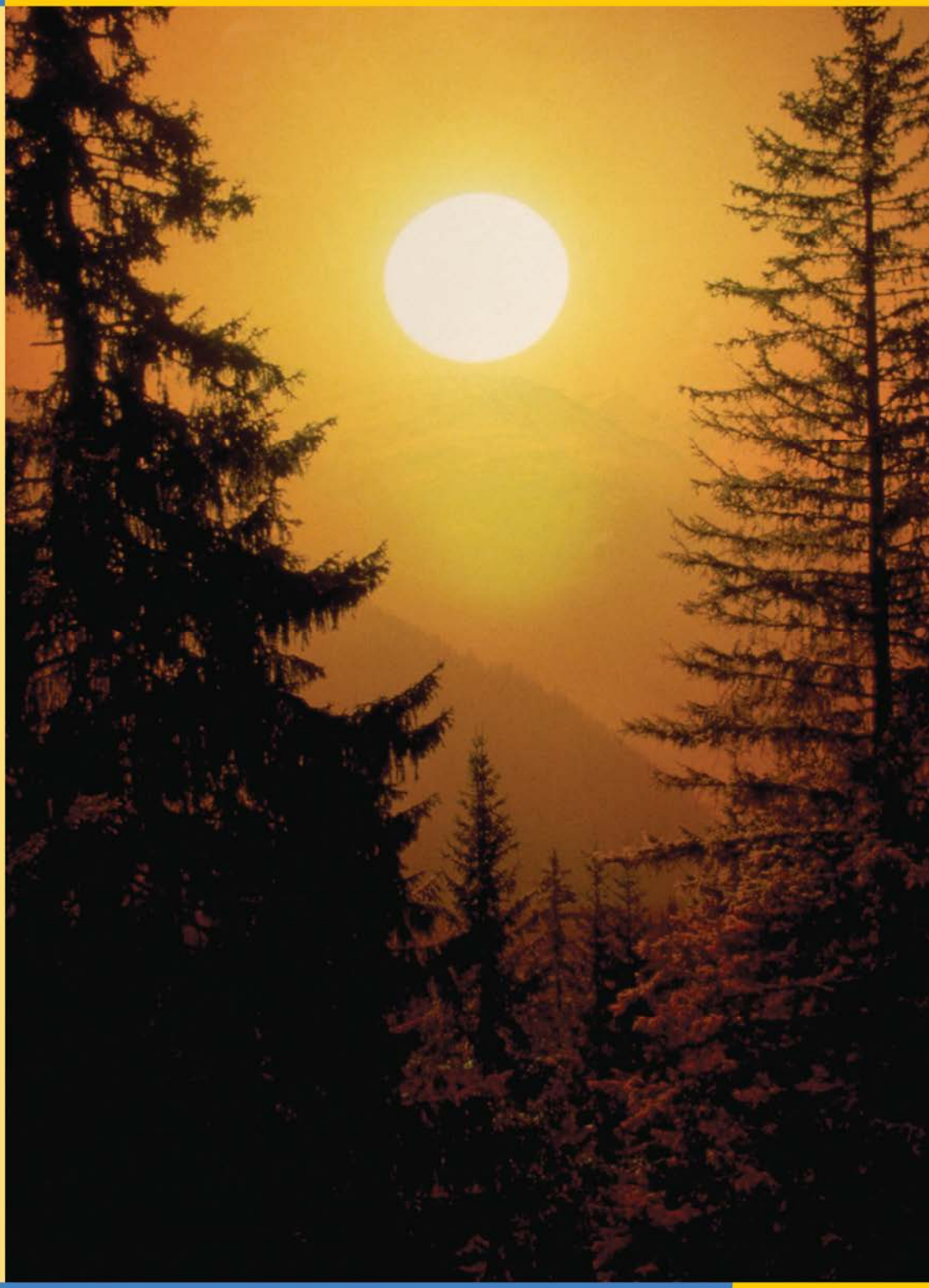
NAPEBT

NORTHERN ARIZONA PUBLIC EMPLOYEES BENEFIT TRUST



PPO Base & Buy Up Plans

Group # 101573 **Effective July 1, 2026**

Northern Arizona Public Employees Benefit Trust (NAPEBT)
Preferred Provider Organization Base and Buy Up Benefit Plans

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

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

AZ Blue 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.

AZ Blue 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 AZ Blue and your employer be deemed partners, joint venturers or governed by any legal relationship other than that of independent contractor. In this book, AZ Blue refers to the administrative services agreement and/or stop loss insurance agreement with your employer as a Group master contract.

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

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

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

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

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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 AZ Blue at one of the numbers on the back of your ID card.

AZ Blue Portal Account

AZ Blue also makes information available at www.azblue.com and you may wish to look there before calling. Your AZ Blue portal account allows you to manage your health insurance plan from anywhere you have Internet access. Go to www.azblue.com/member for more information and to register for an account. After you register, you can*:

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

*Access to AZ Blue portal account links and services will vary based on benefit plan type.

AZ Blue Customer Service

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

Hours:	Customer Service: Monday through Friday, 8:00 a.m. to 6:00 p.m. MST (except holidays) All other services: Monday through Friday, 8:00 a.m. to 5:00 p.m. MST (except holidays).
ID card:	Members can access their ID card 24/7 in the member portal. Prefer a physical card? Order one through your member portal to be mailed to your home or call us. (602) 864-4400 (within the Phoenix Metro area) (800) 232-2345 (outside of Phoenix Metro)
Hearing Impaired (TTY):	(800) 770-8973, TTY: 711
For assistance in Spanish (en Español):	(602) 864-4884
Mailing Address:	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466

Benefits Administrator Contact Information

Chiropractic Benefits Administrator (CBA):	(800) 678-9133
Telehealth Services Administrator (TSA):	Telehealth from AZ Blue is available through the TSA. Log in to your AZ Blue portal account, click Find Care, then Telehealth to start your visit on any device; or call (844) 606-1612 for customer service.

Claim Submissions

Mail new claims to:	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix, AZ 85062-2924
Mail claims for out-of-network services to:	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix, AZ 85062-2924
Claims for Transplant Travel and Lodging:	Attention: Transplant Travel Claim Processor, Mail Stop: A223, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
Claims for services received on a cruise ship:	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
Claims for Chiropractic Services:	Claims Administration, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001

Disputes

Medical Appeals and Grievances:	Call the Customer Service number on the back of your ID card.
Prior Authorization Denial Appeals:	Call the Customer Service number on the back of your ID card.
Chiropractic Care Disputes:	Call the Chiropractic Care Customer Service number on the back of your ID card, or write: Appeals Coordinator, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001 Telephone (800) 678-9133; Fax (877) 248-2746

Social Media

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

DEFINITIONS

"Allowed Amount" means the total amount of reimbursement allocated to a covered service and includes both the AZ Blue payment and the member cost-share payment. AZ Blue calculates deductible and coinsurance based on the Allowed Amount, less any access fees or prior authorization charges. AZ Blue uses the Allowed Amount to accumulate toward any out-of-pocket maximum that applies to the member's benefit plan. The Allowed Amount does not include any balance bills from noncontracted providers. The Allowed Amount is neither tied to, nor necessarily reflective of, the amounts providers in any given area usually charge for their services. The table below shows how AZ Blue determines the Allowed Amount.

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

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

"AZ Blue" 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, "AZ Blue" or "We" may also include contracted vendors, when a contracted vendor is performing functions on behalf of AZ Blue. Blue Cross Blue Shield of Arizona is an independent licensee of the Blue Cross and Blue Shield Association. AZ Blue is a not-for-profit corporation organized under the laws of the state of Arizona as a hospital, medical, dental, and optometric services corporation and is authorized to operate a healthcare services organization as a line of business.

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

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

“Benefit Book” means this document.

“Benefit 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 AZ Blue plan includes this book and your summary of benefits and coverage (SBC), your application for coverage, any plan that is issued to replace this plan and any rider, amendment, or modification to this plan.

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

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

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

“Chiropractic Benefits Administrator (CBA)” means the independent company that administers chiropractic benefits for AZ Blue. The CBA develops and manages the AZ Blue 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, and except as otherwise required by federal or state law, those surgeries, procedures, treatments, and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological, or mental condition or function.

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

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

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

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

“Evidence-based Criteria” means medical, pharmaceutical, dental, and administrative criteria, which are based on industry-standard research and technology. These criteria help AZ Blue determine whether a service, procedure, device, or drug meets the industry standard for medical necessity and/or is a covered benefit. Criteria may include prescription medication or service limitations. AZ Blue 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. AZ Blue 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 AZ Blue.

“Fee Schedule” means proprietary schedule of provider fees compiled by AZ Blue or AZ Blue’s contracted vendors. AZ Blue or AZ Blue’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), AZ Blue’s or the contracted vendor’s historical claims experience, pricing information that may be available to AZ Blue or the vendor, information and comments from providers, and negotiated contractual arrangements with providers. AZ Blue and/or AZ Blue’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.

“Gender-affirming Care” means treatment for gender dysphoria, including hormone replacement therapy and testing to monitor safety, psychotherapy, surgical treatment, and other medical services required by federal or state law.

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

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

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

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

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

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

“Primary Care Provider (PCP)” means a healthcare professional who is contracted with AZ Blue 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 AZ Blue. Your benefit plan does not require you to have a PCP or to have a PCP authorize specialist referrals.

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

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

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

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

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

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

“Summary of Benefits and Coverage (SBC)” means a federally required document in a specified template with information on applicable access fees, coinsurance percentages, copays, deductible amounts, other cost-sharing amounts, benefits, exclusions, limitations, and other important information.

“Telehealth from AZ Blue” means medical and behavioral health services provided online via video using a computer, tablet, smartphone, or other mobile device through the telehealth services administrator.

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

“Telehealth Services from In-network Providers” means services delivered through interactive qualified electronic media.

UNDERSTANDING THE BASICS

Your Responsibilities

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

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

AZ Blue Member ID

Your member ID will have basic information about your coverage:
- Cost-share amounts
- Identification numbers
- Important phone numbers and addresses
- Who is covered

Your member ID is always available in your AZ Blue portal account. When you seek healthcare services, your provider can accept your member ID several ways:
- Access your digital ID card: Members can access their ID card 24/7 in the member portal.
- Email your ID card: Email your member ID card right from your member portal to trusted emails.
- Member verification: Members can give their ID number, full name, and date of birth to the provider, who can then use this information to verify eligibility.
- Mobile wallet: You can download a copy of your ID card to your mobile wallet by logging in to your AZ Blue portal on your smartphone and selecting My ID Card to get started.
- Print your ID card: Members can log in to their AZ Blue portal at www.azblue.com/member to print their ID card.

Changes

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

Covered Services

To be covered, a service or item must be all of the following:
- A benefit of this plan;
- Approved when prior authorization is required;
- Medically or dentally necessary as determined by AZ Blue or AZ Blue's contracted vendor(s);
- Not excluded under any provision of this plan;
- Not experimental or investigational as determined by AZ Blue or AZ Blue's contracted vendor(s) (does not apply to covered services as part of an approved clinical trial);
- 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 AZ Blue or AZ Blue's contracted vendor(s).

Experimental or Investigational Services

AZ Blue, or AZ Blue's contracted vendor, in its sole and absolute discretion, decides whether a service or item is experimental or investigational. A service or item is considered experimental or investigational unless it meets all of the following criteria:
- The improvement resulting from the service or item must be attainable outside the investigational setting;
- The scientific evidence must permit conclusions concerning the effect of the service or item on health outcomes;

- The service or item must be as beneficial as any established alternative;
- The service or item must have final approval from the appropriate governmental regulatory bodies (unless otherwise required by applicable law, final approval of a regulatory body does not, in and of itself, qualify a service or item for coverage) if applicable; **and**
- The service or item must improve the net health outcome.

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

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

Medically Necessary

AZ Blue, or AZ Blue'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 AZ Blue's or its contracted vendor's *"Medical Necessity Guidelines and Criteria"* in effect when the service gets prior authorization or is rendered. If no such guidelines or criteria are available, AZ Blue or its contracted vendor will base its decision on the judgment and expertise of a medical professional or medical consultant retained by AZ Blue or the vendor.

Medical Necessity Guidelines and Criteria

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

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

PROVIDERS

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

Provider Directory

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

Provider Eligibility and Network Status

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

Eligible Providers

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

Benefits may also be available from other healthcare professionals whose services are mandated by federal or Arizona law, or who are accepted as eligible by AZ Blue. The fact that a service is rendered by an eligible provider does not mean that the service will be covered. Not all eligible providers are contracted to participate in the plan network.

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

Choosing a Provider

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

Network Status

In-Network Providers (Contracted)

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

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

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

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

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

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

Locating an In-Network Provider: Check the plan network provider directory at www.azblue.com to locate an in-network provider who offers the services you are seeking, and contact the provider for an appointment. If you cannot get an appointment with an in-network provider, contact Customer Service at the number on your ID card.

Out-of-Network Providers (Contracted and Noncontracted)

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

- *Participating-only Providers:* Participating-only providers are contracted with AZ Blue or a Host Blue plan as "Participating" and are not contracted as PPO or Preferred providers. Participating-only providers are out-of-network providers. Participating-only providers will submit your claims to the plan with which they are contracted. Except for emergency services, and ancillary services provided in an in-network facility, if

you receive covered services from a Participating-only provider, you will pay out-of-network cost share. However, you will not have to pay the balance bill because the provider is contracted.

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

- *Noncontracted Providers:* Eligible providers who have no provider participation agreement with AZ Blue or any Host Blue plan are noncontracted providers. Noncontracted providers are out-of-network providers. Except for emergency services, and ancillary services provided in an in-network facility, if you receive covered services from an eligible noncontracted provider, you will pay out-of-network cost share and the balance bill. Noncontracted providers may bill you up to their full billed charges. The difference between the noncontracted provider's billed charges and payment under this benefit plan may be substantial. Please check with the noncontracted provider regarding the amount of your financial responsibility before you receive services.

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

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

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

including providers who are contracted with AZ Blue but not for your plan network (must be eligible providers)*				
Noncontracted emergency service providers—in and outside Arizona (must be eligible providers)	Out-of-network	No (provider may elect to do so as a courtesy to member)	Yes. If the provider disputes the allowed amount, the provider must resolve the dispute with AZ Blue directly.	AZ Blue reimburses the provider the allowed amount, minus your cost share.

*Except as noted in this Benefit Book

Sample Differences in Financial Responsibility Based on Provider Choice

The following example shows how out-of-pocket expenses can differ depending on the provider you choose. This example is provided for demonstration purposes only. Your savings may vary depending on your benefit plan and your chosen provider. In this example, the member has already satisfied the calendar-year deductible and has a 20% coinsurance for an in-network provider and 40% coinsurance for an out-of-network provider.

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

Prior Authorization for Out-of-Network Providers

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

Continuing Care from an Out-of-Network Provider

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

New Members

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

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

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

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

Current Members

If an in-network provider's contract with AZ Blue is terminated or non-renewed (except for reasons of medical incompetence or unprofessional conduct) a member may continue an active course of treatment with that provider until the treatment is complete or for 90 days from the notice provided to the member, whichever is shorter. This continuity of care timeframe extends through a new policy year period if the member remains enrolled in this benefit plan.

An active course of treatment means the member is:

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

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

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

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

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

When you receive covered services outside AZ Blue's service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

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

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

expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

Special Cases: Value-Based Programs

BlueCard Program

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

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

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

Nonparticipating Providers Outside AZ Blue's Service Area

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

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

Blue Cross Blue Shield Global Core Program

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

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

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

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

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

Services Received on Cruise Ships

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

PRIOR AUTHORIZATION

When Is Prior Authorization Required

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

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

How to Obtain Prior Authorization

Ask your treating provider to contact AZ Blue for prior authorization before you receive services and medications that require it. Your provider must contact AZ Blue because he or she has the information and medical records we need to make a benefit determination. AZ Blue 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 AZ Blue Considers in Evaluating a Prior Authorization Request for Services or Medications

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

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

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

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

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

If AZ Blue Provides Prior Authorization for Your Service

You and your provider will receive a letter explaining the scope of the prior authorization. Payment will be made for the service that has received prior authorization in accordance with plan benefits.

If AZ Blue Denies Your Prior Authorization Request

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

If your request for prior authorization for a service is denied because AZ Blue decides that the service is not medically necessary, remember that AZ Blue'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 AZ Blue denies prior authorization.

CLAIMS INFORMATION

Filing Claims

In-network providers will file claims for you. Noncontracted providers may file your claims for you but have no obligation to do so. Make sure you or your providers file all your claims so AZ Blue 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 AZ Blue, AZ Blue 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 AZ Blue for processing under this benefit plan.

Time Limit for Claim Filing

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

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

Complete Claims

AZ Blue claim forms are available at www.azblue.com/individualsandfamilies/resources/forms, or call the Customer Service number on your ID card to have one mailed to you. AZ Blue may reject claims that are filed without complete information needed for processing. If AZ Blue rejects a submitted claim due to lack of information, AZ Blue will notify you or the provider who submitted the claim. Lack of complete information may also delay processing. A complete claim includes, at a minimum, the following information:

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

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

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

Explanation of Benefits (EOB) Form and Member Health Statement

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

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

Notice of Determination

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

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

Time Period for Claim Decisions

Post-Service Claims

Within 30 days of receiving your claim for a service that was already rendered, AZ Blue will send you an EOB adjudicating the claim, or a notice that AZ Blue has requested records needed to make a decision on your claim. Except for claims covered by the No Surprises Act, if AZ Blue cannot make a decision on your claim within 30 days, AZ Blue may extend the initial processing time by 15 days by notifying you, within the initial 30-day period, of the need for an extension, the decision date, and any additional information that may be needed for the decision. You or your provider will have at least 45 days to submit any requested information.

Pre-Service Claims

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

Concurrent Care Decisions

AZ Blue may require that your provider submit a plan of care. Based on that plan, AZ Blue may provide prior authorization for a certain number of visits or services over a certain period of time. You may request prior authorization for additional periods of care. If your request involves urgent care and is made at least 24 hours prior to the expiration of the existing plan of care, AZ Blue 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, AZ Blue will make a determination as soon as possible in accordance with medical exigencies but no later than 72 hours after receipt of the request. If prior authorization is denied, you may appeal the denial in the same way you appeal any other coverage denial.

Urgent Requests for Prior Authorization

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

- One in which application of the “non-urgent” time periods could seriously jeopardize the member’s life, health, or ability to regain maximum function, **or**

- One, which, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

GENERAL PROVISIONS

Appeal and Grievance Process

Members may participate in AZ Blue's appeal and grievance processes, which are described in detail in the AZ Blue 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 AZ Blue. You may obtain another copy of the AZ Blue Appeal and Grievance Guidelines by visiting us at www.azblue.com or by calling Customer Service at the number on your ID card.

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

Billing Limitations and Exceptions

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

A.R.S. § 33-931 may give providers medical lien rights independent of this benefit plan or any contract with AZ Blue. AZ Blue 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 AZ Blue, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield Plans permitting AZ Blue to use the Blue Cross and/or Blue Shield service marks in the state of Arizona;
ii. AZ Blue 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 AZ Blue; **and**
iv. You will not seek to hold the Association or any Blue Cross and Blue Shield plan other than AZ Blue, accountable or liable for AZ Blue's obligations herein.

Claims Editing Procedures and Pricing Guidelines

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

Confidentiality and Release of Information

We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with federal and state law. If you wish to authorize someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from www.azblue.com or call AZ Blue 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, AZ Blue 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

AZ Blue 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, AZ Blue provides equal parental access to information.

Discretionary Authority

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

Provider Treatment Decisions and Disclaimer of Liability

While rendering services to you, in-network providers are independent contractors and not employees, agents, or representatives of AZ Blue. Their contracts with AZ Blue address reimbursement and administrative policies. Each provider exercises independent medical judgment in deciding what services to provide you, and how to provide them. AZ Blue'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.

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

Lawsuits

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

Legal Action and Applicable Law

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

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

Lawsuits by AZ Blue: Sometimes, AZ Blue 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. AZ Blue reviews these cases and makes a good faith decision based on the unique facts of each case whether to join the case. AZ Blue may also bring lawsuits against vendors or other entities to recover various economic damages. When AZ Blue participates as a plaintiff and recovers damages, those funds are not returned to individual members, but are instead retained by AZ Blue to reduce overall administrative costs. This paragraph is not intended to limit or waive any claims AZ Blue may have against any person or entity.

Non-Assignability of Benefits

Except as otherwise specified in this section, the benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to these benefits, or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against AZ Blue and imposes no duty or obligation on AZ Blue. If you receive Covered Services from an out-of-network Provider and wish to assign your payment to the Provider, you or the Provider may submit the documents requesting assignment to AZ Blue. AZ Blue, at our sole discretion, will determine whether to honor the assignment and, if approved, remit any payment due directly to the Provider.

No Surprises Act

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

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

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

www.cms.gov/nosurprises

You can also call (800) 985-3059.

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

Medicaid Reimbursement

Member acknowledges that state Medicaid agencies, including the Arizona Health Care Cost Containment System (AHCCCS), (collectively referred to as "Medicaid Agencies") are considered payers of last resort for healthcare expenses of individuals who are Medicaid beneficiaries. Member further acknowledges that AHCCCS does, and other state Medicaid Agencies may, have a legal right to reimbursement of expenditures that the Medicaid Agencies have made on behalf of a member who was also a Medicaid Beneficiary, not to exceed the lesser of the member's benefits under this plan or the Medicaid Agencies' payment. Member acknowledges and agrees that AZ Blue 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

AZ Blue sends some notices and other communications to members by U.S. mail to the last address on file with AZ Blue Customer Service. AZ Blue may also elect to send some notices and communications electronically if the member has consented to electronic receipt. Notice is deemed complete when sent to the member's last address of record, as follows:

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

Payments Made in Error

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

Plan Amendment

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

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

Retroactive Changes

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

Provider Contractual Arrangements

The AZ Blue allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors. For that reason, plan network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate. This means that your in-network cost share for a particular service can vary based on the network provider you choose, because not all providers have the same negotiated reimbursement rate for the same service. For information on your estimated cost share for a particular service, please call Customer Service at the number on your ID card. You will need to provide the name of the provider and the diagnosis and procedure code to receive an estimated cost share. The estimated cost share is only an estimate and the actual cost share may vary from the estimated cost share based on factors such as the services actually performed and the place where the services are actually rendered.

Release of Records

Subject to federal or Arizona law, the member agrees that AZ Blue 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, AZ Blue may need to obtain copies of your health records from your provider. In-network providers generally cannot charge you for providing AZ Blue with health records. Noncontracted providers have no contractual obligation to provide records to AZ Blue 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 AZ Blue 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. AZ Blue 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.

AZ Blue will give a 30-day written notice of its intent to rescind, during which time the person may protest the decision by writing to AZ Blue 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.

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

As a member of a group health insurance benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For purposes of ERISA, your group is the **"Plan Administrator."** AZ Blue is not the Plan Administrator. ERISA provides that all members shall be entitled to:

- Receive information about your plan and benefits: Under ERISA, you are entitled to examine, without charge, at the Plan Administrator's office and other locations, such as worksites and union halls, all documents governing the plan that are available from the Plan Administrator, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series)

filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Upon written request to the Plan Administrator, you may obtain copies of the plan documents, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series), and updated summary plan description. The Plan Administrator may charge you for the copies.

- Continue group health plan coverage: COBRA is the term we use for federal and state laws that regulate continuation of healthcare coverage for you, your spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. Unless you have an agreement with your employer to pay your COBRA premiums, you or your dependents will be responsible for full payment of the premium to continue coverage under your group plan. Review your Benefit Book and talk to your benefits administrator about your COBRA continuation coverage rights.

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

- Enforce your rights: No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you have a right to know why it was denied, obtain copies of documents related to the decision (at no charge) and appeal any denial, all within the time periods required by ERISA.

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

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

Third-Party Beneficiaries

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

Your Right to Information and Availability of Notice of Privacy Practices

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

The AZ Blue "Notice of Privacy Practices" describes how AZ Blue may use and disclose your information to administer your health plan. It also describes some of your individual rights and AZ Blue's responsibilities under federal privacy regulations. You can view the "Notice of Privacy Practices" by visiting the AZ Blue website, www.azblue.com, and clicking on the "Privacy & Legal" link under the Resources heading at the

bottom of the home page. If you would like AZ Blue to mail you a copy of the “Notice of Privacy Practices,” please call the Customer Service number on your ID card, or call (602) 864-4400 or (800) 232-2345 to make your request.

Subrogation

Your employer sponsors a self-funded Employee Health Care Plan (“the Plan”) that provides its employees and their dependents (“Participants”) with healthcare coverage. AZ Blue 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, AZ Blue, on behalf of the Plan, will continue to pay your covered hospital and medical services on behalf of the Plan just as it always has. However, if a third party is legally obligated to pay for your expenses, the Plan will then exercise its rights to be reimbursed for 100% of what the Plan paid without any reduction for attorneys’ fees and/or court costs and regardless of whether you were made whole. In addition, the Plan has first priority from any judgment, payment or settlement.

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

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

MEMBER COST SHARING

Members pay part of the costs for benefits received under this plan. Depending on your particular benefit plan, the service you receive, and the provider you choose, you may have an access fee, balance bill, coinsurance, copay, deductible, or some combination of these payments. Each cost-share type is explained below. This section, the benefit descriptions in this book, and your SBC explain which cost-share types apply to each benefit. AZ Blue uses your claims to track whether you have met certain cost-share obligations. We apply claims based on the order in which we process the claims and not based on date of service.

Access Fee

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

Balance Bill

The balance bill refers to the amount you may be charged for the difference between a noncontracted provider's billed charges and the allowed amount. Any amounts paid for balance bills do not count toward deductible, coinsurance, or the out-of-pocket maximum. Except for emergency services, and ancillary services provided in an in-network facility, noncontracted providers have no obligation to accept the allowed amount. You are responsible to pay a noncontracted provider's billed charges, even though AZ Blue 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 AZ Blue reimburses you on a claim.

Benefit Maximums

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

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for covered services each January through December before the 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. The deductible is calculated based on the allowed amount. Amounts you pay for copays and access fees do not count toward the deductible.

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

Your benefit plan has per member and family deductibles that apply to services received from in-network providers and per member and family deductibles that apply to services received from out-of-network providers. Amounts are applied to both in- and out-of-network deductibles. For example, amounts applied to the out-of-network deductible will also apply to meet the in-network deductible. The amounts of these deductibles are shown on your SBC.

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for certain covered services after meeting any applicable deductible. AZ Blue subtracts any applicable access fees and prior authorization charges from the allowed amount before calculating coinsurance. Coinsurance applies to every covered service unless the specific benefit section says it does not apply. AZ Blue 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, AZ Blue will calculate your coinsurance based on the lesser billed charge.

Copay

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

Out-of-Pocket Maximum (Individual and Family)

An out-of-pocket maximum is the amount each member must pay each year before the plan begins paying 100% of the allowed amount on covered services, for the remainder of the calendar year. The payments listed below do not count toward the out-of-pocket maximum. You must keep paying them even after you reach your out-of-pocket maximum:

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

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

Your benefit plan has per member and family out-of-pocket maximums that apply to services received from in-network providers and per member and family out-of-pocket maximums that apply to services received from out-of-network providers. Amounts are applied to both in- and out-of-network out-of-pocket maximums. For example, amounts applied to the out-of-network out-of-pocket maximum will also apply to meet the in-network out-of-pocket maximums.

Prior Authorization Charges

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

DESCRIPTION OF BENEFITS

Please review this section for an explanation of covered services and benefit-specific limitations and exclusions. Also, be sure to review the information about covered services in *"Understanding the Basics"* and refer to *"What is Not Covered"* for general exclusions and limitations that apply to all benefits. AZ Blue does not determine whether a service is covered under this benefit plan until after services are provided and AZ Blue receives a complete claim describing the services actually rendered.

A. ACUPUNCTURE SERVICES

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

Benefit-Specific Maximum: There is a benefit maximum of $500 per member, per calendar year.

Benefit Description: Acupuncture services provided by an acupuncturist, MD, DO, NMD (doctor of naturopathy), HMP (homeopathic practitioner), or a chiropractor who are licensed acupuncturists.

B. AMBULANCE SERVICES

Your Cost Share: Deductible is waived. You pay in-network coinsurance.

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

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

Benefit-Specific Exclusions:

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

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

C.1 Inpatient Hospital

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

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

Benefit Description: Benefits are available for:

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

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

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

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

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

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

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

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

Your Cost Share:

In-Network: You pay 1 copay per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. You pay in-network deductible and coinsurance for outpatient services delivered in locations other than the provider's office, the member's home, or a walk-in clinic.

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

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

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

Your Cost Share:

In-Network: You pay 1 copay per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. You pay in-network deductible and coinsurance for outpatient services delivered in locations other than the provider's office, the member's home, or a walk-in clinic.

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

Benefit-Specific Definitions: **"Autism Spectrum Disorder"** means a pervasive, developmental disorder that meets the criteria for Autism Spectrum Disorder, as defined in current evidence-based criteria and in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

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

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

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

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

D. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

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

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

E. CATARACT SURGERY AND KERATOCONUS

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

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

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

F. CHIROPRACTIC SERVICES

Your Cost Share:

In-Network: You pay 1 copay, per visit for services provided during an office, home, or walk-in clinic visit, including physical medicine and rehabilitative services performed by a chiropractor. You pay in-network deductible and coinsurance for services received in locations other than the provider's office, the member's home, or a walk-in clinic.

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

Benefit-Specific Maximum: Benefits are limited to 12 combined in- and out-of-network visits per member, per calendar year. Physical medicine provided by a chiropractor applies toward the chiropractic limit. This limit does not apply to claims submitted with a primary behavioral health diagnosis.

Benefit Description: Benefits are available for chiropractic services.

Benefit-Specific Exclusion: Maintenance or preventive treatment consisting of routine, long-term, or non-medically necessary care provided to prevent reoccurrences or to maintain the patient's current status.

G. CLINICAL TRIALS

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

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

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

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

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

Benefit-Specific Exclusions:

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

- Investigational medications (except as stated in *"Medications for the Treatment of Cancer")* and devices
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services otherwise not covered under this plan

H. DENTAL SERVICES – MEDICAL

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

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

H.1 Dental Accident Services

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

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

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

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

H.2 Dental Services Required for Medical Procedures

Benefit Description: Benefits are available for dental services required to perform the medical services listed in this benefit. These dental services may either be part of the medical procedure or may be performed in conjunction with and made medically necessary solely because of the medical procedure:
- Diagnostic services prior to planned organ or stem cell transplant procedures
- Removal of teeth required for covered treatment of head and neck cancer or osteomyelitis of the jaw
- Restoration of teeth made medically necessary because of the covered treatment of head and neck cancer or osteomyelitis of the jaw

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

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

Benefit Description: Benefits are available for facility and professional anesthesiologist charges to perform dental services under anesthesia in an inpatient or outpatient facility for a patient having one or more of the following concurrent or co-morbid conditions:
- Children 5 years or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office
- Dental extractions due to cancer related conditions
- Diabetes
- Heart problems
- Hemophilia
- Intellectual disability
- Malignant hypertension
- Other conditions that could increase the danger of anesthesia
- Probability of allergic reaction
- Senility or dementia
- Uncontrolled seizure disorder
- Unstable cardiovascular condition
- Other conditions for which these services are required by federal or state law to be covered

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

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

Benefit-Specific Maximums:
- Benefits are limited to 1 unit or 1 pair of prosthetic appliances and orthotics per member, per calendar year. This limit does not apply to claims submitted with a primary behavioral health diagnosis.
- Benefits are limited to 1 breast pump and breast pump supplies per member, per calendar year per Health Resources and Services Administration guidelines (see the "*Preventive Services*" section). This limit does not apply to claims submitted with a primary behavioral health diagnosis.

I.1 Durable Medical Equipment (DME)

Benefit Description: To be eligible for coverage, DME must meet all of the following criteria:
- Be designed for appropriate medical use in the home setting;
- Be specifically designed to improve or support the function of a body part; **and**
- Cannot be primarily useful to a person in the absence of an illness or injury.

Benefits are available for DME rental or purchase, as determined by AZ Blue, and for DME repair or replacement, as determined by AZ Blue, 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. AZ Blue determines what is covered as the base model. Deluxe or upgraded DME items may be eligible for coverage based upon AZ Blue medical necessity criteria.

Benefit-Specific Exclusions:

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

I.2 Medical Supplies

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

- Any device or supply required by applicable law or as otherwise permitted under current evidence-based criteria
- Insulin pumps (except when delivery through a pharmacy is required by the manufacturer) and insulin pump supplies
- Ostomy and urinary catheter supplies
- Peak flow meters
- Supplies associated with oxygen or respiratory equipment
- 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. AZ Blue determines what is covered as the base model. Deluxe or upgraded medical supplies may be eligible for coverage based upon AZ Blue medical necessity criteria. Note: If you have a pharmacy benefit plan, certain diabetic equipment and supplies may be covered under your pharmacy benefit. Contact your plan administrator for more information.

I.3 Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

- Cochlear implants
- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- External and internal prosthetic devices, which are used as a replacement or substitute for a missing body part and are necessary for the support or function of a body part or for the alleviation or correction of illness, injury, or congenital defect. External prosthetic appliances shall include artificial arms and legs, wigs, hairpieces, and terminal devices such as a hand or hook. Wigs and hairpieces are covered:
  - For individuals diagnosed with alopecia (absence of hair) caused by chemotherapy, radiation therapy, or second- or third-degree burns;
  - For individuals diagnosed with a behavioral health condition; **and**
  - For individuals with any other condition for which coverage is required under federal or state law.
- Orthopedic shoes that are:
  - Attached to a brace; and
  - Covered in accordance with AZ Blue medical necessity criteria; **and**
  - Depth inlay or custom-molded, along with inserts, for individuals with diabetes.
- Podiatric appliances, including foot orthotic devices and inserts (therapeutic shoes: including Depth Shoes or Custom-molded Shoes, as defined below) for prevention of complications associated with diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg. Custom-molded Shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and any of the following complications of diabetes involving the foot: peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. Depth Shoes and Custom-molded Shoes are defined as follows:
  - **"Depth Shoes"** shall mean the shoe has a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of 3 widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.
  - **"Custom-molded Shoes"** shall mean constructed over a positive model of the member's foot; made from leather or other suitable material of equal quality; have removable inserts

that can be altered or replaced as the member's condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

- Other prosthetic appliances and orthotics required by federal or state law to be covered.

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

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

- Biomechanical devices, which are any external devices operated through or in conjunction with nerve conduction or other electrical impulses
- Certain equipment and supplies that can be purchased over-the-counter, as determined by AZ Blue. 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 health diagnosis

J. EDUCATION AND TRAINING

J.1 Diabetes and Asthma Education and Training

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

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

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

J.2 Nutritional Counseling and Training

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

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

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

- Behavioral health
- Cardiovascular disease

- Coronary artery disease
- Diabetes
- Eating disorders
- Food allergies
- Gastrointestinal disorders
- Heart failure
- High cholesterol
- Hypertension
- Obesity
- Pre-diabetes
- Renal failure/renal disease

K. EMERGENCY SERVICES

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

Emergency Room: You pay 1 access fee per member, per facility, per day, plus in-network deductible and coinsurance for professional services provided while in the emergency room.

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

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

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

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

Benefit Description: Benefits are available for services needed to treat an Emergency Medical Condition, whether the providers of these services are in- or out-of-network. This includes emergency services provided in an emergency department of a hospital or in an independent freestanding emergency department and certain post-stabilization services as required by law.

L. EOSINOPHILIC GASTROINTESTINAL DISORDER (EGID)

Your Cost Share: You pay applicable deductible, then 20% of the Cost for Formula.

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

"Formula" is amino acid-based Formula.

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

M. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Your Cost Share:

In-Network:

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

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

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

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

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

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

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

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

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

N. GENDER DYSPHORIA SERVICES

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

Benefit Description: Benefits are available for gender dysphoria services. Treatment of Gender Identity Disorder are covered to the same extent as would be covered if the same covered service was rendered for another medical condition. Treatment is subject to all plan provisions. Coverage includes medically necessary surgical and non-surgical treatment such as:

- Psychotherapy; and
- Continuous hormone replacement therapy and corresponding testing to monitor the safety; and
- Surgical treatment; and
- Medical services

O. HEARING AIDS AND SERVICES

Your Cost Share:

Hearing Exams: You pay 1 copay per visit for hearing exams received from in-network providers. You pay out-of-network deductible and coinsurance for hearing exams received from out-of-network providers. If you receive services from a noncontracted provider, you also pay the balance bill.

Hearing Aids: You pay applicable deductible and coinsurance for hearing aids received from in- and out-of-network providers. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Maximums:
- Hearing exams are limited to 1 exam per member, per calendar year
- Hearing aids are limited to $2,500 per member, per every 3 calendar years

Benefit Description: Routine hearing exams and hearing aids.

Benefit Specific Exclusion: Replacement of lost, stolen or damaged hearing aids when the member has already met the benefit maximum of $2,500 per member, per every 3 calendar years.

P. HOME HEALTH SERVICES

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

Benefit-Specific Maximum: Benefits are limited to any combination of skilled nursing services necessary to provide home infusion medication administration, enteral nutrition (tube feeding) and/or other services requiring skilled nursing care, up to a maximum of 6 hours per member, per day. The home health visit limit does not apply to home health services provided in lieu of hospitalization or hospital outpatient services, or to claims for home health services submitted with a primary behavioral health diagnosis.

Benefit Description: Benefits are available for the following services:
- 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 AZ Blue
  - Total parenteral nutrition services
- Physical therapy, occupational therapy, and speech therapy
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition (tube feeding), 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 healthcare 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 healthcare 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 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 the "*Eosinophilic Gastrointestinal Disorder*" and the "*Medical Foods for Inherited Metabolic Disorders*" sections of this book
- All services in excess of the 6 hour per member, per day maximum, except as stated in this section
- Custodial care
- Domiciliary care
- Respite care

Q. HOSPICE SERVICES

Your Cost Share: Deductible and coinsurance are waived for in-network and out-of-network Hospice Services. If you receive services from a noncontracted provider, you pay the balance bill.

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

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

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

Benefit Description: When a member elects to use the hospice benefit, it is in lieu of other medical benefits available under this plan, except for care unrelated to the terminal illness or related complications. The hospice agency determines the required level of care, which is subject to the medical necessity provisions of this benefit plan. Once the member selects the hospice benefit, the hospice agency coordinates all of the member's healthcare needs related to the terminal illness.

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

- *Continuous Home Care:* 24-hour skilled care provided by an LPN or RN during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- Home health services
- Individual and family counseling provided by a psychologist, social worker, or family counselor
- *Inpatient Acute Care:* Inpatient admission for pain control or symptom management that cannot be provided in the home setting
- Outpatient services
- *Respite Care:* Admission of the member to an approved facility to provide rest to the member's family or primary caregiver
- *Routine Care:* Intermittent visits provided by a member of the hospice team

R. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

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

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

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

S. INPATIENT HOSPITAL

Your Cost Share: You pay applicable inpatient admission access fees, deductible and coinsurance for all inpatient admissions. You pay a separate access fee for all bariatric surgeries in addition to applicable deductible and coinsurance. See your SBC for the amount of the bariatric surgery access fee, which applies toward professional charges for the bariatric surgery. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

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

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

Benefit Description:

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

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

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

Your Cost Share:

First 60 Days of Services in a Calendar Year: You pay applicable inpatient admission access fees, deductible and coinsurance.

Second 60 Days of Services in a Calendar Year: You pay applicable inpatient admission access fees, deductible and 50% coinsurance (at both in-network and out-of-network providers). However, for claims submitted with a primary behavioral health diagnosis, you continue to pay applicable inpatient admission access fees, deductible and coinsurance after the first 60 days of services in a calendar year.

If you receive services at a noncontracted provider, you also pay the balance bill.

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

Benefit-Specific Maximum: Benefits are limited to 120 in- and out-of-network combined days of EAR services per member, per calendar year. This limit does not apply to claims for EAR services submitted with a primary behavioral health diagnosis.

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

- A physician or RN practitioner is present on the premises of the facility or on-call at all times;
- Room and board in a semi-private room or a standard private room (not deluxe) is covered if the hospital only has private rooms or if a private room is medically necessary;
- Services must be for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time;
- The facility has 24/7 onsite RN coverage;
- The facility has sufficient professional staff to provide appropriate treatment;

- The facility's designated medical director is a physician or RN practitioner and provides direction for services provided at the facility; **and**
- The services meet the AZ Blue medical necessity criteria for inpatient level of care.

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

U. LONG-TERM ACUTE CARE (INPATIENT)

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

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

Benefit-Specific Maximum: Benefits are limited to 365 in- and out-of-network combined 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 behavioral health diagnosis. If you have questions about the benefit maximum, contact AZ Blue Customer Service at the number on your ID card.

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

Benefit-Specific Exclusions:
- Custodial care
- Domiciliary care
- Medications dispensed at the time of discharge from the facility
- Respite care

V. MATERNITY

Your Cost Share:

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

Outpatient Services:

In-Network: You pay 1 physician visit copay, which covers all prenatal visits, the physician's Global Charge and other physician office and home visits submitted with a primary diagnosis of maternity. If the amount of your physician visit copay changes during the course of your pregnancy, you will also pay the difference between the two copay amounts in addition to the original copay amount (even though you already paid the original copay amount). If maternity is not the primary diagnosis on a claim submitted by your provider for a physician visit, you will pay an additional physician visit copay per visit. You pay in-network deductible, coinsurance, and copays for other covered maternity services from any other in-network providers.

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

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

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

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

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

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

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

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

This adopted child maternity benefit is secondary to any other coverage available to the birth mother. Contact Customer Service at the number on your ID card to receive an AZ Blue adoption packet.

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

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

In addition, a plan or issuer may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours for the mother and newborn child following a normal vaginal delivery or 96 hours for the mother and newborn child following a cesarean section delivery. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, call the Customer Service number on your ID card.

W. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Your Cost Share: You pay applicable deductible, then 20% of the Cost for Medical Foods.

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

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

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

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

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

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

Benefit-Specific Exclusions:

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

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

- Member's diagnosis for which the Medical Foods were prescribed or ordered;
- Member's name, identification number, Group number, and birth date;
- Prescribing or ordering physician or RN practitioner;
- The amount paid for the Medical Foods;
- The dated receipt or other proof of purchase; **and**
- The name, telephone number, and address of the medical food supplier.

Medical Foods claim forms are available from AZ Blue. 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.

X. MEDICATIONS FOR THE TREATMENT OF CANCER

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

Benefit-Specific Definition: **"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, AZ Blue does not represent or warrant that the prescribed medication is safe or effective for the purpose for which your treating provider has prescribed the medication. Decisions regarding whether the medication is safe and effective for the type of cancer for which it has been prescribed and whether it is appropriate for you, are decisions to be made by your provider using his or her independent medical judgment. If the medication is subject to prior authorization, your provider must specifically notify AZ Blue that your provider is requesting approval for this off-label use. After receiving your provider's request, AZ Blue will review the criteria and eligibility for benefits.

Y. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

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

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

Z. OUTPATIENT SERVICES

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

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

Diagnostic Laboratory Services

- **In-Network Physician's Office:** You pay the physician visit copay (copay is waived if you receive only covered laboratory services during your visit).
- **In-Network Clinical Laboratory:** Your cost share is waived.
- **In-Network Hospital Outpatient Laboratory Department:** You pay in-network deductible and coinsurance.
- **Out-of-Network Physician's Office, Clinical Laboratory or Hospital Outpatient Laboratory Department:** You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Radiology Services

- **In-Network Physician's Office:** You pay the physician visit copay, except covered professional services provided by a radiologist will be subject to in-network deductible and coinsurance.
- **In-Network Hospital Radiology Department and Free-Standing Radiology Facility:** You pay in-network deductible and coinsurance.
- **Out-of-Network Physician's Office, Free-Standing Radiology Facility or Hospital Radiology Department:** You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided by a radiologist or pathologist, including a dermatopathologist, are always subject to applicable deductible and coinsurance, even when the services are provided in a physician's office. You pay applicable deductible and coinsurance and balance bill for sleep studies, regardless of where the sleep study is performed.

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:

- Allergy testing, antigen administration, and desensitization treatment
- Bariatric surgery and bariatric surgery adjustments, even if the previous surgery was covered by a different health plan
- Blood transfusions, whole blood, blood components, and blood derivatives
- Diagnostic radiology services, including:
  - CAT/CT imagery
  - Mammograms and other modalities for breast cancer screening and diagnosis, as recommended by the National Comprehensive Cancer Network
  - Outpatient and ambulatory magnetic resonance imaging (MRI/MRA), PET scans, ECT, brain electrical activity mapping (BEAM)
  - X-rays
- Diagnostic testing, including but not limited to, laboratory services and biomarker testing
- Dialysis
- End-stage renal disease services
- Epidural and facet injections and radio frequency ablation for pain management
- Gender-affirming care
- Infusion/IV therapy in an outpatient setting
- In-network benefits are available for covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction Center.
- Maternity services provided in birthing centers
- Medications and the administration of medications in an outpatient setting
- Orthognathic treatment and surgery, including but not limited to dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)
- Outpatient and ambulatory cardiac testing, angiography, sleep testing (including sleep studies and polysomnography), and video EEG
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant
- Surgery and other invasive procedures
- Treatment of temporomandibular joint (TMJ) disorders

AA. PHARMACY BENEFIT

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

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

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

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

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

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

Benefit Description: Benefits are available for PT, OT, and ST services related to a specific illness or injury and includes coverage for members diagnosed with autism spectrum disorder.

Benefit-Specific Exclusions:

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

CC. PHYSICIAN SERVICES; SERVICES PROVIDED BY NATUROPATHIC AND HOMEOPATHIC PROVIDERS

Your Cost Share:

In-Network: You pay 1 copay for each in-network physician office, home and walk-in clinic visit, except as specified within this benefit. If you receive preventive services during one of these visits, your copay may be waived, as described in the *"Preventive Services"* section of this Benefit Book.

Please note: There is a different copay for PCPs and specialists, as shown on your SBC.

Your copay will be waived if you receive only the following services and no other covered service during your visit:

- Covered allergy injections
- Covered immunizations
- Covered laboratory services
- Covered PT, OT, ST; these services are subject to in-network deductible and coinsurance

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

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

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

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

You pay applicable deductible and coinsurance, and balance bill for sleep studies, regardless of where the sleep study is performed.

Benefit Description: Benefits are available for the following:

- Abortifacient medications for the abortions covered under this plan, including oral medications as described in current evidence-based criteria
- Allergy testing, antigen administration, and desensitization treatment
- Foot care, including trimming of nails or treatment of corns or calluses, when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg
- Gender-affirming care
- Inpatient medical visits
- Medications and the administration of medications in a physician's office
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics) for the diagnosis and treatment of a sickness or injury
- Orthognathic treatment and surgery
- Second diagnostic surgical opinions
- Services for FDA-approved patches, rings, and contraceptive injections; FDA-approved diaphragms, cervical caps, cervical shields, condoms, sponges, and spermicides, and FDA-approved emergency contraception.
- Services for FDA-approved female sterilization procedures
- Services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices
- Services for FDA-approved female implanted contraceptive devices
- Sleep studies
- Surgical procedures (including assistance at surgery). Call Customer Service at the number on your ID card to verify that the surgical assistant chosen by your physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your physician are in-network providers.
- Treatment of temporomandibular joint (TMJ) disorders

The following circumstances may impact member cost share for physician services:

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

DD. POST-MASTECTOMY SERVICES

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

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

Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving the mastectomy-related benefits described above under "Benefit Description," coverage will be provided in a manner determined in consultation between the attending physician and the member being treated. These benefits are subject to the same cost share generally

applicable to other medical and surgical benefits provided under this plan, as described in the "Member Cost Share" section of your SBC. If you would like more information on WHCRA benefits, call AZ Blue Customer Service at the number listed on your ID card.

EE. PREGNANCY, TERMINATION

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

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

- The treating provider certifies in writing the abortion is medically necessary in order to save the life of the mother or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.
- Benefits are also available for abortifacient medications for the abortions covered under this plan, including some oral medications, as described in current evidence-based criteria.

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

FF. PREVENTIVE SERVICES

Your Cost Share:

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

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

Out-of-Network Mammography Services: Deductible is waived. You pay out-of-network coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Out-of-Network Preventive Services (except Mammography and Routine Physicals): You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

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

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

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

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

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

- Contraceptives and female sterilization as described in the *"Family Planning (Contraceptives and Sterilization)"* section

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

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

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

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
- Routine physicals received from out-of-network providers

GG. RECONSTRUCTIVE SURGERY AND SERVICES

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

Benefit Description: Benefits are available for reconstructive surgery, which is surgery performed to improve or restore the impaired function of a body part or organ resulting from one of the following:
- Congenital defects;
- Illness and disease;
- Injury and trauma;
- Surgery;
- Therapeutic intervention

Benefit-Specific Exclusion: Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations, and other services for cosmetic purposes. This exclusion does not apply to:
- Breast reconstruction following a medically necessary mastectomy, to the extent required by federal and state law
- Medically necessary breast implant removal
- Other services required by federal or state law to be covered

HH. SKILLED NURSING FACILITY (SNF) SERVICES

Your Cost Share:

First 90 Days of Services in a Calendar Year: You pay applicable deductible and coinsurance.

Second 90 Days of Services in a Calendar Year: You pay applicable deductible and 50% coinsurance (at both in-network and out-of-network providers). However, for claims submitted with a primary behavioral health diagnosis, you continue to pay applicable deductible and coinsurance after the first 90 days of services in a calendar year.

If you receive SNF services at a noncontracted provider, you also pay the balance bill.

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

Benefit-Specific Maximum: Benefits are limited to 180 in- and out-of-network combined days of SNF services per member, per calendar year. This limit does not apply to claims for SNF services submitted with a primary behavioral health diagnosis.

Benefit Description: Benefits are available for inpatient SNF services, provided in a facility licensed to offer 24-hour skilled nursing services and that meet the following criteria:

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

Benefit-Specific Exclusions:

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

II. SPECIALTY MEDICATIONS

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

JJ. TELEHEALTH SERVICES – IN-NETWORK PROVIDERS

Your Cost Share: You pay the cost-share amount applicable to the service provided via Telehealth Services from In-network Providers. Cost share applies for the service provided at your physical location and for the service rendered remotely by the telehealth provider. You will always pay in-network cost-share for emergency services provided via this Telehealth Services benefit.

Benefit Description: Benefits are available for telehealth services delivered by an in-network provider through interactive electronic media. Benefits are also available for emergency or urgent telehealth services from out-of-network providers.

Benefit-Specific Exclusions:

- Non-emergency and non-urgent telehealth 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, unless otherwise required by law
- Services provided through the *"Telehealth Services – Telehealth from AZ Blue"* benefit
- Telehealth services for noncovered diseases or disorders

KK. TELEHEALTH SERVICES – TELEHEALTH FROM AZ BLUE

Your Cost Share: Waived.

Benefit Description: Remote medical and behavioral health consultations between a provider and a patient are offered by the TSA through Telehealth from AZ Blue, including:

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

To use Telehealth from AZ Blue, 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 *"Telehealth Services – In-network Providers"* benefit
- Services not provided through the TSA

LL. TRANSPLANT OR GENE THERAPY TRAVEL AND LODGING

Your Cost Share: Waived.

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

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

Benefit Description: Transplant travel and lodging expenses are eligible for reimbursement during evaluation, transplant, post-transplant care, and complications directly related to the transplant. Reimbursement is available for transplant or gene therapy travel and lodging expenses when all the following criteria are met:

- AZ Blue has given prior authorization for the service or, if AZ Blue did not give prior authorization for the service, upon review we determine the service meets the requirements of this benefit plan;
- The distance from the member's, donor's, or caregiver's residence must be more than 60 miles from the facility;
- The expenses are 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; **and**
- The expenses are incurred by the member, donor, or the member's Caregiver.

Benefit-Specific Exclusions:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or Internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of the benefit-specific maximum
- Ambulance transportation (ground or air)
- Caregiver salary, stipend, and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with services that do not qualify for coverage under this benefit plan
- Food preparation services
- Furniture or supplies for a rental apartment

- Home modifications
- Security deposits
- Travel and lodging expenses for transplants other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service
- Travel and lodging expenses for members, donors, or caregivers when the member, donor, or Caregiver does not travel more than 60 miles for authorized transplant- or gene therapy-related services
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement: To request reimbursement of eligible travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to AZ Blue. 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.

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

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

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

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

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

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

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

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

Benefit-Specific Exclusions:

- Expenses related to a noncovered transplant
- Expenses related to donation of an organ to a recipient who is not covered by AZ Blue
- Transplants that do not meet current evidence-based criteria

NN. URGENT CARE

Your Cost Share: You pay 1 Urgent Care copay per visit for services from a provider who is contracted with the plan network to offer Urgent Care services. You pay applicable cost share if you receive Urgent Care services from an in-network provider who is not specifically contracted for Urgent Care services. You pay out-of-network deductible and coinsurance if you receive services from an out-of-network Urgent Care provider. If you receive services from a noncontracted provider, you also pay the balance bill. No matter what the circumstances, if you obtain Urgent Care services at a hospital or a hospital's on-site Urgent Care department, you will be responsible for the applicable emergency room cost share.

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

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

OO. VISION EXAMS (ROUTINE)

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

WHAT IS NOT COVERED

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

Abortions, except as stated in this plan

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

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

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

Biofeedback

Blood Administration for the purpose of general improvement in physical condition

Body Art, Piercing, and Tattooing – Services related to body piercing, cosmetic implants, body art, tattooing, and any related complications, except for services included in the *"Post-Mastectomy Services"* and the *"Reconstructive Surgery and Services"* sections of this book

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

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

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

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

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

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

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

Cosmetics and health and beauty aids

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

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

Custodial Care

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

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

Domiciliary Care

Expenses for services that exceed benefit limitations

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

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

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

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

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

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

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

Growth Hormone to treat idiopathic short stature (ISS)

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

Hearing Services and Devices, except as stated in this plan

Hypnotherapy

Inpatient or Outpatient Non-acute Long-term Care

Laboratory Services Provided Without an Order From an Eligible Provider

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

Lodging and Meals, except as stated in this plan

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

Manipulation of the Spine Under Anesthesia

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

Massage Therapy

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

Medications that are:
- Not FDA approved
- Not required by the FDA to be obtained with a prescription, except as stated in this plan
- Not used in accordance with current evidence-based criteria
- Off-label, unlabeled, and orphan medications, except as stated in this plan
- Used to treat a condition not covered by AZ Blue

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 home health agency or hospital emergency room

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

Neurofeedback

Non-Medically Necessary Services – Services that are not medically necessary as determined by AZ Blue or AZ Blue's contracted vendor. AZ Blue 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 service is performed at the time the expenses are incurred

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

Phase 3 Cardiac Rehabilitation

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

Private Duty Nursing

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 AZ Blue

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

Sensory Integration and Music Therapy

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

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

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

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

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

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

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

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

Services Prior to Member's Coverage Effective Date

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

Services Related to or Associated with Developmental Delays, except as stated in the *"Neuropsychological and Cognitive Testing"* section of this book

Services Related to or Associated with Noncovered Services

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

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

Spinal Decompression or Vertebral Axial Decompression Therapy

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

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

Therapy Services, except as stated in this plan

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

Training and Education, except as stated in this plan

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

Vision – 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

Vocational Therapy – Services related to employability

Wigs and hairpieces, except as stated in this plan

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

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

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

PLAN ADMINISTRATION

Changes to Your Information

If you do not tell us about changes, correspondence from AZ Blue may not reach you in a timely manner. Also, you may have to reimburse AZ Blue 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 AZ Blue for collection of claims payments made after you or your dependents became ineligible.

Notify AZ Blue Customer Service 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 federal or state Exchange.
- Eligibility of you or your dependents for Medicare during the term of this contract
- Eligibility of you or your dependents for the Children's Health Insurance Program (CHIP) coverage during the term of this contract
- Individuals being added to the benefit plan: Spouse, newborns, adopted children, children placed for adoption, stepchildren
- Individuals removed from the benefit plan due to divorce or death
- Other medical coverage that you or your dependents add or lose, including any changes in benefits
- Your mailing address or phone number

Coordination of Benefits (COB)

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

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

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

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 AZ Blue, the rules described in *"Coordination of Benefits"* will be used to determine which coverage pays first. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed the amount that AZ Blue would have paid if you had no other coverage.

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

Information Related to Eligibility Requirements

Please refer to NAPEBT's administrative manual for information related to eligibility requirements at https://www.coconino.az.gov/DocumentCenter/View/58082/NAPEBT-2023-Administrative-Manual-FINAL-712023?bidId= or contact your human resources department

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

English: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-475-4799.

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 602-864-4884.

Navajo: Diné bee yániłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-877-475-4799.

Chinese Simplified: 如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-475-4799 。

Chinese Traditional: 如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-877-475-4799。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-475-4799.

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-475-4799.

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-475-4799.

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-475-4799.

Korean: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-475-4799.

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-475-4799.

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-475-4799.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-475-4799 ।

Farsi (Persian)

توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-877-475-4799.

Thai: หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-475-4799 หรือปรึกษาผู้ให้บริการของคุณ"

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-475-4799 。

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Plan Arranged By:
The Segal Company Consultants

NAPEBT

Serving Those Who Serve The Public

13979 0726

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