



# EPO

## Teal Plan

### Benefit Book

Town of Marana

Group # 35929

Effective July 1, 2020

[azblue.com](http://azblue.com)



An Independent Licensee of the Blue Cross Blue Shield Association

## **Town of Marana EPO Teal Benefit Plan**

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

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

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

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

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

This book is a health benefits Summary Plan Description (SPD). Your employer is responsible for the Plan Document. This benefit book may use words used in an insured plan. All such references shall be read to indicate that the plan is self-insured.

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

The employer reserves the right to amend or terminate this benefit plan at any time at its sole discretion. In the event of termination of the benefit plan, claims incurred prior to the date of termination will be covered.

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

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## PLAN INFORMATION

**Plan Name:** Town of Marana

**Plan Sponsor:** Town of Marana

**Employer Identification Number (EIN):** 86-0331775

**Plan Type:** Welfare

**Plan Administrator:**

Jennifer Lindblom; [jlindblom@maranaaz.gov](mailto:jlindblom@maranaaz.gov)  
11555 W. Civic Center Drive, Building A1  
Marana, AZ 85363

**Agent for Service of Legal Process:**

Town Clerk  
11555 W. Civic Center Drive, Building A1  
Marana, AZ 85363

**Claims/Benefits Administrator:**

Blue Cross Blue Shield of Arizona  
P.O. Box 2924  
Phoenix, AZ 85062-2924  
Telephone: (855) 801-4633

**Collective Bargaining Agreements:** Not applicable.

## 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 phone numbers on the back of your ID card.

### MyBlue<sup>SM</sup>

BCBSAZ also makes information available at [www.azblue.com](http://www.azblue.com) and you may wish to look there before calling. MyBlue is the member area on [www.azblue.com](http://www.azblue.com) that allows you to manage your health insurance plan from anywhere you have Internet access. Go to [www.azblue.com/member](http://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
- Research prescription benefits
- Access HealthyBlue<sup>®</sup> – tools for a healthier life

\*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.**

<b>Hours:</b>	Customer Service hours are Monday through Friday, 6:00 a.m. to 6:00 p.m. MST (except holidays). All other services are Monday through Friday, 8:00 a.m. to 4:30 p.m. MST (except holidays). Please call (855) 818-0237 for customer service.
<b>If you lose your ID card and need a replacement:</b>	(800) 232-2345
<b>Hearing Impaired (TDD):</b>	(602) 864-4823
<b>For assistance in Spanish (en Español):</b>	(602) 864-4884
<b>Mailing Address:</b>	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466

### Provider Locator & Benefit Vendor Information

<b>BlueCard<sup>®</sup> Program</b> (getting care outside of Arizona):	Blue Cross Blue Shield Association: (800) 810-2583 or website at <a href="http://www.bcbs.com">www.bcbs.com</a>
<b>Chiropractic Benefits Administrator (CBA)</b>	(800) 678-9133
<b>Pharmacy Benefit Customer Service</b>	(866) 325-1794
<b>Provider Network Status</b>	Check the online provider directory at <a href="http://www.azblue.com">www.azblue.com</a> or call BCBSAZ Customer Service at the numbers listed above
<b>Telehealth Services Administrator (TSA):</b>	Log in to MyBlue and click on the BlueCareAnywhere link; download the BlueCareAnywhere app available on Google Play or the App Store <sup>®</sup> go to <a href="http://www.BlueCareAnywhereAZ.com">www.BlueCareAnywhereAZ.com</a> ; or call (844) 606-1612.

### Claim Submissions

<b>Mail New Claims to:</b>	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix AZ 85062-2924
<b>Claims for Transplant Travel and Lodging:</b>	Attention: Transplant Travel Claim Processor, Mail Stop: A225, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
<b>Claims for Services Received on a Cruise Ship:</b>	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
<b>Claims for Chiropractic Services:</b>	Claims Administration, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001

### Disputes

<b>Medical Appeals and Grievances:</b>	Call the Customer Service number on the back of your ID card.
<b>Precertification Denial Appeals:</b>	Call the Customer Service number on the back of your ID card.
<b>Chiropractic Care Disputes:</b>	Call the Chiropractic Care Customer Service number on the back of your ID card, or write: Appeals Coordinator, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001 Telephone (800) 678-9133; Fax (619) 209-6237

### Social Media

Like us on Facebook: [www.facebook.com/bcbsaz](http://www.facebook.com/bcbsaz)

Follow us on Twitter: [www.twitter.com/bcbsaz](http://www.twitter.com/bcbsaz)

Email complaints and concerns to [socialcares@azblue.com](mailto:socialcares@azblue.com)

iPhone and Android phone users can download our mobile application via Google Play or App Store®

Android is a trademark of Google LLC.

iPhone is a trademark of Apple Inc., registered in the U.S. and other countries.

### Terms

Certain terms in this benefit book have specific meanings. Please see the "Definitions" section.



## 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 will explain which cost-share types apply to each benefit.

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

### ***Balance Bill***

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

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

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

### ***Benefit Maximums***

Some benefits may have a specific benefit maximum or limit based on the number of days or visits, type, timeframe (plan 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.

### ***Coinsurance***

Coinsurance is a percentage of the allowed amount that you pay for certain covered services after meeting any applicable deductible. BCBSAZ subtracts any applicable precertification charges from the allowed amount before calculating coinsurance. Coinsurance applies to every covered service unless the specific benefit section says it does not apply.

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 percent of the allowed amount on covered services, for the remainder of the plan year. The payments listed below do not count toward the out-of-pocket maximum. You must keep paying them even after you reach your out-of-pocket maximum:

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

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

***Plan-Year Deductible (Individual and Family)***

A plan-year deductible is the amount each member must pay for covered services each July through June before the benefit plan begins to pay for covered services. The deductible applies to every covered service unless the specific benefit section says it does not apply.

If you have family coverage, there is also a plan-year deductible for the family. Amounts counting toward an individual's plan-year deductible will also count toward any family deductible. When the family satisfies its plan-year deductible, it also satisfies the deductible for all the individual members. An individual member cannot contribute more than his or her individual deductible toward the family's deductible.

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

***Precertification Charges***

**Your provider must obtain precertification from BCBSAZ for any service that requires it.** Applicable precertification charges are shown on your SBC.

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

The following table shows your cost-share for covered services. More complete information can be found in the "**Description of Benefits**" section.

## COST-SHARE GRID

The following tables show your cost-share for your covered services. See the “Description of Benefits” section for additional information about these covered services.

	<b>COST-SHARE</b>
Physician Services (office, home, or walk-in clinic)	PCP – \$20 copay per member, per provider, per day Specialist – \$45 copay per member, per provider, per day
Plan-Year Deductible	\$800 per member, per Plan year \$1,600 family, per Plan year
Coinsurance	Plan pays 70%, member pays 30% of the BCBSAZ allowed amount, after meeting deductible. Please see benefits below for the exact cost-share amount.
Out-of-Pocket Maximum	\$3,200 per member, \$6,400 family, per Plan year.

**Please note:** Only emergency, ambulance, EGID and Medical Foods are covered out-of-network.

<b>BENEFIT</b>	<b>COST-SHARE</b>
AMBULANCE SERVICES	You pay deductible and 30% coinsurance.
BEHAVIORAL AND MENTAL HEALTH SERVICES (Inpatient)	You pay deductible and 30% coinsurance for inpatient facility and professional charges.
BEHAVIORAL AND MENTAL HEALTH SERVICES (Outpatient Facility and Professional Services and Treatment of Autism Spectrum Disorder)	You pay a \$20 PCP or \$45 Specialist copay per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. The amount of the copay will depend on type of provider. You pay deductible and 30% coinsurance for services received in locations other than office, home, or walk-in clinics.
CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES	You pay a \$20 PCP or \$45 Specialist copay, deductible and 30% coinsurance.
CATARACT SURGERY AND KERATOCONUS	You pay a \$20 PCP or \$45 Specialist copay, deductible and 30% coinsurance.
CHIROPRACTIC SERVICES	You pay a \$45 copay per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. The copay does not apply if you receive only physical medicine and rehabilitation services and no other covered service during your visit. You pay deductible and 30% coinsurance for physical medicine and rehabilitation services and for Chiropractic services received in other locations.
CLINICAL TRIALS	You pay a \$20 PCP or \$45 Specialist copay, deductible and 30% coinsurance.
DENTAL SERVICES BENEFIT – MEDICAL	You pay deductible and 30% coinsurance.
DIABETES AND ASTHMA EDUCATION AND TRAINING	Your cost-share is waived.
DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS	You pay a \$20 PCP or \$45 Specialist copay, deductible and 30% coinsurance. Your cost-share is waived for one FDA-approved manual or electric breast pump and breast supplies per member, per plan year.
EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)	<p>You pay your network cost-share for emergency services, even for services from out-of-network providers.</p> <p><u>Emergency Room:</u> You pay a \$175 copay per member, per facility, per day. Deductible and coinsurance are waived for professional services provided while in the emergency room.</p> <p><u>Admission to the Hospital from the Emergency Room:</u></p> <ul style="list-style-type: none"> <li>• The emergency room copay is waived if you are admitted as an inpatient to the hospital.</li> <li>• You pay deductible and 30% coinsurance for facility and ancillary services related to the emergency, including facility and ancillary services provided while you were in the emergency room.</li> </ul>

BENEFIT	COST-SHARE
	<ul style="list-style-type: none"> <li>You pay deductible and 30% coinsurance for the inpatient admission and any professional services provided while you are an inpatient in the hospital.</li> </ul> <p>If you receive emergency services from a noncontracted facility or professional provider, BCBSAZ will base the allowed amount used to calculate your cost-share on the provider's billed charges.</p> <p>For all non-emergency services following the emergency treatment and stabilization, you pay applicable cost-share. The cost-share amount will depend on the place you receive services. If you receive non-emergency services from a noncontracted provider, your benefits will be denied.</p>
EOSINOPHILIC GASTROINTESTINAL DISORDER	The deductible is waived. You pay 25% of the Cost for Formula.
FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)	<p><u>Implanted Devices:</u> Your cost-share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved implanted contraceptive devices when the purpose of the procedure is contraception, as documented by your provider on the claim.</p> <p><u>Sterilization Procedures:</u> Your cost-share is waived for professional and facility charges from 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 deductible and 30% coinsurance for FDA-approved male sterilization procedures.</p> <p><u>Hormonal Contraceptive Methods:</u> Your cost-share is waived for oral contraceptives, patches, rings and contraceptive injections. See the "Physician Services" and "Pharmacy Benefit" sections for benefits.</p> <p><u>Emergency Contraception:</u> 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.</p> <p><u>Barrier Contraceptive Methods:</u> Your cost-share is waived for diaphragms, cervical caps, cervical shields, sponges, and spermicides. See the "Physician Services" and the "Pharmacy Benefit" sections for benefits.</p>
HOME HEALTH SERVICES	You pay deductible and 30% coinsurance.
HOSPICE SERVICES	You pay deductible and 30% coinsurance.
INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES	You pay deductible and 30% coinsurance.
INPATIENT HOSPITAL	<p>You pay deductible and 30% coinsurance. You pay deductible and 30% coinsurance for bariatric surgeries.</p> <p>Your cost-share is waived for facility charges from network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim.</p>
INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR) AND SKILLED NURSING FACILITY (SNF) SERVICES	You pay deductible and 30% coinsurance.
LONG-TERM ACUTE CARE (INPATIENT)	You pay deductible and 30% coinsurance.
MATERNITY Inpatient: Outpatient:	<p>You pay deductible and 30% coinsurance.</p> <p>You pay a \$20 PCP or \$45 Specialist copay, which covers all prenatal visits, the physician's global charge, and other visits submitted with a primary diagnosis of maternity. If maternity is not the primary diagnosis, you will pay an additional copay. You pay applicable copays, deductible and 30% coinsurance for other covered maternity services from other providers.</p>

BENEFIT	COST-SHARE
MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS	The deductible is waived. You pay 30% of the Cost for Medical Foods.
NEUROPSYCHOLOGICAL AND COGNITIVE TESTING	You pay a \$20 PCP or \$45 Specialist copay, deductible and 30% coinsurance.
NUTRITIONAL COUNSELING/TRAINING	Your cost-share is waived.
<p>OUTPATIENT SERVICES</p> <p>Laboratory:</p> <p>Radiology:</p>	<p>You pay deductible and 30% coinsurance. You pay deductible and 30% coinsurance for bariatric surgeries.</p> <p>Your cost-share is waived for facility charges from network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim.</p> <p>You pay a \$20 PCP or \$45 Specialist copay for services received in a physician's office. The copay is waived if you received only covered lab services during your visit. Your cost-share is waived for services received from free-standing, independent clinical labs. At all other facilities, you pay deductible and 30% coinsurance.</p> <p><b>Professional Services:</b> Your cost-share is waived for professional services received by a pathologist, including a dermapathologist, in a physician's office and from freestanding clinical labs. You pay deductible and 30% coinsurance for services received from outpatient facilities.</p> <p>You pay a \$20 PCP or \$45 Specialist copay for services received in a physician's office. You pay deductible and 30% coinsurance for services received from hospital radiology departments and free-standing radiology facilities.</p> <p><b>Professional Services:</b> For professional services, you pay deductible and 30% coinsurance at all locations.</p>
PHARMACY BENEFIT	<p>You pay the following cost-share for Retail and Mail Order Pharmacies:</p> <p>\$10 Level One \$50 Level Two \$100 Level Three</p> <p>For compounded medications, you pay the greater of \$100 (the Level 3 copay), or 50% coinsurance.</p> <p>For weight loss medications, you pay the applicable copay based on the Level of the medication at the time it is dispensed.</p> <p>You may obtain up to a 90-day supply of covered medications. Not all medications are available for more than a 30- or 60-day supply. Your Cost Share will vary depending on the type of pharmacy, the quantity, and level of the medication.</p> <p>Retail or mail order: If you receive a 31 to 60 day supply, you will pay 2 times the applicable cost-share for a 30 day supply. If you receive a 61-90 day supply, you will pay 2 ½ times the applicable cost-share for a 30 day supply.</p> <p>If you purchase a brand-name medication when a generic equivalent is available, you will pay the Level 1 Copay plus the difference between the Allowed Amount for the generic and the brand-name medication, even if the prescribing Provider indicates on the prescription that the brand-name medication should be dispensed. If you have completed Step Therapy and are taking a brand-name medication with a generic equivalent as a result of the Step Therapy process, you pay the Cost Share applicable to the brand-name medication. Certain medications are not medically necessary unless the Member participates in the Step Therapy program.</p> <p>Your Cost Share is based on the level to which BCBSAZ has assigned the medication at the time the prescription is filled. No exceptions will be made regarding the assigned level of a medication. BCBSAZ may change the level of</p>

BENEFIT	COST-SHARE
	a medication at any time without notice. Go to <a href="http://www.azblue.com">www.azblue.com</a> to view the lists of prescription drug tiers. To confirm the level of a particular medication, you may also call Pharmacy Benefit Customer Service at the number on your ID card.
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST) SERVICES	You pay deductible and 30% coinsurance.
PHYSICIAN SERVICES	<p>You pay a \$20 PCP or \$45 Specialist copay per member, per provider, per day for office, home and walk-in clinic visits. If you receive preventive services during these visits, your copay may be waived. See "Preventive Services."</p> <p>Your copay will be waived if you receive any of the following covered services and no other covered service: Allergy injections, Immunizations, Laboratory services, and PT, OT and ST (these services are subject to deductible and 30% coinsurance).</p> <p>You pay deductible and 30% 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.</p> <p>Your cost-share is waived for professional services received by a pathologist, including a dermapathologist, in a physician's office and from freestanding clinical labs. You pay deductible and 30% coinsurance for services received from a pathologist, including a dermapathologist, from outpatient facilities.</p> <p>You pay deductible and 30% coinsurance for professional services received from a radiologist at all locations.</p> <p>You pay deductible and 30% coinsurance for sleep studies, regardless of where the sleep study is performed.</p>
POST-MASTECTOMY SERVICES	You pay a \$20 PCP or \$45 Specialist copay, deductible and 30% coinsurance.
PREGNANCY, TERMINATION	You pay a \$20 PCP or \$45 Specialist copay, deductible and 30% coinsurance.
PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER	You pay applicable copays, deductible and 30% coinsurance.
PREVENTIVE SERVICES	Your cost-share is waived. <i>Please Note: Foreign Travel Immunizations are excluded.</i>
RECONSTRUCTIVE SURGERY AND SERVICES	You pay a \$20 PCP or \$45 Specialist copay, deductible and 30% coinsurance.
<p>SPECIALTY MEDICATIONS</p> <p>Copays do not apply to deductibles.</p> <p>For Cancer Treatment Medications that are also classified as Specialty Medications, you pay the Level 1 retail/mail order pharmacy copay. BCBSAZ determines which Cancer Treatment Medications are classified as Specialty Medications.</p>	<p>You pay a \$150 copay.</p>
TELEHEALTH SERVICES	You pay a \$10 copay.
TELEMEDICINE SERVICES	You pay the cost-share amount that is applicable to the service being provided via telemedicine. Your location and the provider's network status determines the amount of your cost-share.

<b>BENEFIT</b>	<b>COST-SHARE</b>
TRANSPLANTS – ORGAN – TISSUE – BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES	You pay a \$20 PCP or \$45 Specialist copay, deductible and 30% coinsurance.
TRANSPLANT TRAVEL AND LODGING	Your Cost Share is waived.
URGENT CARE	You pay a \$75 copay per member, per provider, per day for services from a provider contracted with BCBSAZ to render urgent care services. You pay a \$75 copay, deductible and 30% coinsurance for services received from a network provider who is not contracted specifically as an urgent care provider.

# UNDERSTANDING YOUR PLAN

## ***Your Responsibilities***

Before you receive services:

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

After you receive services:

- Read your explanations of benefits (EOBs) and/or monthly health statements.
- Tell BCBSAZ if you see any differences between the amounts on your claims documents and what you actually paid.

## ***BCBSAZ ID Card***

BCBSAZ will mail you an ID card with basic information about your coverage:

- Who is covered (Contract Holder and Dependent names)
- Identification numbers
- Cost-share amounts
- Important phone numbers and addresses

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

## ***Coverage Changes***

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

## ***Covered Services***

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

- A benefit of this plan;
- Medically or dentally necessary as determined by BCBSAZ or BCBSAZ's contracted vendor(s);
- Not excluded;
- Not experimental or investigational as determined by BCBSAZ or BCBSAZ contracted vendor(s);
- Precertified where precertification is required;
- Provided while this benefit plan is in effect and while the person claiming benefits is eligible for benefits;  
**and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ or BCBSAZ's contracted vendor(s).

## ***Experimental or Investigational Services***

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

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



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

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

### ***Medically Necessary***

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

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

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

### ***Medical Necessity Guidelines and Criteria***

BCBSAZ uses Evidence-based Criteria to make medical necessity decisions. Call the Customer Service number on your ID card for additional information on Evidence-based Criteria.

Decisions about medical necessity may differ from your provider's opinion. A provider may prescribe, order, recommend or approve a service that BCBSAZ decides is not medically necessary and therefore is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered. Also, not all medically necessary services are covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A service may be medically necessary and still excluded from coverage.

BCBSAZ contracts with vendors to administer some or all of the benefits covered under this plan. These contracted vendors make medical necessity determinations based on their own medical necessity criteria, which are also available to you on request.

## PROVIDERS

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

### **Provider Directory**

The BCBSAZ provider directory is available online at [www.azblue.com](http://www.azblue.com). If you do not have Internet access, and would like to request a paper copy of the directory, or if you have any questions about a provider's network participation with BCBSAZ, please call Customer Service 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 health care professionals whose services are mandated by Arizona state law or federal law or who are accepted as eligible by BCBSAZ. The following are examples of ineligible providers: acupuncturists and doctors of naturopathy and homeopathy. Other provider types may also be ineligible. The fact that a service is rendered by an eligible provider does not mean that the service will be covered. Not all eligible providers are contracted to participate in the Plan Network.

<b>ELIGIBLE PROVIDER LIST</b>	
<b>Professional</b>	<b>Facility Ancillary</b>
<ul style="list-style-type: none"> <li>• Board Certified Applied Behavioral Analyst (BCABA)</li> <li>• Certified Nurse First Assist (CRNFA)</li> <li>• Certified Nurse Midwife</li> <li>• Certified Registered Nurse Anesthetist (CRNA)</li> <li>• Doctor of chiropractic (DC)</li> <li>• Doctor of dental surgery (DDS)</li> <li>• Doctor of medical dentistry (DMD)</li> <li>• Doctor of medicine (MD)</li> <li>• Doctor of optometry (OD)</li> <li>• Doctor of osteopathy (DO)</li> <li>• Doctor of podiatry (DPM)</li> <li>• First Assist (FA)</li> <li>• Licensed clinical social worker</li> <li>• Licensed independent substance abuse counselor</li> <li>• Licensed marriage and family therapist</li> <li>• Licensed nurse practitioner</li> <li>• Licensed professional counselor</li> <li>• Physician Assistant (PA)</li> <li>• Psychologist (PhD, EdD and PsyD)</li> <li>• Perfusionist</li> <li>• Registered Dietician</li> <li>• Registered Nurse First Assist (RNFA)</li> <li>• Speech, occupational or physical therapist</li> <li>• Surgical Assist (SA)</li> <li>• Surgical Technician (ST)</li> </ul>	<ul style="list-style-type: none"> <li>• Ambulance</li> <li>• Ambulatory Surgical Center (ASC)</li> <li>• Audiology Center</li> <li>• Birthing Center</li> <li>• Clinical Laboratory</li> <li>• Diagnostic Radiology</li> <li>• Dialysis Center</li> <li>• Durable Medical Equipment (DME)</li> <li>• Extended Active Rehabilitation (EAR)</li> <li>• Home Health Agency (HHA)</li> <li>• Home Infusion Therapy</li> <li>• Hospice</li> <li>• Hospital, Acute Care</li> <li>• Hospital, Long-Term Acute Care (LTAC)</li> <li>• Hospital, Psychiatric</li> <li>• Orthotics/Prosthetics</li> <li>• Pain Management Clinics</li> <li>• Rehabilitation Treatment Centers (substance abuse centers)</li> <li>• Retail, mail order and specialty pharmacies</li> <li>• Skilled Nursing Facility</li> <li>• Specialty Laboratory</li> <li>• Sleep Lab</li> <li>• Urgent Care</li> </ul>

### **Choosing a 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 Providers

Network providers are Arizona health care providers who have an EPO contract with BCBSAZ and/or an out-of-state Blue Cross and/or Blue Shield plan. Network providers will file your claims with BCBSAZ and in most cases, are prohibited by their contracts from charging you more than the allowed amount for covered services. Their contracts do allow them to charge you for noncovered services. We recommend that you discuss costs with your provider before you obtain noncovered services.

BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan directly reimburse 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.**

Network providers must be licensed in the United States. Except for emergencies, network providers must render covered services in the United States.

## Out-of-Network Providers (Contracted and Noncontracted)

**Generally, you have coverage for services from out-of-network providers only for emergencies, ambulance services, EGID, and Medical Foods formulas.**

Out of network providers are: (1) Providers who are contracted with a Host Blue plan as "Participating" only providers; (2) Providers who have no contract with BCBSAZ or a Host Blue plan (Noncontracted providers); and (3) Providers who are contracted with the Blue Cross Blue Shield Global Core.

- **Participating-Only Providers**

**Participating-only providers are contracted with a Host Blue plan as "Participating" and are not contracted as EPO or Preferred providers. Participating-only providers are out-of-network providers.** Participating-only providers will submit your claims to the Host Blue plan with which they are contracted. If you receive covered services from a Participating-only provider, you will pay your cost-share amount. However, you will not have to pay the balance bill because the provider is contracted.

- **Noncontracted Providers**

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

**Noncontracted providers may bill you up to their full billed charges.**

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

- **Providers Contracted with 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 your cost-share amount.

## Sample Differences in Financial Responsibility

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

In this example, the member has already satisfied the plan-year deductible and has a 20 percent coinsurance.

Billed Charges	Allowed Amount	Financial Responsibility	Network Providers 20% Coinsurance	Out-of-Network (noncontracted) Providers
\$1,000	\$400	This benefit plan pays:	\$320	\$0

		You pay:	\$ 80 coinsurance amount	\$1,000
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**Locating a Network Provider**

Check the BCBSAZ Provider Directory to locate a network Provider who offers the Services you are seeking, and contact the Provider for an appointment. If you cannot get an appointment with a network Provider, contact Customer Service at the number on your ID card.

**Precertifications for Out-of-Network Providers**

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

**Continuing Care from an Out-of-Network Provider**

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

Continuity of care only applies to otherwise covered services rendered by providers. Continuity of care is not available for facility services. If the hospital or other facility at which your provider practices is not a network facility, the facility services will not be covered.

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

**Out-of-Area Services**

**Overview**

BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside of BCBSAZ's service area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of BCBSAZ's service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan

in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. We explain below how BCBSAZ pays both kinds of providers.

Your plan covers healthcare services received outside of our service area (“Out-of-Area Covered Healthcare Services”). Emergency services and EGID and Medical Foods formulas are covered when provided by providers contracted with a Host Blue and when provided by non-contracted providers. All other covered services must be obtained from providers contracted with a Host Blue.

### **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<sup>®</sup> Program**

Under the BlueCard Program, when you receive Out-of-Area Covered Healthcare 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.

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

**Emergency Care Services:** If you experience an Emergency Medical Condition while traveling outside BCBSAZ’s service area, go to the nearest emergency or urgent care facility.

When you receive Out-of-Area Covered Healthcare Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for the Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed charges for your Out-of-Area Covered Healthcare Services; or
- The negotiated price that the Host Blue makes available to us.

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

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

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, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

### **Nonparticipating Providers Outside BCBSAZ’s Service Area**

#### **1. Your Liability Calculation**

When Out-of-Area Covered Healthcare 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. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

## 2. Exceptions

In certain situations, BCBSAZ may use other payment methods, such as billed charges for Out-of-Area Covered Healthcare 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 we will pay for services provided by nonparticipating providers.

### ***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 the Blue Cross Blue Shield Global® Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the 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.

- **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 precertification for non-emergency inpatient services.
- **Outpatient Services:** Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services.
- **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. The claim form is available from BCBSAZ, the Service Center or online at [www.bcbsglobalcore.com](http://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 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 BCBSAZ 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.

## PRECERTIFICATION

### ***When Is Precertification Required and What Happens If You Don't Obtain It***

Not all services require precertification. Precertification 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. Precertification may be required for services to be covered when provided in certain settings.

Log on to MyBlue for a current listing of medications and services that require precertification, or call the Customer Service number on your ID card. BCBSAZ may change the services that require precertification by posting a revised listing of medications and services that require precertification at [www.azblue.com](http://www.azblue.com).

### ***How to Obtain Precertification***

Ask your treating provider to contact BCBSAZ for precertification before you receive services and medications that require precertification. 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 request or claim.

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

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

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

### ***Prescription Medication Exception***

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

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

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

### ***If BCBSAZ Precertifies Your Service***

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

### ***If BCBSAZ Denies Your Precertification Request***

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

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

## CLAIMS INFORMATION

### ***Filing Claims***

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

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 one year from the date of service. Any claim not filed with all required content within the one 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. BCBSAZ determines good cause in its sole discretion. Examples of good cause:
  - ◆ BCBSAZ gave the member wrong information about the filing date;
  - ◆ The member had an extended illness that prevented the member from filing the claim; or
  - ◆ Other similar situations outside the member's reasonable control.

### ***Claim Forms***

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

### ***Complete Claims***

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

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

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

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

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



## ***Explanation of Benefits (EOB) Form 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](http://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, BCBSAZ may refund that amount to a network provider, and the provider will be responsible for refunding you. Your EOB will show any refunds for cost-share overpayments. BCBSAZ and/or any contracted vendors will also send your network provider the information that appears on your EOB. This information is not sent to out-of-network providers. Out-of-network providers do not receive any written information on how much was paid on a claim or the reasons for how the claim processed. Save the EOB for your personal records. BCBSAZ or any contracted vendor may charge a fee for duplication of claims records.

### ***Notice of Determination***

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

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

### ***Pharmacy Prescriptions; Submission of Claims by Members***

When you submit a prescription to a retail, mail order, or specialty pharmacy, it is possible that the pharmacy could tell you that you are not eligible for coverage, that your medication is not covered, or that you have to pay more for the medication than you think you should pay. If this happens, you can:

- Call the Pharmacy Benefits Customer Service number on your ID card for assistance, or
- Pay the pharmacy for the medication, and then submit a claim to BCBSAZ for reimbursement.

If you submit a claim to BCBSAZ, BCBSAZ will review your request to determine if you should be reimbursed for some or all of the money you paid to the pharmacy, and will send you an EOB. If BCBSAZ denies your claim, you will receive a document describing your appeal rights along with the EOB. Submitting a prescription to a pharmacy is not considered to be a claim and will not result in an EOB.

Coupons, patient assistance programs, and other discount programs are occasionally used by members, providers, and pharmacies to reduce out-of-pocket member costs associated with prescription medications. Coupons, patient assistance programs, and other discount programs do not count toward your deductible and out-of-pocket maximum. Your deductible and out-of-pocket maximum balances may be adjusted at any time to reflect the actual amount paid for that prescription after discounts have been applied.

### ***Time Period for Claim Decisions:***

#### ***Post-Service Claims***

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

If BCBSAZ cannot make a decision on your claim within thirty (30) days, BCBSAZ may extend the initial processing time by fifteen (15) days by notifying you, within the initial 30-day period, of the need for an

extension, the expected decision date, and any additional information that may be needed for the decision. You or your provider will have at least forty-five (45) days to submit any requested information.

### ***Pre-Service Claims***

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

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

### ***Concurrent Care Decisions***

BCBSAZ may require that your provider submit a plan of care. Based on that plan, BCBSAZ may precertify a certain number of visits or services over a certain period of time. You may request precertification for additional periods of care. 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 precertification is denied, you may appeal the denial in the same way you appeal any other coverage denial.

### ***Urgent Claims***

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

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

## DESCRIPTION OF BENEFITS

Please review this section for an explanation of covered services and benefit-specific limitations and exclusions. Also be sure to review *“What is Not Covered”* for general exclusions and limitations that apply to all benefits. BCBSAZ does not determine whether a service is covered under this benefit plan until after services are provided, and BCBSAZ receives a complete claim describing the services actually provided.

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

- A benefit of this plan;
- Medically necessary, as determined by BCBSAZ or BCBSAZ's contracted vendor;
- Not excluded under any provision of this plan;
- Not experimental or investigational, as determined by BCBSAZ or BCBSAZ's contracted vendor (does not apply to covered services as part of an approved clinical trial);
- Precertified if precertification by your treating provider is required;
- Provided while this benefit plan is in effect and while the person claiming benefits is an eligible member; and
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ or BCBSAZ's contracted vendor.

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.

See the cost-share table in this benefit book for the cost-share amounts, such as deductible amounts, copays, and coinsurance percentages.

### A. AMBULANCE SERVICES

**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 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 Travel and Lodging.”*

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

#### B.1.1 Inpatient Hospital

**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

## **B.1.2 Inpatient Subacute Hospitalization – Behavioral Health Facility Services**

**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 and mental health services that meet all the following criteria:

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

**Changing Types of Inpatient Care (applicable to B.1.1 and B.1.2 above):** Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient subacute and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

### **Benefit-Specific Exclusions:**

- 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

### **Benefit-Specific Exclusions (applicable to B.1.1 and B.1.2 above):**

- Domiciliary Care
- Medications dispensed at the time of discharge from an inpatient facility
- Private Duty Nursing
- Respite Care

## **B.2 Behavioral and Mental Health Services (Outpatient Facility and Professional Services)**

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

## **B.3 Behavioral Therapy Services For The Treatment Of Autism Spectrum Disorder**

**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 and Mental Health Services):**

- Activity therapy, milieu therapy and any care primarily intended to assist an individual in the activities of daily living
- Biofeedback and hypnotherapy
- 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

**C. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES**

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

**D. CATARACT SURGERY AND KERATOCONUS**

**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.

**E. CHIROPRACTIC SERVICES**

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

**Benefit-Specific Exclusions:**

- Massage therapy, except in limited circumstances as described in current Evidence-based Criteria
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Spinal decompression
- Vertebral axial decompression therapy (VAX-D)

**F. CLINICAL TRIALS**

**Benefit Description:** Benefits are available for covered services directly associated with a member’s participation in a clinical trial meeting all requirements specified by applicable law. Benefits are limited to those services eligible for coverage under this plan that would be required if you received standard,

non-investigational treatment. If you have any questions about whether a particular service will be covered, please call Customer Service at the number on your ID card. You or your provider must inform BCBSAZ that you are enrolled in a clinical trial, that the trial meets the requirements of applicable law, and that the services to be rendered are directly associated with the trial. Otherwise, BCBSAZ will administer your benefits according to the other terms of your benefit plan, which may result in a denial of benefits.

**Benefit-Specific Exclusions:**

- Investigational medications (except as stated in “*Prescription Medications for the Treatment of Cancer*”) and devices
- Any item, device or service that is the subject of the clinical study, or which is provided solely to meet the need for data collection and analysis
- Costs and services customarily paid for by government, biotechnical, pharmaceutical and medical device industry sources
- Costs to manage the clinical trial research
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services not otherwise covered under this plan

**G. DENTAL SERVICES BENEFIT – MEDICAL**

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

**G.1 Dental Accident Services**

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

A “**sound tooth**” is a tooth that is:

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

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

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

**Benefit-Specific Exclusions:**

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

## **G.2 Dental Services Required for Medical Procedures**

**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
- Routine dental care
- Routine extractions
- Repair and replacement of fixed or removable complete or partial dentures

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

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

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

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

### **Benefit-Specific Maximums:**

- Benefits are limited to one unit or one pair of prosthetic appliances and orthotics per member, per plan year. This limit does not apply to claims submitted with a primary mental health and/or substance abuse diagnosis.
- Benefits are limited to one (1) breast pump and breast pump supplies per member, per plan year. This limit does not apply to claims submitted with a primary mental health and/or substance abuse diagnosis.

### **H.1 Durable Medical Equipment (DME)**

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

- Be designed for appropriate medical use in the home setting;

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

Benefits are available for DME rental 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 allowed amount 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

**H.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
- Blood glucose monitors for the legally blind and visually impaired
- Diabetic injection aids and drawing-up devices (including drawing-up devices for the visually impaired)
- Diabetic syringes and lancets, including automatic lancing devices
- Insulin cartridges, including insulin cartridges for the legally blind
- Insulin preparations and glucagon
- Insulin pumps and insulin pump supplies
- Ostomy and urinary catheter supplies
- Peak flow meters
- Prescribed oral agents for controlling blood sugar that are included on the plan
- Supplies associated with oxygen or respiratory equipment
- Test strips for glucose monitors and visual reading and urine test strips
- 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.

**H.3 Prosthetic Appliances and Orthotics**

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

- Cochlear implants
- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- External prosthetic devices which are used as a replacement or substitute for a missing body part and are necessary 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 substance abuse or a behavioral or mental health condition
  - ♦ 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
  - ◆ Shoes (depth inlay or custom-molded) along with inserts, for individuals with diabetes; and
  - ◆ Covered in accordance with BCBSAZ medical necessity criteria.
- Podiatric appliances for prevention of complications associated with diabetes, including foot orthotic devices and inserts (therapeutic shoes: including depth shoes or custom-molded shoes, as defined below.) 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: 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 appliance 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 Durable Medical Equipment, Medical Supplies and Prosthetic Appliances and Orthotics:**

- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, corsets, cushions, dentures, diathermy 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.
- 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 or mental health or substance abuse diagnosis

## I. EDUCATION AND TRAINING

### I.1 Diabetes and Asthma Education and Training

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

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

### I.2 Nutritional Counseling and Training

**Benefit-Specific Maximum:** Benefits are limited to six (6) nutritional counseling and training visits per member, per plan year.

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

- Cardiovascular Disease
- Coronary Artery Disease
- Diabetes
- Eating Disorders
- Food Allergies
- Gastrointestinal Disorders
- Heart Failure
- High Cholesterol
- Hypertension
- Mental Health or Substance Abuse
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

## J. EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)

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

## K. EOSINOPHILIC GASTROINTESTINAL DISORDER

**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 a network provider.

"Formula" is amino-acid based formula.

**Benefit Description:** Benefits are available for Formula for members who are:

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

## L. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

**Benefit Description:** Benefits are available for FDA-approved contraceptive methods and devices and sterilization procedures when prescribed by the member's provider.

**Benefit-Specific Exclusion:** All prescription and over-the-counter contraceptive medications and devices for male members.

## M. HOME HEALTH SERVICES

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

**Benefit-Specific Maximum:** Benefits are limited to any combination of skilled nursing services necessary to provide home infusion medication administration, enteral nutrition and/or other services requiring skilled nursing care, up to a maximum of six (6) hours per member, per day. For any claims received after the six (6) hour per member, per day limit, medical records must be pulled to verify medical necessity. 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 mental health and/or substance abuse diagnosis.

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

- Enteral nutrition (tube feeding) when it is the sole source of nutrition
- Home infusion medication administration therapy, including:
  - ◆ Blood and blood components
  - ◆ Hydration therapy
  - ◆ Intravenous catheter care
  - ◆ Intravenous, intramuscular or subcutaneous administration of medication
  - ◆ Specialty medications, as defined by BCBSAZ and not covered under the “*Specialty Medications*” benefit
  - ◆ Total parenteral nutrition
- Physical therapy, occupational therapy, and speech therapy
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition, and other services that require skilled nursing care.
- Other home health services required by federal or state law to be covered

Each service must meet all of the following criteria:

- A health care provider must order the service pursuant to a specific plan of home treatment;
- A licensed home health agency must provide the service in the member’s residence;
- The health care provider must review the appropriateness of the service at least once every 30 days or more frequently, if appropriate under the treatment plan; and
- The service must be provided by an LPN, RN, or another eligible provider.

### **Benefit-Specific Exclusions:**

- All services in excess of the six (6) hour per day maximum, except as stated in this section
- Custodial Care
- Private Duty Nursing
- Respite Care
- Domiciliary Care

## N. HOSPICE SERVICES

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

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

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

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

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

Benefits are available for the following services:

- **Continuous Home Care:** 24-hour skilled care provided by an R.N. or L.P.N. during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- **Inpatient Acute Care:** Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- **Respite Care:** Admission of the member to an approved facility to provide rest to the member's family or primary caregiver
- **Routine Care:** Intermittent visits provided by a member of the hospice team

#### O. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

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

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

#### P. INPATIENT HOSPITAL

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

**Benefit Description:**

- 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 and laboratory services
- General, spinal and caudal anesthetic provided in connection with a covered service
- 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 state or federal law to be covered

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

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

**Benefit-Specific Maximum:** Benefits are limited to One Hundred Eighty (180) combined days of EAR and SNF services per member, per plan year. This limit does not apply to claims for EAR or SNF services submitted with a primary mental health and/or substance abuse diagnosis.

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

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

- A physician or registered nurse 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 registered nurse 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
- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

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

**Benefit-Specific Maximum:** Benefits are limited to Three Hundred Sixty-Five (365) days of long-term acute care services per member. This limit does not apply to claims for long-term acute care services submitted with a primary mental health and/or substance abuse diagnosis. If you have questions about the benefit maximum, contact BCBSAZ Customer Service at the number on your ID card.

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

**Benefit Description:** Benefits are available for specialized acute, medically complex care for patients who require extended hospitalization and treatment in a facility that is licensed to provide long-term acute care and which offers specialized treatment programs and aggressive clinical and therapeutic interventions. 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

- Private Duty Nursing
- Medications dispensed at the time of discharge from the facility
- Respite Care

## S. MATERNITY

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.*

**Cost-share is waived for maternity services covered under the “Preventive Services” benefit and delivered by a network provider.**

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

**Benefit-Specific Definition:** “Global Charge” is defined as 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.

### Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act

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

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

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

## T. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

**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 a network provider.

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

- The disorder is one of the diseases tested under the newborn screening program required under Arizona law (A.R.S. § 36-694);
- The disorder is such that an afflicted individual will need to consume Medical Foods throughout life in order to avoid serious mental or physical impairment; **and**

- The disorder must involve amino acid, carbohydrate or fat metabolism and have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues, as determined by BCBSAZ.

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

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

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

**Benefit-Specific Exclusions:**

- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available for purchase without a prescription or order from an M.D. or D.O. physician or registered nurse practitioner
- Foods and formulas that do not require supervision by an M.D. or D.O. physician or a registered nurse practitioner
- Food thickeners, baby food or other regular grocery products
- Medical foods and formulas for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
- Nutrition for a diagnosis of anorexia
- Nutrition for nausea associated with mood disorder, end stage disease etc.
- Spices and flavorings
- Standard oral infant formula

***Claim submission for Medical Foods***

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

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

Medical Foods claim forms are available from BCBSAZ. Submit the completed Medical Foods Claim Form and the dated receipt to the address for claims submission at the front of this book.

Medical Foods also may be covered under the *“Home Health Services”* benefit. Medical Foods are not covered under the *“Pharmacy Benefit.”*

**U. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING**

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

**V. OUTPATIENT SERVICES**

**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
- Diagnostic testing, including laboratory and radiology services
- Dialysis
- End-stage renal disease services
- Epidural and facet injections and radio frequency ablation for pain management
- Infusion/IV therapy in an outpatient setting
- 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)

## W. PHARMACY BENEFIT

### Information About This Benefit

Contact the Pharmacy Benefit Customer Service number on your ID card to request any of the following:

- A list of covered medications that require precertification;
- A list of covered vaccines;
- An exception to BCBSAZ prescription medication limitations;
- Information on the assigned cost-share Level of a covered medication;
- Information regarding Maintenance Medications;
- A list of Specialty Medications;
- Other information about this Pharmacy Benefit.

You may obtain up to a 90-day supply of covered medications. Not all medications are available for more than a 30- or 60-day supply.

Your cost-share is based on the Level to which BCBSAZ has assigned the medication at the time the prescription is filled. **No exceptions will be made regarding the assigned Level of a medication.** BCBSAZ may change the Level of a medication at any time without notice.

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

Your cost-share is waived for preventive medications and for covered vaccines. BCBSAZ will determine which medications are considered preventive and for which your cost-share is waived. BCBSAZ also determines which vaccines are covered and for which your cost-share is waived.

Your cost-share is waived for all FDA-approved contraceptive methods when prescribed by your provider and obtained from a network pharmacy, including the following:

- FDA-approved diaphragms, cervical caps and cervical shields
- FDA-approved emergency contraception for members of any age
- FDA-approved generic oral, patch, vaginal ring and injectable contraceptives
- FDA-approved brand oral, patch, vaginal ring and injectable contraceptives with no generic equivalent components
- Sponges and spermicides



Contraceptives must be prescribed for or include the purpose of contraception and not be prescribed solely for some other medical reason to be covered with no member cost-share.

If you are taking two or more prescription medications for a chronic condition, you may request early or short refills of eligible covered medications by contacting the Pharmacy Benefit Customer Service number on your ID card and requesting enrollment in the BCBSAZ Medication Synchronization program. If you are enrolled in the BCBSAZ Medication Synchronization program, your cost-share for eligible covered medications will be adjusted for any early or short refills of those medications.

**Benefit-Specific Definitions:** “**Compounded Medications**” are medications that contain at least one FDA-approved component and are custom-mixed by a pharmacist.

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

“**Generic medications**” are medications defined as generic by the national database system used by BCBSAZ to pay prescription claims.

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

“**Medication Synchronization**” is defined as the coordination of medication refills for a patient taking two or more medications for a chronic condition that are being dispensed by a single network pharmacy to facilitate the synchronization of the patient’s medications for the purpose of improving medication adherence.

“**PBM**” means the independent pharmacy benefit manager that contracts with BCBSAZ to administer the prescription medication benefits covered under this benefit plan.

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

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

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

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

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

**Covered medications are subject to limitations, including but not limited to, quantity, age, gender, dosage, and frequency of refills. BCBSAZ and/or the PBM determine which**

**medications are subject to limitations. Medication limitations are subject to change at any time without prior notice.**

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

If you are currently obtaining a covered medication from the network mail order pharmacy, you have the option to receive that medication from a network retail pharmacy. Please call Pharmacy Benefit Customer Service at the number on your ID card if you need assistance with this issue. Also, if you are currently obtaining a Specialty Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact Pharmacy Benefit Customer Service. BCBSAZ will decide whether you are eligible to receive the Specialty Medication from a retail pharmacy instead of a Specialty Pharmacy.

Certain members, as determined by BCBSAZ or the PBM, will be required to participate in the Designated Prescription Network Program to obtain coverage of certain medications under this benefit plan. BCBSAZ or the PBM decide which network pharmacies or provider are eligible to dispense designated medications to members in the Designated Prescription Network Program.

#### **Benefit-Specific Exclusions:**

- Abortifacient medications
- Administration of a covered medication
- All prescription and over-the-counter contraceptive medications and devices for male members.
- Biologic serums
- Certain categories of injectable medications
- Compounded medications obtained from a mail order pharmacy
- Designated medications prescribed by an ineligible provider or dispensed by an unapproved pharmacy or provider to members enrolled in the Designated Prescription Network Program
- Formula for Eosinophilic Gastrointestinal Disorder
- Medical devices, except as stated in this benefit
- Medical foods
- Medication delivery implants
- Medications designated as clinic packs
- Medications designed for weight gain or loss, including but not limited to, Xenical® and Meridia®, regardless of the condition for which it is prescribed
- Medications, devices, equipment and supplies lawfully obtainable without a prescription, except as stated in this benefit plan
- Medications dispensed to a member who is an inpatient in any facility
- Medications for athletic performance
- Medications for lifestyle enhancement
- Medications for sexual dysfunction
- Medications for which the principal ingredient(s) are already available in greater and lesser strengths and/or combinations, as described in the BCBSAZ Medication Benefit exclusion policy in addition to all other exclusions in this benefit book. See the “*Other Forms and Resources*” section within the pharmacy information on [www.azblue.com](http://www.azblue.com) for a list of these specific exclusion details.
- Medications labeled “Caution – Limited by Federal Law to Investigational Use” or words to that effect and any experimental medications as determined by BCBSAZ and/or the PBM, except as stated in this benefit plan
- Medications obtained from an out-of-network mail order pharmacy
- Medications packaged with one other or multiple other prescription products
- Medications packaged with over-the-counter medications, supplies, medical foods, vitamins or other excluded products
- Medications taken or prescribed for the purpose of gender transition
- Medications that exceed BCBSAZ and/or the PBM’s limitations, including, but not limited to, quantity, age, gender and refill limits.
- Medications to improve or achieve fertility or treat infertility

- Medications used for any cosmetic purpose, including but not limited to, Tretinoin for members age 26 and older
- Medications used to treat a condition not covered under this plan
- Medications which modify the dosage form (tablet, capsule, liquid, suspension, extended release, tamper resistant) of drugs already available in a common dosage form, as described in the BCBSAZ Medication Benefit exclusion policy in addition to all other exclusions in this benefit book. See the “*Other Forms and Resources*” section within the pharmacy information on [www.azblue.com](http://www.azblue.com) for a list of these specific exclusion details.
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging or name
- Prescription medications dispensed in unit-dose packaging, unless that is the only form in which the medication is available
- Prescription refills for medications that are lost, stolen, spilled, spoiled or damaged
- Specialty Medications

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

**Benefit Description:** Benefits are available for PT, OT, and ST services.

### **Benefit-Specific Exclusions:**

- Activity therapy and milieu therapy including community immersion or integration and home independence
- Any care for comfort and convenience
- Cognitive therapy
- Computer speech training and therapy programs and devices
- Custodial Care
- Domiciliary Care
- Massage therapy, except in limited circumstances as described in current Evidence-based Criteria
- Occupational therapy for any purpose other than training the member to perform the activities of daily living
- Phase III cardiac rehabilitation programs
- Physical or occupational therapeutic services performed in a group setting of 2 or more individuals
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Strength training, cardiovascular endurance training, fitness programs, strengthening programs and other services designed primarily to improve or increase strength
- Work re-entry therapy, services or programs

## Y. PHYSICIAN 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
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics)
- Orthognathic treatment and surgery
- Inpatient medical visits
- Medications, and the administration of medications in a physician’s office
- Second surgical opinions
- Services for FDA-approved patches, rings, and contraceptive injections; FDA-approved diaphragms, cervical caps, cervical shields, sponges, and spermicides; and FDA-approved emergency contraception. See the “Guidance Regarding Preventive Medications” section on [www.azblue.com](http://www.azblue.com) for a list of contraceptive methods covered as preventive services under the pharmacy benefit.
- Services for FDA-approved sterilization procedures

- Services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved contraceptive devices
- Services for FDA-approved implanted contraceptive devices
- Sleep studies
- Surgical procedures (including assistance at surgery) provided outside a physician's office. Only certain surgical assistants are eligible providers. 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 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 durable medical equipment from a medical supply company, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

## Z. POST-MASTECTOMY SERVICES

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

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

## AA. PREGNANCY, TERMINATION

**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.

## BB. PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER

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

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

In administering claims for an off-label prescription medication, BCBSAZ does not represent or warrant that the prescribed medication is safe or effective for the purpose for which your treating provider has prescribed the medication. Decisions regarding whether the medication is safe and effective for the type of cancer for which it has been prescribed and whether it is appropriate for you, are decisions to be made by your provider using his or her independent medical judgment. If the medication is subject to precertification, your provider must specifically notify BCBSAZ that your provider is requesting approval for this off-label use. After receiving your provider's request, BCBSAZ will review the criteria and eligibility for benefits.

## CC. PREVENTIVE SERVICES

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

**Benefit-Specific Maximum:** Benefits are limited to one (1) manual or electric (not hospital grade) breast pump and breast pump supplies per member, per plan year. These limits do not apply to claims for preventive services submitted with a primary mental health and/or substance abuse diagnosis.

**Benefit Description:** Benefits are available 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
- Health Resources and Services Administration (HRSA) guidelines for pediatric and adolescent preventive care and screening
- HRSA guidelines for women's health care services
- U.S. Preventive Services Task Force (USPSTF) A or B rated services

Benefits are also specifically available for the following services:

- Mammograms for routine breast cancer screening, including:
  - ♦ A single baseline mammogram for members ages 35-39; and
  - ♦ One mammogram per year for members age 40 and older
- 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 a list of covered preventive medications, go to the "Guidance Regarding Preventive Medications" section on [www.azblue.com](http://www.azblue.com). For questions about preventive services covered under this benefit, call Customer Service at the number on your ID card.

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 appropriate 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
- Immunizations for foreign travel

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

## **DD. RECONSTRUCTIVE SURGERY AND SERVICES**

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

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

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

- Breast reconstruction following a Medically Necessary mastectomy, to the extent required by state and federal law
- Other services required by federal or state law to be covered

## **EE. SPECIALTY MEDICATIONS**

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

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

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

**Benefit Description:** Benefits are available for Specialty Medications obtained from a Specialty Pharmacy contracted with BCBSAZ. Coverage of Specialty Medications and limitations on these medications are determined by current Evidence-based Criteria and Pharmacy Coverage Guidelines, and may change at any time without prior notice.

If a member obtains a Specialty Medication from an eligible provider other than a Specialty Pharmacy, the medication is excluded from coverage under this benefit, but may be covered under another benefit and subject to the cost-sharing provisions and precertification requirements of that benefit.

If you are currently obtaining a Specialty Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact Pharmacy Benefit Customer Service at the number on your ID card. BCBSAZ and/or the PBM will decide whether you are eligible to receive the Specialty Medication from a retail pharmacy instead of a Specialty Pharmacy.

If you are taking two or more prescription medications for a chronic condition, you may request early or short refills of eligible covered medications by contacting the Pharmacy Benefit Customer Service number on your ID card and requesting enrollment in the BCBSAZ Medication Synchronization

program. If you are enrolled in the BCBSAZ Medication Synchronization program, your cost-share for eligible covered medications will be adjusted for any early or short refills of those medications.

## **FF. TELEHEALTH SERVICES**

**Benefit Description:** Remote medical and behavioral health consultations are available through the Telehealth Services Administrator (TSA), including:

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

To obtain Telehealth Services, see the Customer Service section of this benefit book 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 covered under the "*Telemedicine Services*" benefit
- Services not provided through the Telehealth Services Administrator

## **GG. TELEMEDICINE SERVICES**

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

- Burns
- Cardiologic conditions
- Dermatologic conditions
- Infectious diseases
- Mental health disorders
- Neurologic diseases, including strokes
- Pain medicine
- Pulmonary diseases
- Substance abuse
- Trauma
- Urology
- Other conditions for which coverage is required by federal or state law

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

### **Benefit-Specific Exclusions:**

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

## **HH. TRANSPLANTS – ORGAN – TISSUE – BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES**

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

- Administration of high dose chemotherapy and high dose radiotherapy as prescribed by the treating physician;
- Harvesting of stem cells from the bone marrow or the blood of a third-party donor (allogeneic transplant) or the member (autologous transplant) and all component parts of the procedure;

- Hospitalization and management of reasonably anticipated complications;
- Infusion of the harvested stem cells; **and**
- Processing and storage of the stem cells after harvesting.

**Benefit Description:** The following transplants are eligible for coverage if they meet current Evidence-based Criteria:

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

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

- Inpatient and outpatient facility and professional services
- Air and ground transportation of a medical team to and from the site in the contiguous states of the United States to obtain tissue that is subsequently transplanted into a member
- Bone marrow search and procurement of a suitable bone marrow donor when a member is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
- Chemotherapy or radiation therapy associated with transplant procedures
- Harvest and reinfusion of stem cells or bone marrow
- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ. Covered donor expenses include complications and follow-up care related to the donation for up to six (6) months post-transplant, as long as the recipient's coverage with or administered by BCBSAZ remains in effect
- Pre-transplant testing and services

Benefits are available for covered transplant Services from plan network providers, providers contracted with Host Blue plans, and Blue Distinction Centers for Transplants.

**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

**II. TRANSPLANT TRAVEL AND LODGING**

**Benefit-Specific Maximums:** Benefits are limited to a maximum of \$10,000 per member, per transplant. Covered expenses incurred by a Caregiver accumulate towards the member's \$10,000 per transplant maximum.

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

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

- BCBSAZ has precertified the transplant or, if BCBSAZ did not precertify the transplant, the transplant met the requirements of this Benefit Plan;
- The distance from the member's or caregiver's residence must be more than 60 miles from the transplant facility
- The expenses are incurred by the member 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 incurred by a donor or the donor's Caregiver
- All travel and lodging expenses in excess of the benefit-specific maximums stated above
- Ambulance transportation (ground or air)
- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with noncovered transplant services or any follow-up care, including treatment of complications
- Expenses for travel or lodging incurred in connection with transplant 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 or Caregivers when the member or Caregiver does not travel more than sixty (60) miles for an authorized transplant or transplant-related services
- Vehicle maintenance or services (such as tires, brakes, oil change)

**Claims for Reimbursement:** To request reimbursement of eligible transplant travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to BCBSAZ. The address for claims submission 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.

**JJ. URGENT CARE**

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

**Benefit Description:** Benefits are available for urgent care services rendered by a free-standing urgent care provider contracted with the Plan Network. These providers are listed in your provider directory and on the BCBSAZ website at [www.azblue.com](http://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. 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.

## WHAT IS NOT COVERED

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

**Abortions**, except as stated in this plan

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

### **Acupuncture**

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

**Bariatric Surgeries** excluded by current Evidence-based Criteria

**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

**Body Art, Piercing and Tattooing** – Services related to body piercing, cosmetic implants, body art, tattooing and any related complications. This exclusion does not apply to services required by federal or state law to be covered.

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

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

**Certain Types of Facility Charges** – Inpatient and outpatient facility charges for treatment provided by the following facilities are not covered: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes.

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

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

**Complications of Noncovered Services** – Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under this plan. Medical complications arising from an abortion are covered under this plan. This exclusion does not apply to services required by federal or state law to be covered.

**Computer Speech Training, Therapy Programs and Devices**

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

**Cosmetic Services and any Related Complications** – Surgery and any related complications, procedures, treatment, office visits, consultations, and other services for Cosmetic purposes. This exclusion does not apply to breast reconstruction following a Medically Necessary mastectomy, Medically Necessary surgery to improve or restore the impaired function of a body part or organ, Services required by federal or state law to be covered, or 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

### **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**, except as stated in this plan

**Fees** – Fees that are a) Associated with the collection or donation of blood or blood products; b) other than for medically appropriate, in-person, direct member services, except as stated in this plan; or c) for concierge medicine services

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

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

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

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

### **Gender Transition Surgery and Medications Taken for the Purpose of Gender Transition**

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

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

**Growth Hormone** – Growth hormone, except as specified in current Evidence-based Criteria. Growth hormone to treat Idiopathic Short Stature (ISS) is expressly excluded.

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

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

### **Hypnotherapy**

### **Immunizations for Foreign Travel**

### **Inpatient or Outpatient 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** – 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** – Massage therapy, except in limited circumstances as described in current Evidence-based Criteria

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

**Medications** – Medications which are:

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

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

**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

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

**Payments** for exclusions imposed by any certification requirement

**Payments** for services that are unlawful in the location where the person resides at the time the expenses are incurred

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

## **Phase 3 Cardiac Rehabilitation**

## **Private Duty Nursing**

**Refills or Replacements** – Refills or replacements for medications covered under this benefit plan that are lost, stolen, spilled, spoiled or damaged

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

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

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

**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

**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 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**

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

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

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

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

**Services Provided by Out-of-Network Providers**, except for emergencies, ambulance services, EGID and Medical Foods formulas

**Services Related to or Associated with Noncovered Services.** This exclusion does not apply to services required by federal or state law to be covered.

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

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

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

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

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

**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 acute care

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

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

**Vision** – Routine vision exams, except for preventive vision screenings for members under age 5, 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 which are (1) covered by Workers' Compensation; and (2) 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.

## GENERAL PROVISIONS

### ***Appeal and Grievance Process***

Members may participate in BCBSAZ's appeals and grievance processes, which are described in detail in the BCBSAZ Appeal and Grievance Guidelines, a separate document provided to you. You 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](http://www.azblue.com) or by calling Customer Service at the number on your ID card.

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

### ***Billing Limitations and Exceptions***

When there is another source of payment such as a liability insurer, network providers may be entitled to collect any difference between the allowed amount and the provider's billed charges from the other source or from proceeds received from the other source, pursuant to A.R.S. § 33-931. A.R.S. § 33-931 may give providers medical lien rights independent of this benefit plan or any contract with BCBSAZ. BCBSAZ is not a party to any collection dispute that may arise under the provisions of A.R.S. § 33-931.

### ***Blue Cross and Blue Shield Association***

You hereby expressly acknowledge and agree to the following:

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

### ***Broker Commissions***

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

### ***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 state and federal law. If you wish to authorize someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from [www.azblue.com](http://www.azblue.com) or call BCBSAZ Customer Service and request a hard copy of the CIRF form.

### ***Court or Administrative Orders Concerning Dependent Children***

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

### ***Access to Information Concerning Dependent Children***

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

### ***Discretionary Authority***

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

### ***Provider Treatment Decisions and Disclaimer of Liability***

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

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

### ***Lawsuits***

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

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

### ***Legal Action and Applicable Law***

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

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

### **Jurisdiction and Venue**

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

### **Lawsuits by BCBSAZ**

Sometimes, BCBSAZ has an opportunity to join class action lawsuits, where third party payers (insurance companies) assert that an entity's conduct resulted in higher payments by the insurance company than otherwise would have been required. BCBSAZ reviews these cases and makes a good faith decision based on the unique facts of each case whether to join the case. BCBSAZ may also bring lawsuits against vendors or other entities to recover various economic damages. When BCBSAZ participates as a plaintiff and recovers



damages, those funds are not returned to individual members, but are instead retained by BCBSAZ to reduce overall administrative costs. This paragraph is not intended to limit or waive any claims BCBSAZ may have against any person or entity.

### ***Non-Assignability of Benefits***

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

### ***Medicaid Reimbursement***

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

### ***Member Notices and Communications***

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

### ***Payments Made in Error***

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

### ***Plan Amendment***

There is no guarantee of continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted or changed upon notice to the Group and/or Contract Holder and/or participant or as required to comply with state or federal laws. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your Group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available. Please review and retain this book, any replacement books, any SBCs, all riders and amendments and other communications concerning your coverage.

### ***Retroactive Changes***

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

### ***Prescription Medication Rebates***

BCBSAZ participates in contracts with pharmaceutical companies to receive rebate payments based on the volume and/or market share of pharmaceutical products utilized by BCBSAZ members. These rebate contracts are subject to renegotiation and/or termination from time to time at BCBSAZ's sole discretion.

The rebates BCBSAZ receives are not reimbursable to you. Depending on your employer group's contract with BCBSAZ, BCBSAZ may retain the rebates or your employer may receive either: (a) a credit against administrative costs/fees or (b) the prescription medication rebate dollar amount attributable to your employer group.

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

### ***Provider Contractual Arrangements***

The BCBSAZ allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors. For that reason, BCBSAZ network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate. This means that your network cost-share for a particular service can vary based on the network provider you choose, because not all providers have the same negotiated reimbursement rate for the same service.

### ***Release of Records***

Subject to Arizona or federal law, the member agrees that BCBSAZ may obtain, from any provider, insurance company or third party, all records or information relating to the member's health, condition, treatment, prior health insurance claims or health benefit program. Failure to provide records needed to adjudicate a claim can result in denial of the claim.

### ***Cost of Records***

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. Network providers generally cannot charge you for providing BCBSAZ with health records. 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 benefit plan as described in the Group Master Contract will be rescinded, that is, as never having been in effect. Premiums paid for the coverage for the ineligible person will be refunded, minus any claims paid for that person. BCBSAZ is entitled to recover claim payments that exceed the amount of premium paid. Such rescission does not affect the coverage of those persons on the benefit plan who remain eligible for coverage.

BCBSAZ will give 30 days' written notice of its intent to rescind, during which time the person may protest the decision by writing to BCBSAZ at the address indicated in the notice and explaining why a rescission is not appropriate or allowable.

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

### ***Third-Party Beneficiaries***

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

### ***Your Right to Information; Availability of Notice of Privacy Practices***

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

The BCBSAZ “Notice of Privacy Practices” describes how BCBSAZ may use and disclose your information to administer your health plan. It also describes some of your individual rights and BCBSAZ’s responsibilities under federal privacy regulations. BCBSAZ mails a copy of this Notice of Privacy Practices to your address shortly after you enroll for coverage with BCBSAZ.

You can also view the “Notice of Privacy Practices” by visiting the BCBSAZ website, [www.azblue.com](http://www.azblue.com), and clicking on the Privacy Statement link at the bottom of the home page.

If you would like BCBSAZ to mail you another copy of the “Notice of Privacy Practices,” please call the Customer Service 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 health care coverage.

BCBSAZ performs claims administration for the Plan and now also provides subrogation recovery services for the Plan as described in this section.

Here is the way subrogation works. Sometimes you and/or your dependent (“you”) require hospital and/or medical services due to an injury in an accident or due to a condition caused by another person’s negligence. In such cases, the person causing the accident (“third party”) is responsible for payment of your hospital and medical expenses. The Plan, who pays for your covered hospital and medical services, has the right to recover these payments from the third party or from you if you have recovered from the third party. When the Plan exercises its rights to be reimbursed, the process is known as subrogation, recovery and/or reimbursement (“subrogation”).

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

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

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

## 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 your employer, Town of Marana, about changes to the following:

- A disabled Dependent age 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 state or Federal 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 are eligible for benefits under another group health plan, and the other group plan is the primary payer, then the combined benefit payments from all coverages will not exceed the greater of the primary payer's or BCBSAZ's allowed amount, with one exception. If the benefit payment is for emergency services from a noncontracted provider, the combined payments from all plans will not exceed the provider's billed charges. You will be responsible for the difference between the provider's billed charges and the total of BCBSAZ's and the primary payer's payments if the provider is noncontracted (except for emergency services).

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

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

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

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.

BCBSAZ does not coordinate benefits for services covered by the pharmacy benefit. For this benefit, BCBSAZ will pay primary, without regard to the member's other coverage.

### ***Non-Duplication of Benefits***

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

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

**BCBSAZ does not coordinate benefits for services covered by the pharmacy benefit. For this benefit, BCBSAZ will pay primary, without regard to the member's other coverage.**

### ***Definitions Related to Plan Administration***

- **"Dependents"** are the following individuals: (1) the Contract Holder's spouse under a legally valid existing marriage; and (2) the Contract Holder's children or the children of the Contract Holder's spouse, including birth children, legally adopted children, stepchildren, children placed for adoption, children under legal guardianship substantiated by a court order and children who are entitled to coverage under a medical support order.
- **"Disabled Dependent Child"** is a child who has reached age 26 and who meets criteria for coverage under this plan described in "Eligibility Requirements," below.
- **"Employee"** refers to the person eligible for this benefit plan because of his/her employment relationship or affiliation to the Group. An employee is also the Contract Holder under this plan.
- **"Group"** refers to the employer or other entity to which a Group Master Contract is issued by BCBSAZ.
- **"Group Master Contract"** refers to the agreement between the employer or other entity and BCBSAZ.
- **"Open Enrollment"** is an annual period during which the Contract Holder and Dependents are eligible to enroll for coverage or change benefit plan options. Your Group's benefit plan administrator will notify the Contract Holder of the Group's open enrollment period. Contract Holders and/or any Dependents can change benefit plans only during an open enrollment period, except as set forth in this benefit book or as allowed under applicable law.

### ***Eligibility Requirements***

- **Contract Holder** – A Contract Holder becomes eligible to enroll for coverage after meeting the Group's eligibility requirements outlined in the Group Master Contract.
- **Children** – Children are eligible for Dependent coverage until their 26<sup>th</sup> birthday.
- **Disabled Dependent Child** – A child who has reached age 26 may continue coverage as a Dependent under this plan if the child is otherwise eligible for the plan and meets all of the following criteria:
  - ◆ Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;

- ◆ Is totally disabled due to a continuous physical or mental/behavioral impairment or condition, as defined in current Evidence-based Criteria, on the date the Dependent reaches age 26; **and**
- ◆ Is dependent on the Contract Holder for maintenance and support, as determined by BCBSAZ criteria.

Medical reports, acceptable to BCBSAZ, must substantiate the incapacity and must be submitted by the Contract Holder within thirty (30) days of the date such child reaches age 26. The child's eligibility to continue this coverage as a Dependent under this plan is subject to periodic review by BCBSAZ.

BCBSAZ will determine whether your child meets disability criteria in its sole and absolute discretion and will provide a copy of the criteria used to make this decision upon request. A Contract Holder has an affirmative obligation to inform BCBSAZ if the child's disability ceases. Cessation of the child's disability or dependency will terminate the child's coverage as a Dependent under this plan.

### ***Effective Date of Coverage***

- **Contract Holder** – A Contract Holder's effective date of coverage will be either the date the Contract Holder becomes eligible to enroll or the first billing date after the Contract Holder becomes eligible to enroll as determined by the Group, as long as the Contract Holder completes the application process within thirty (30) days of becoming eligible.
- **Dependent** – Dependent coverage is available only if an eligible Contract Holder has enrolled for coverage. Eligible Dependents will have the same effective date as the Contract Holder if they are included on the application at the time the Contract Holder first enrolls. If the Contract Holder and/or Dependents do not enroll when first eligible, the Contract Holder and/or Dependents may only apply for coverage at the Group's annual open enrollment period, except as stated in "*Special Enrollment Periods*" or if court-ordered. The effective date of coverage for an application made during an open enrollment period is the Group's anniversary date following that open enrollment period.
- **Spouse** – The effective date for a new spouse is the date of notification of the marriage, if the Contractholder completes an application within thirty (30) days of the date of the marriage; otherwise, the spouse may not enroll until the next open enrollment period, unless he or she qualifies under "*Special Enrollment Periods*."
- **Newborn/Adopted Child/Child Placed for Adoption** – A child is automatically eligible for coverage for the first thirty (30) days after the date of birth, adoption or placement for adoption, so long as the parent or guardian covered under this benefit plan remains eligible for coverage during that period and the newborn or child adopted or placed for adoption is otherwise an eligible dependent under this benefit plan. BCBSAZ will continue coverage for the child after the thirty (30) day period if the group receives a completed application for the child within thirty (30) days of the birth, adoption or placement for adoption. Contact Customer Service at the number listed on your ID card to receive a BCBSAZ adoption packet.
- **Other Children** – The effective date for a Dependent child who is not a newborn child, adopted child or a child placed for adoption (as described above) shall be the date the child becomes an eligible Dependent, as long as the Contract Holder completes an application to add the child within thirty (30) days of that date. If an application is not completed within thirty (30) days, the child may not enroll until the next open enrollment period, unless the child qualifies under "*Special Enrollment Periods*."

### ***Loss of Eligibility***

#### **Contract Holder eligibility ends on the following days:**

- The end of the month in which the Contract Holder was entitled to receive compensation from the Group, regardless of the date such compensation is actually paid and for which BCBSAZ has received payment from the Group.
- The end of the month in which an approved leave of absence expires, if the Contract Holder fails to return to active employment.
- The date on which the Contract Holder's death occurs.
- The end of the month in which Group and/or Contract Holder fails to pay amounts due and any grace period available under Arizona law is exhausted.

### **Dependent eligibility ends on the following days:**

- For a Dependent spouse and any children of that spouse who are not the natural or adopted children of the Contract Holder, the end of the month in which the final divorce decree is effective.
- The end of the month in which a child turns age 26, if the child is not a disabled child.
- The end of the month in which disability or dependency ceases for a disabled child over age 26.
- The end of the month in which a child covered by a medical support order is no longer eligible under the court order or administrative order.
- The end of the month in which the Contract Holder's death occurs.
- The date on which the Dependent's death occurs.

Some Groups have up to thirty (30) days to notify BCBSAZ that a Contract Holder or Dependent has become ineligible. Until BCBSAZ receives notice and processes the termination of eligibility, BCBSAZ may quote benefits, give precertification or pay claims that ultimately will be recouped from members or providers, if it is later determined the member was ineligible on the date services were received. Such benefit quotations or precertifications become null and void, regardless of whether the Group has notified the Contract Holder that eligibility terminated.

### ***Special Enrollment Periods***

A special enrollment period is available for the following qualifying events, as applicable to the individual seeking coverage when such individual requests coverage under this benefit plan by completing an application within 30 days of the loss of other coverage:

- A dependent child ceases to be a dependent child under the generally applicable requirement of the plan.
- A person exhausts a lifetime maximum on all benefits under the other policy or plan (qualifying event is denial of claim due to operation of a lifetime maximum)
- A person gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption
- A person has coverage through his or her spouse and a divorce or legal separation occurs
- A person has coverage through his or her spouse and the spouse dies
- A person loses minimum essential coverage, as that term is defined in applicable law
- A person no longer lives, resides or works in the other plan's service area and no other benefit plan is available to that person
- A proceeding in a case under title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time
- Exhaustion of a person's COBRA coverage
- Termination of the covered employee's eligibility for coverage
- Termination of the employer's contribution toward coverage
- The covered employee becomes entitled to Medicare
- The covered employee is employed by an employer that offers multiple health benefit plans and the covered employee elects a different plan during open enrollment
- The covered employee's employer terminates coverage
- The death of the covered employee
- The divorce or legal separation of the covered employee from the covered employee's spouse.
- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of the covered employee's employment

A special enrollment period is available for the following qualifying events, as applicable to the individual seeking coverage when such individual requests coverage under this benefit plan by completing an application within 60 days of the loss of other coverage:

- A person loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- A person received notice that he or she is eligible for a Medicaid or CHIP premium assistance subsidy
- Any other special enrollment rights available under applicable federal or state law

## ***Termination of Coverage***

### ***Reasons for Termination***

The Contract Holder and/or any Dependents' coverage under this benefit plan may terminate for the following reasons, including but not limited to:

- The Contract Holder and/or any Dependent(s) die
- The Contract Holder and/or Dependent(s) request termination of coverage
- Nonpayment of amounts due by the Group and/or Contract Holder, after expiration of any applicable grace period available under Arizona law
- Coverage for the Contract Holder and/or Dependents is rescinded

### ***Termination Date of Coverage***

BCBSAZ will notify the Group and/or the Contract Holder of any termination dates of coverage for the Contract Holder and/or any Dependents. The Contract Holder and/or Dependents' coverage ends no later than the date the Group Master Contract terminates. If the Contract Holder's coverage terminates, coverage for all Dependents also terminates on same day.

### ***Benefits After Termination***

Except as described below, you have no coverage on and after the date coverage ends, regardless of the reason for termination. This applies even if the expense was incurred because of an accident, injury or illness that occurred or existed while this coverage was in effect (except as described below).

### ***COBRA Continuation of Coverage***

**This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and your dependents when group health coverage would otherwise end.

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The parents become divorced or legally separated; or



- The child stops being eligible for coverage under the Plan as a “dependent child.”

Sometimes, if the Plan offers retiree coverage, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **When is COBRA continuation coverage available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer, if the Plan offers retiree coverage; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.**

### **How is COBRA continuation coverage provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

#### **Disability extension of 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

#### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

#### **Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may

cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified in the “Plan Information” in the front of this book. For more information about your rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **Keep your Plan informed of address changes**

To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

### **Medical Support Orders**

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

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

Following receipt of the above information from the Group, BCBSAZ will add the child to the Contract Holder’s coverage, subject to BCBSAZ’s guidelines for adding Dependent children, as outlined above. If the Contract Holder does not have family coverage, the Contract Holder is required to enroll for family coverage and pay any additional required amounts due.

### **Benefit-Specific Eligibility**

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

- If a transplant recipient is covered under this plan and the donor is not a member, the donor may be eligible for limited benefits (see benefit descriptions for Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures).

### **Nondiscrimination Statement**

Blue Cross Blue Shield of Arizona (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 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.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ’s Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, [crc@azblue.com](mailto:crc@azblue.com). You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ’s Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## DEFINITIONS

**“Allowed amount”** means the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost-share payment. BCBSAZ calculates Deductible and coinsurance based on the allowed amount, less any precertification charges. BCBSAZ uses the allowed amount to accumulate toward any out-of-pocket maximum that applies to the member’s benefit plan. The allowed amount does not include any balance bills from noncontracted providers. The allowed amount is neither tied to, nor necessarily reflective of, the amounts providers in any given area usually charge for their services. If the allowed amount is based on a fee schedule, a change to the fee schedule may result in higher member cost share. The table below shows how BCBSAZ determines the allowed amount.

**If the allowed amount is based on a Fee Schedule, a change to the Fee Schedule may result in higher member cost-share.**

The table below shows how BCBSAZ determines the allowed amount.

<b>Type of Provider</b>	<b>Type of Claim</b>	<b>Basis for Allowed Amount</b>
Providers contracted with BCBSAZ as Plan Network Providers	Emergency and non-emergency	Generally, the lesser of the provider’s Billed Charges or the applicable Plan Network Fee Schedule, with adjustments for any negotiated contractual arrangements and certain <i>“Claim Editing Procedures and Pricing Guidelines”</i>
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”) as PPO providers.	Emergency and non-emergency	Lesser of the provider’s Billed Charges or the price the Host Blue plan has negotiated with the Provider.
Noncontracted Providers (in Arizona and out-of-state)	Emergency	Billed Charges.

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

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

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

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

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

**“Benefit plan” or “plan”** means the document describing the benefits and terms of coverage that the sponsor of a group health plan provides to its group members and their Dependents. Your BCBSAZ plan includes this book and any SBC, your application for coverage, your ID card, any plan that is issued to replace this plan and any rider, amendment or modification to this plan, including but not limited to, any changes in deductible, coinsurance or copay amounts.

**“Billed charges” means:**

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

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

**“Chiropractic Benefits Administrator (CBA)”** means American Specialty Health Networks, Inc., the independent company that administers chiropractic benefits for BCBSAZ. The CBA develops and manages the BCBSAZ network of chiropractic providers, processes chiropractic claims, determines medical necessity and handles utilization management, grievances and appeals related to chiropractic services.

**“Contract Holder”** means the person to whom the benefit plan 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, those surgeries, procedures, treatments and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological or mental condition or function.

**“Cost-share”** means the member’s financial obligation for a covered service. Depending on the plan type, cost-share may include one or more of the following: deductible, copay, coinsurance, pharmacy deductible, and precertification charges.

**“Custodial care”** means health services and other related services that meet any one or more of the following criteria:

1. Are for comfort or convenience;
2. Do not seek to cure;
3. Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition or other self-care; **or**
4. Are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as an L.P.N., R.N. or licensed therapist.

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

**“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.

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

**“Evidence-based Criteria”** means BCBSAZ medical, pharmaceutical, dental, and administrative criteria, which are based on industry-standard research and technology. These criteria help BCBSAZ determine whether a Service, procedure, medical 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.

**“FDA”** means the federal Food and Drug Administration.

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

**and/or BCBSAZ's contracted vendors may change their Fee Schedules at any time without prior notice to members. If the allowed amount is based on a Fee Schedule, a change to the Fee Schedule may result in higher member cost-share.**

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

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

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

**"Medication Synchronization"** is defined as the coordination of medication refills for a patient taking two or more medications for a chronic condition that are being dispensed by a single network pharmacy to facilitate the synchronization of the patient's medications for the purpose of improving medication adherence.

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

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

**"Pharmacy Coverage Guidelines"** means pharmaceutical and administrative criteria that are developed from review of published peer-reviewed medical and pharmaceutical literature and other relevant information and are used to help determine whether a medication or other products such as medical devices or supplies are eligible for benefits under the "Pharmacy Benefit." Pharmacy Coverage Guidelines are available by going to [www.azblue.com](http://www.azblue.com) under Prescription Medications and then Pharmacy Coverage Guidelines. Guidelines are also available by calling the number listed for the Pharmacy Benefit Customer Service on your ID card.

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

**"Precertification"** is the process BCBSAZ uses to determine coverage for certain benefits.

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

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

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

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

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

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

**"Summary of Benefits and Coverage" (SBC)** means a federally required document in a specified template with information on applicable copays, coinsurance percentages, deductible amounts, other cost-sharing

amounts, benefits, exclusions, limitations; and other important information. BCBSAZ generally sends SBCs with member ID cards. Please keep your current SBC with your benefit book.

**“Telehealth Services”** means medical and behavioral health services provided online or telephonically through the Telehealth Services Administrator.

**“Telehealth Services Administrator”** means American Well Corporation, an independent company that is contracted with BCBSAZ to provide contracted providers, an interactive web platform allowing members to interact with providers, and technical support for telehealth services covered under this plan.

**“Telemedicine Services”** means Services delivered through interactive audio-video electronic media to treat certain covered conditions.

