:
  - ♦ Has been covered under this plan up to the day they are no longer eligible for coverage based on age limit(s) specified in this plan;
  - ♦ Is totally disabled due to a continuous physical or intellectual disability or condition, as defined by evidence-based medical criteria, on the date the dependent reaches age 26; and
  - ♦ Contract holder completes and submits application to continue coverage under this plan within thirty-one (31) days from date of coverage termination.

Effective Date of Coverage

For an Employee who has satisfied the eligibility requirements as of the effective date of the Group Master Contract, the effective date of the Group Master Contract is his/her effective date of coverage.

For an Employee who does not meet the eligibility requirements until after the Effective date of the Group Master Contract, unless the Eligible Employee becomes eligible on the first day of a month, the effective date will be on that date (as long as the Eligible Employee makes their election within thirty-one (31) days from the date of hire).

1. Dependents

    a) For a Dependent (other than a newborn or a child adopted or placed for adoption) who is acquired after the Employee's effective date, his/her effective date of coverage will be the date of acquisition, as long as the Employee enrolls the Dependent within thirty-one (31) days after the date of acquisition.
    b) A newborn child of an Employee who has coverage or a child who is adopted by or placed for adoption with an Employee will automatically be covered for thirty-one (31) days from the date of birth, adoption or placement for adoption.

    To continue coverage beyond the first sixty (60) days, the Employee must enroll the child for Dependent coverage during the first 60 days from the date of birth, adoption or placement for adoption.

2. If Employees and/or their Dependents are covered by another medical plan sponsored by the City of Phoenix up to the day on which they become covered under this medical plan, the effective date of coverage for such individuals, except as otherwise provided herein, will be the renewal date immediately following an open enrollment period.

Loss of Eligibility/Termination Date of Coverage

1. Employee eligibility ceases upon:

    a) The date the Employee ceases to be Eligible as defined by the City of Phoenix or ceases to qualify for insurance;
    b) the last day for which the Employee has made any required contribution for coverage;
    c) the date the policy is cancelled;

2. Dependent eligibility ceases upon the date the Dependent ceases to be Eligible as defined by the City of Phoenix or ceases to qualify for insurance, to include:

    a) the date of death;
    b) the date the Employee dies;
    c) the date the Employee's coverage ceases;
    d) the date the Employee ceases to be eligible for Dependent insurance;
    e) the last day for which the Employee made any required contribution for coverage; or
    f) the date the Dependent insurance is cancelled.

3. Qualified Domestic Partner eligibility ceases:

    In addition to the reasons stated above concerning dependent spouses and children, a qualified domestic partner and/or the children of the qualified domestic partner also lose eligibility for coverage as follows:

    a) The end of the month in which the qualified domestic partner who is the eligible Employee loses coverage under this Medical Certificate;
    b) The end of the month in which the qualified domestic partnership is terminated or dissolved;
    c) The end of the month the group discontinues eligibility for qualified domestic partners and/or eligible children of the domestic partner.

Termination Date of Coverage

1. Employee coverage ends on the date the Employee ceases to be Eligible as defined by the City of Phoenix or ceases to qualify for insurance to include:

    - The date of death.

2. Dependent coverage ends on the date the Employee ceases to be Eligible as defined by the City of Phoenix or ceases to qualify for insurance to include:

    - The end of the month during which the divorce decree is filed with the Clerk of the Court (such date will be stamped on the order by the Clerk).
    - The end of the month in which the disability or dependency ceases for a child over age twenty-six (26).
    - The end of the month in which a child covered by a medical child support order is no longer eligible under the court order or administrative order.

- The end of the month in which the Employee's death occurs.

3. The coverage terminates for a qualified domestic partner and/or the children of the qualified domestic partner is the same as described in this Medical Certificate for employees and Dependents.

   A qualified domestic partner and/or their children who become ineligible for this coverage may be eligible for continuation coverage. Please contact the City of Phoenix Benefits Office for information concerning eligibility for group continuation coverage. For information on other individual (non-group) coverage, such as individual portability coverage, please contact BCBSAZ.

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

   - The date the Group Master Contract terminates; **or**
   - The dates set forth above.

   Employees' and/or Dependents' coverage ends no later than the date the Group Master Contract terminates. The date of termination will be 11:59 PM on the last day of the month in which eligibility ceased or such other date as the City of Phoenix requests.

   When an Employee's coverage terminates, coverage for all Dependents also terminates unless, approved by the City of Phoenix, due to Survivor Benefit allocation. Members may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Members may also be eligible for individual portability coverage.

   BCBSAZ will issue a certificate of creditable coverage upon receipt of notice of the Employee'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

Special Enrollment Provisions are defined by the City of Phoenix Life Event Chart and current 125 Plan document. The following is a list of examples, not all inclusive. Current City 125 Plan document prevails.

1. If Employees and/or their Dependents are covered by another medical plan sponsored by the City of Phoenix up to the day on which they become covered under this Medical Certificate, the effective date of coverage for such individuals, except as otherwise provided herein, will be the renewal date immediately following an open enrollment period.

2. If Employees and/or their Dependents lose coverage under another group health plan or qualify for special enrollment upon the occurrence of one of the events set out below, (referred to in this subparagraph as "the event"), the effective date of coverage for such individuals, unless otherwise indicated, will be the first day of the month following the event, as long as the Employee/Dependent enrolls within thirty-one (31) days of the loss of other coverage.

   a) The Employee or Dependent at the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefits plan and lost that coverage due to one of the following:

      1. the Dependent's termination of employment or eligibility;
      2. the death of an employed spouse;
      3. legal separation or divorce;
      4. termination of the other plan's coverage;
      5. reduction in the number of hours of employment;
      6. Dependent's employer terminates contributions toward coverage;
      7. an Employee or Dependent no longer resides, lives or works in a coverage service area and no other benefit package is available;
      8. exhaustion of COBRA continuation coverage;
      9. cessation of Dependent status under the other group health plan;
      10. reaching lifetime maximum under the other group health plan;
      11. any other special enrollment rights available under applicable law

   b) The City of Phoenix offers multiple medical plans and the Employee elects to move from one of the City of Phoenix' other medical plans to coverage under this medical plan during an open enrollment period.

c) A court orders that coverage be provided for a minor child who is otherwise eligible under an Employee's health benefits plan, and that Employee or the ex-spouse requests enrollment under this medical plan for the otherwise eligible minor child within thirty-one (31) days after the court order is issued.
d) An Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this medical plan was previously offered to the Employee or Dependent; the Employee's or Dependent's coverage was under COBRA and the coverage was exhausted or coverage was terminated as a result of loss of eligibility or employer contributions toward such coverage terminated, as long as the Employee enrolls in this medical plan within thirty-one (31) days of the loss of other coverage.

3. If an Employee declines coverage when first eligible and later acquires a Dependent as a result of marriage, birth, adoption or placement for adoption, the Employee and Dependent(s) are entitled to enroll for coverage upon such occurrence within thirty-one (31) days of the occurrence.

    a) If an Employee acquires a Dependent due to marriage, the effective date of coverage for the Employee and eligible Dependent(s) will be the date of the marriage as long as the Employee enrolls the Dependent within thirty-one (31) days of the date of marriage.
    b) If an Employee acquires a Dependent as a result of birth, adoption or placement for adoption, the effective date of coverage for the Employee, the newly acquired Dependent and any other eligible Dependent(s) will be the date of birth, adoption or placement for adoption. The Employee must enroll the Dependent within sixty (60) days in order to continue coverage after the first sixty (60) days.
    c) If enrollment information is not received by the City of Phoenix within the required time periods, an Employee and/or his or her Dependents will be considered "late enrollees," unless they fall into one of the exceptions set forth above. The Employee may not apply for coverage for himself or herself and/or his or her Dependents until the next annual open enrollment period, and the effective date of coverage will be the renewal date immediately following that open enrollment period.

4. If a court orders that coverage be provided for an otherwise eligible minor child of an Employee (or an Employee who is eligible but not currently enrolled) the effective date of coverage for such otherwise eligible minor child will be the date of the court order.

Leave of Absence

1. If Active Service ends due to layoff, coverage will continue to the end of the month in which the Employee's Active Service ceases.

2. If Active Service ends and the Employee is on an approved leave of absence, he/she may continue medical coverage as defined by the City's 125 Plan Document.

Medical Support Orders

Coverage is available to an eligible child of the employee in accordance with any court order or administrative order issued by a court of competent jurisdiction to provide medical benefits coverage to a child of the employee. The order must clearly specify the name and last known mailing address of the employee, and each child covered by the order, and the time period to which the order applies.

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

Termination of Coverage

Benefits After Termination

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

Continuation of Coverage

Under applicable law, it is the City's responsibility to inform employees and dependents of the availability, terms and conditions of continuation of coverage available under COBRA. COBRA laws require most employers that 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 the City of Phoenix Benefits Office to determine if you qualify for continuation coverage.

Benefit-Specific Eligibility

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

- If a transplant recipient is covered under this plan and the donor is not a member, the donor may be eligible for limited benefits. (See benefit description for *"Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures."*)
- If a non-member is pregnant with a baby that is to be adopted by a member of this plan, the non-member may be eligible for maternity benefits under the following circumstances:
  - The child is adopted by a member within 1 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.

Nondiscrimination Statement

BCBSAZ complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to enable people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and (877) 475-4799 for all other languages and other aids and services.

MULTI-LANGUAGE INTERPRETER SERVICES

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hólǫ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب .877-475-4799

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 877-475-4799
.[تماس حاصل نمایید.

Assyrian:

ܐܢ ܐܢܬܘܢ، ܐܘ ܚܕ ܦܪܨܘܦܐ ܕܥܡܘܕܪܝܬܘܢ ܠܗܘܢ، ܐܝܬܠܘܟܘܢ ܫܘܐܠܐ ܒܘܬ Blue Cross Blue Shield of Arizona، ܐܝܬ ܠܘܟܘܢ ܙܕܩܐ ܕܡܩܒܠܝܬܘܢ ܗܝܪܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܢܝܢܐ ܗܢܐ 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคณ หรอคนทคณกาลงชวยเหลอมคาถามเกยวกบ Blue Cross Blue Shield of Arizona
คณมสทธทจะไดรบความชวยเหลอและขอมลในภาษา ของคณไดโดยไมมคาใชจาย พดคยกบลาม โทร 877-475-4799