IBEW Local No 640 and Arizona Chapter NECA Health & Welfare Trust Fund

PLAN BOOKLET - PPO BENEFITS

EFFECTIVE DATE: May 1, 2022

This document printed in 2022 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

This Booklet describes the benefits available to employees, early retirees and their families who are covered by the IBEW Local No. 640 and Arizona Chapter NECA Health and Welfare Trust Fund. Active Employees who have secured eligibility are covered by the Preferred Provider Organization ("PPO") Medical Benefits, Outpatient Prescription Drug Benefits, Vision PPO Benefits and the Dental, Weekly Disability Income, Life Insurance and Accidental Death and Dismemberment Insurance Benefits described in this booklet. Early Retirees who have secured eligibility are covered by the PPO Medical Benefits, Outpatient Prescription Drug Benefits, PPO Vision Benefits and the Dental Insurance Benefits described in this booklet.

Here are some important tips on using your Medical, Dental and Vision Benefits:

- The Medical Plan, Dental Plan and Vision Plan give you access to a network of Preferred PPO Providers. Preferred PPO Providers give a discount off their usual cost of services. Using Preferred PPO Providers will result in a substantial savings to you and to the Plan.
- Because PPO providers are added to or removed from the PPO network each month, it is a wise idea to check with the provider to see if they are still participating in the PPO network before you schedule an appointment or go get lab work or x-rays or other services. Don't rely on your Doctor or health provider to know your benefit plan.
- Certain services require pre-approval (also called precertification or prior authorization) before the service is performed. This is discussed in Article VII on Utilization Review and Case Management.
- Notify the Administrative Office of any address changes to ensure that you receive updated Plan, COBRA and self-pay information. Inform the Administrative Office of any changes in your Eligible Dependents (for example, marriage, divorce, child reaches the age of 26 years).
- Important and helpful contact information is listed on the Quick Reference Chart located in the front of this document.

The Medical Plan, Dental Plan and Vision Plan give you access to a network of Preferred PPO Providers. Preferred PPO Providers give a discount off their usual cost of services. Using Preferred PPO Providers will result in a substantial savings to you and to the Plan.

You should review this Booklet to familiarize yourself with the benefits available, any limitations on those benefits, and how to apply for and secure the benefits. Obviously, not all questions can be answered in the Booklet, so you are encouraged to call or write the contacts identified in the Quick Reference Chart, when necessary to secure help in understanding and obtaining benefits.

Please note: Not all services are covered. As this is a self-funded ERISA 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.

This Booklet, effective May 1, 2022, replaces all other Plan Rules/Plan Summaries previously provided to you.

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IMPORTANT INFORMATION

Keep Benefit Information Handy.

Be sure to keep this booklet, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them. Also, keep the worksheets (called Explanation of Benefits or EOB forms) that are sent to you each time payment is made. These worksheets are useful for reference and for your income tax records.

Finally, keep a record of the hours worked for participating employers, along with your check stubs. This information may be used to assist in establishing eligibility in the event of discrepancies.

The Trustees have the Right to Amend the Plan.

IBEW Local No. 640 and Arizona Chapter NECA Health and Welfare Trust Fund is committed to maintaining health care coverage for employees and their families at an affordable cost, however, because future conditions cannot be predicted, **the Plan reserves the right to amend or terminate coverages at any time and for any reason.**

As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Name, Marital Status or Dependent Status Changes?

You or your Dependents must promptly furnish to the Plan Administrator information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

Failure to do so may cause you or your Dependents to lose certain rights under the Plan or may result in your liability to the Plan if any benefits are paid to an ineligible person.

- If your name or marital status has changed, you must provide a copy of your marriage certificate or divorce decree to the Administrative Office.
- You must also notify the Administrative Office when Dependent children no longer qualify as Dependents. You must provide this information so that the Fund can make reports required by law.

Dependent Identification Information.

Please note that no individual will be considered a dependent under the Plan in the absence of specific documentation to substantiate dependent status, including accurate Identification Information (e.g. Social Security number, Medicare health insurance claim number, etc.).

Qualified Medical Child Support Orders.

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The Fund will honor a valid QMCSO. See also the detail in the ERISA section of this booklet at Page 97.

For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Administrative Office.

Work Related Condition

If your condition was caused by a work related illness/injury, benefits will be provided by your participating Employer's workers' compensation insurance. If either of these occurs, contact your participating Employer promptly to file for benefits under the compensation plan.

Hour Bank Freeze

If an eligible Employee's work related illness/injury results in the employee being totally disabled, the

Employee's eligibility hour bank may be "frozen" in accordance with the continuation of eligibility while totally disabled provisions of the Plan.

Questions?

The Administrative Office is ready to help you with any of your claim filing needs, or to direct you to the appropriate place to pose your questions/issues. Please call or write if you have any questions.

Zenith American Solutions, Inc.
2001 W. Camelback, Suite B350
Phoenix, AZ 85015
Phone: (602) 248-8434 or 1-800-553-2801
Fax: (602) 248-8301
www.zenith-american.com

Under the Collective Bargaining Agreements, the Agreement and Declaration of the Trust for the Fund, and these Rules of the Plan, the Board of Trustees has full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and any other related matters.

The Trustees have full power to construe the provisions of the Trust Agreement and these Rules. Any such determinations and any such constructions adopted by the Trustees in good faith are binding on the Employers, the Unions, and the participants or beneficiaries of the Fund. Conflicts between these Rules and the Trust Agreement will be resolved in favor of the Trust Agreement provisions.

The Board of Trustees has contracted with BCBSAZ to provide certain administrative claims processing and utilization management services for this PPO benefit plan. Benefits under the Plan are paid from the general assets of the Fund. BCBSAZ, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BCBSAZ IS AN INDEPENDENT CONTRACTOR AND SHALL NOT FOR ANY PURPOSE BE DEEMED AN AGENT OF YOUR EMPLOYER OR THE EMPLOYER'S PLAN ADMINISTRATOR, NOR SHALL BCBSAZ AND YOUR EMPLOYER BE DEEMED PARTNERS, JOINT VENTURERS OR GOVERNED BY ANY LEGAL RELATIONSHIP OTHER THAN THAT OF INDEPENDENT CONTRACTOR. IN THIS SPD, BCBSAZ REFERS TO THE ADMINISTRATIVE SERVICES AGREEMENT AND/OR STOP LOSS INSURANCE AGREEMENT WITH YOUR PLAN SPONSOR AS A GROUP MASTER CONTRACT.

THIS PPO BENEFIT PLAN GIVES YOU ACCESS TO A NETWORK OF PROVIDERS THAT HAVE AGREED TO NEGOTIATED DISCOUNTS WITH BCBSAZ OR A LOCAL BLUE CROSS AND/OR BLUE SHIELD PLAN IF COVERED SERVICES ARE RENDERED OUTSIDE OF ARIZONA.

Quick Reference Chart

<table>
<tr><th>Information Needed:</th><th>Whom to Contact:</th></tr>
<tr><td>Administrative Office
• Eligibility for Coverage
• Plan Benefit Information
• Weekly Disability Benefits, Claims and Appeals
• Medicare Notice of Creditable Coverage</td><td>Zenith American Solutions, Inc.
2001 W. Camelback, Suite B350
Phoenix, AZ 85015
Phone: (602) 248-8434 or 1-800-553-2801
Fax: (602) 248-8301
www.zenith-american.com
Hours:
8:30 a.m. to 4:30 p.m. MST Monday through Friday</td></tr>
<tr><td>PPO Network for the Medical Plan
• Medical Network Provider Directory for PPO Providers
• Additions/Deletions of Medical Network Providers</td><td>BCBSAZ
(602) 864-4400 (Local)
(800) 232-2345 (Long Distance)
Blue Cross Blue Shield of Arizona, P.O. Box 13466
Phoenix, AZ 85002-3466
www.azblue.com</td></tr>
<tr><td>Behavioral Health Program
• Inpatient and Outpatient Mental Health and Substance Abuse Providers
• Precertification of outpatient and inpatient mental health and substance abuse services
• Behavioral Health Claims and Appeals</td><td>BCBSAZ Behavioral Out of Network Claims:
BCBSAZ Behavioral Health
P.O. Box 13466
Phoenix, AZ 85002-3466
Claim forms may be printed from the www.azblue.comwebpage</td></tr>
<tr><td>Utilization Management (UM) Program
• Precertification and Case Management
• Appeals of UM decisions</td><td>BCBSAZ
(602) 864-4400 (Local)
(800) 232-2345 (Long Distance)</td></tr>
<tr><td>Prescription Drug Program
• Retail Network Pharmacy Locations
• Mail Order (Home Delivery Service)
• Prior Authorization (precertification or pre-approval) of certain drugs
• Specialty Drugs
• Reimbursement of prescription drugs claims purchased out of network</td><td>MedImpact Healthcare System – Pharmacy Benefit Management Customer Service: 833-229-3589
MedImpact Direct Mail Order (Home Delivery) 855-873-8739
MedImpact Direct Specialty Pharmacy: 877-391-1103
MedImpact Pharmacy Out of Network Claims:
Pharmacy Service Center
Claim forms may be obtained by calling MedImpact Customer Service Center at 833-229-3589</td></tr>
<tr><td>Dental DPPO Plan (Insured)
• Dental Network Provider Directory
• Additions/Deletions of Dental Providers
• Dental Claims (Appeals managed by Delta Dental)</td><td>Delta Dental Plan of Arizona (DDPAZ)
602-938-3131 or 800-352-6132
P. O. Box 43000 Phoenix, AZ 85080-3000
www.deltadentalaz.com</td></tr>
<tr><td>Employee Assistance Program (EAP)
• Up to 6 visits at no cost for short-term counseling and/or referral services</td><td>Beacon Health Options
24 hour Customer Service: 1-877-219-3971
www.beaconhealthoptions.com</td></tr>
<tr><td>COBRA Administrator
• Information about COBRA and cost of COBRA
• Adding or Dropping Dependents
• COBRA Premium payments</td><td>Zenith American Solutions, Inc.
2001 W. Camelback, Suite B350
Phoenix, AZ 85015
Phone: (602) 248-8434 or 1-800-553-2801
Fax: (602) 248-8301
www.zenith-american.com</td></tr>
<tr><td>Life Insurance (Death benefit) and Accidental Death and Dismemberment Benefits
• Claims and Appeals</td><td>Union Labor Life Insurance Company
1-310-318-8419</td></tr>
</table>

Quick Reference Chart

Information Needed:	Whom to Contact:
Plan Administrator (Board of Trustees)	**Board of Trustees of IBEW Local 640/AZ NECA Health & Welfare Fund** 2001 W. Camelback, Suite B350 Phoenix, AZ 85015 Phone: (602) 248-8434 or 1-800-553-2801 Fax: (602) 248-8301
HIPAA Privacy Officer **HIPAA Security Officer**	**Privacy Officer and Security Officer for IBEW Local 640/AZ NECA Health and Welfare Fund** 2001 W. Camelback, Suite B350 Phoenix, AZ 85015 Phone: (602) 248-8434 or 1-800-553-2801 Fax: (602) 248-8301 www.zenith-american.com
Vision Benefits Claim Administrator • Vision Network Provider Directory • Vision claims and appeals	**Vision Service Plan** P.O. Box 385018 Birmingham, AL 35238 Phone: 1-800-877-7195 www.vsp.com

Explanation of Terms

You will find terms starting with capital letters throughout this document. To help you understand your medical benefits, most of these terms are defined in the Definitions section of this booklet.

The Schedule

The Schedules for Medical, Dental, Vision, Short Term Disability and Death/Accidental Death benefits are a brief outline of the maximum benefits which may be payable under your coverage. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

ELIGIBILITY FOR BENEFITS

Definitions Relating to Eligibility

Active Employee—The term "Active Employee" means any person who, by reason of active employment under the terms of a collective bargaining agreement requiring contributions to the Fund, participates in the Fund's Plan.

Administrative Office—The term "Administrative Office" means the company or firm with which the Trustees have contracted for day to day administrative services, including maintaining eligibility records.

Board or Board of Trustees—The term "Board or "Board of Trustees" means the Board of Trustees established by the Trust Agreement for the IBEW Local No. 640 and Arizona Chapter NECA Health and Welfare Trust Fund.

Dependent—The term "Dependent" means your **lawful spouse** (a person is a lawful spouse if they are lawfully married in the jurisdiction where the marriage was celebrated), and any of your children listed below who are under the age of 26 (whether married or unmarried):

- **Son or daughter** (proof of relationship and age may be required including birth certificate and social security number).
- **Stepson or stepdaughter** (proof of relationship and age may be required including birth certificate and social security number and marriage certificate).
- **Legally adopted child** or child placed for adoption with the employee (proof of adoption or placement for adoption and age may be required including birth certificate and social security number).
- **A child** named as an "alternate recipient" under a **Qualified Medical Child Support Order (QMCSO)**.
- **A child** with respect to whom the employee has **legal guardianship** under a court order (proof of guardianship and age may be required, including birth certificate, guardianship court order, guardian's income tax returns showing the child is dependent on participant for support and social security number).
- The Board will require immediate notice of changes in marital status of an eligible employee based upon marriage or divorce.
- The term "legally adopted children" includes children placed for adoption and as to which you assume and retain a legal obligation for total or partial support in anticipation of adoption. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.
- With respect to Medical Benefits, Dependent children are covered from birth for charges for the treatment of hereditary abnormality.
- **Disabled Dependent Child Provision**: Medical Benefits only can be continued for never married children who are incapable of earning a living because of mental retardation or physical disability, and who's disability existed prior to the attainment of the Plan's age limit, and who are chiefly dependent on you for support on the date they cease to be eligible for Medical Benefits due to attainment of the limiting age and are eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively. Coverage for such children can be continued for the duration of the incapacity provided coverage does not terminate for any other reason.
- A Dependent becomes eligible according to the enrollment process outlined below.
- No person can be eligible both as an Employee and as a Dependent or as a Dependent of more than one Employee with the exception of any applicable coordination of benefits provisions.
- With the exception of a Dependent Child who is disabled prior to age 26, coverage will terminate at the end of the month in which the individual attains age 26.
- The following individuals are **not eligible** under the Plan: a foster child, grandchild, niece/nephew, or a spouse of a Dependent Child (e.g. employees' son-in-law or daughter-in-law).

Fund or Trust Fund—the term "Fund" or "Trust Fund" means the IBEW Local No. 640 and Arizona Chapter NECA Health and Welfare Trust Fund.

Pre-Journeymen – The term "Pre-Journeymen" is a classification of employee whose eligibility rules are different and whose benefits are limited to PPO Medical, Outpatient Prescription Drug, Dental, EAP, Weekly Disability, PPO Vision benefits as described in the document. These individuals are sometimes referred to as Plan B participants.

Member or You—The term member or you means an individual, employee, participant or Dependent covered under a benefit plan.

Non-Jobsite Employee—The term "Non-Jobsite Employee" means an employee of IBEW Local No. 640, an employee of the Phoenix Joint Apprenticeship and Training Committee, and any other employee who once participated as an Active Employee under a collective bargaining agreement and is permitted to participate in the Fund pursuant to a Non-Jobsite Agreement with the Fund.

Non-Bargained Employee—The term "Non-Bargained Employee" means a Participating Employer's employee who has never participated in the Fund's Plan by virtue of employment under a collective bargaining agreement, but who is permitted to participate pursuant to a Non-Bargaining Agreement with the Fund.

Participating Employer—The term "Participating Employer" means any employer signatory to or otherwise bound by a collective bargaining agreement that requires contributions on behalf of that employer's employees to this Trust Fund. The term may also include Local No. 640, the Arizona Chapter NECA, and the Phoenix Joint Apprenticeship and Training Committee.

Plan—The term "Plan" means the program of benefits as adopted and as thereafter amended by the Trustees.

Retired Employee – The term "Retired Employee" means an individual retired from employment covered by the IBEW Local 640 and Arizona Chapter NECA Health and Welfare Trust Fund who meets the eligibility rules for participation in this Plan. Early Retirees' benefits are limited to PPO Medical, Outpatient Prescription Drug, Dental and Vision benefits. These individuals are sometimes referred to as Retirees.

Trust Agreement—The term "Trust Agreement" means the Agreement and Declaration of Trust establishing the IBEW Local No. 640 and Arizona Chapter NECA Health and Welfare Trust Fund.

Establishment and Maintenance of Eligibility for Active Employees.

As an Active Employee, you and your Dependents are eligible for benefits on the first day of the second Calendar Month that follows a period of three consecutive Calendar Months during which you have worked at least 420 hours in a Plan A classification for one or more Participating Employers. As an Active Employee, you and your Dependents are eligible for benefits on the first day of the second Calendar Month that follows a Calendar Month during which you have worked at least 120 hours in a Plan B (Pre-Journeyman) classification for one or more participating employers. Notwithstanding that, if you have completed participation in Plan B operated under this Fund, you become eligible for benefits (together with your Dependents) on the first day of the second Calendar Month which follows a month in which you have worked 140 hours in a Plan A classification for one or more Participating Employers.

If you are a Non-Bargained Employee, you become eligible for benefits for you and your Dependents on the first day of the Calendar Month following receipt of a Trustee-approved agreement specifying the monthly contributions required by the Trustees for such participation, and the relevant contributions. Non-Bargained Employees do not accrue an Hour Bank as described in the Hour Bank provisions of these eligibility rules nor will such employees be entitled to either the Continuation of Eligibility provisions or the Reinstatement of Eligibility provisions set forth below. Your eligibility as such an employee will end at the end of the Calendar Month following receipt of the last monthly contribution required by the Trustees that is received on your behalf.

Immediate Coverage for New Active Employees: The Plan generally requires that an Active Employee work 3 consecutive Calendar Months during which the Active Employee works at least 420 hours to be eligible for coverage under the Plan. Coverage then begins on the first day of the second calendar month after completing this requirement. Excess hours accumulate in an Hour Bank for future eligibility. New Active Employees will have 360 hours (280 Hours for Pre-Journeymen) advanced to their hour bank (an "hour bank loan") in their first month of work. In order to qualify, an Active Employee must:

1. be dispatched to work in the jurisdiction of the Plan by Local 640 to a Contributing Employer between October 1, 2021 and December 31, 2022;
2. not have any Covered Hours under or participated in the Plan in the 24 months prior to dispatch and beginning employment;
3. have had employer sponsored medical coverage in the month of or prior to dispatch by Local 640.

The hour bank loan is provided the first month of employment; coverage will then begin the first month *following* the month employment began.

Each month, any hours worked will apply first toward the minimum 140 hours required to maintain eligibility. Any excess will be applied to repay the member's hour bank loan.

Exceptions and Limitations on Immediate Coverage

If the hour bank loan is not fully repaid after 24 months, then the obligation to repay the hour bank loan will end and any remaining hour bank loan hours will be cancelled. At that point, the member must satisfy the continuing eligibility requirements under the Plan in order to continue coverage.

If during the first 12 months of coverage a member loses Plan coverage and has an outstanding hour bank loan, the loan and banked hours will be cancelled. In order to have coverage reinstated, the member must reestablish Initial Eligibility by working at least 420 Covered Hours within three consecutive months.

Hour Banks

Your eligibility as an Active Employee continues if your Hour Bank (as defined below) contains at least 140 hours of work credit (120 hours for Pre-Journeymen). An Hour Bank is an account of hours established for each Active Employee and includes all hours credited thereto less all hours deducted therefrom, as provided below:

1. Subject to the maximum set forth in Subsection 3 below, all hours worked by you as an Active Employee for one or more Contributing Employers in a Plan A classification are credited to your Hour Bank. If you are an employee completing participation in the Plan B of this Trust Fund, any remaining hours in your Plan B Hour Bank, after deduction for the last month of eligibility under Plan B, are credited to your Plan A Hour Bank.

2. 140 hours of work credit are deducted from your Hour Bank to maintain eligibility for one month (120 hours for Pre-Journeymen).
3. The maximum balance in your Hour Bank is 420 hours after the 140 hour deduction has been made for the current month's eligibility (360 maximum balance/120 hour deduction for Pre-Journeymen).
4. In order that there will be sufficient time for Employer reports to be received and processed by the Administrative Office, a "lag month" will be used in determining your monthly eligibility. The lag month is the month between the payroll period and the month of actual coverage.

   For example: As an Active Employee you work 420 hours from October through December. You become covered on February 1 – in this example, January is the lag month.
5. All hours of work credit will be deducted from your Hour Bank if, following your leaving the employ of Participating Employers, you do not remain available for employment with Participating Employers. "Available for employment with Participating Employers" means being duly registered for work referrals to Participating Employers from I.B.E.W. Local No. 640.

   The Hour Bank deduction required by this Subsection 5 will not apply to you if you leave employment for military service, because of total disability, retirement, death, or for travel to an area governed by a reciprocity provision with another electrical workers' plan. It will also not apply to you if you are on vacation, on leave from the industry, or are performing work other than the type of work performed by Participating Employers. Absent evidence of the circumstances set forth in this paragraph, it will be presumed that the Hour Bank deduction provisions are applicable.

   Hours of work credit deducted under this Subsection 5 will be reinstated if you return to employment with Participating Employers within twelve (12) calendar months of the date you lost eligibility.

Family Medical Leave Act (FMLA)

If you qualify under the **Family Medical Leave Act (FMLA)**, you are entitled to unpaid leave for specified time periods and can continue to maintain coverage under this Plan for the duration of the leave. Contributions will be maintained at the same terms as prior to the leave. Qualifications for this leave are outlined in the FMLA and subsequent regulations.

Continuation of Eligibility While Totally Disabled.

If you become Totally Disabled and the disability lasts for more than 30 days, no deduction will be made from your Hour Bank during the time beginning on the first day of the month in which the disability begins. In other words, the Hour Bank accumulation will be "frozen" and all Fund benefits will continue. This extended coverage may continue until the first day of the month in which the disability ends or the first day of the seventh month of disability, whichever occurs sooner. However, in order to be eligible for this continuation, the Active Employee must have a physician's statement certifying the disability and must advise the Administrative Office of the disability within six months of the date of the Illness or Injury causing the disability.

Your Hour Bank may be frozen under this Section for a maximum period of six months. No Hour Bank "freeze" will extend into any month for which you receive retirement benefits from the companion I.B.E.W. Local No. 640 and Arizona Chapter N.E.C.A. Pension Trust Fund.

Reinstatement of Eligibility.

If your eligibility terminates because of insufficient hours in your Hour Bank, it can be reinstated if your Hour Bank shows a total of at least 140 hours in a Plan A classification within the 12 Calendar Month period subsequent to the termination of eligibility (120 hours for Pre-Journeymen). Such reinstatement shall be effective on the first day of the second Calendar Month following the Calendar Month in which this requirement is met. If your eligibility is not reinstated after a period of 12 consecutive Calendar Months, any hours remaining in you Hour Bank are canceled, and you again become eligible only by satisfying the eligibility requirements of a new Employee as set forth in the Establishment and Maintenance of Eligibility Section.

Reciprocity.

There is a Reciprocity Agreement between the I.B.E.W. Local No. 640 and Arizona Chapter N.E.C.A. Health and Welfare Trust Fund and the International Brotherhood of Electrical Workers that permits hours worked in reciprocal jurisdictions of the Union to be transferred to this plan to maintain eligibility. The text of that Reciprocity Agreement is available at the Administrative Office of the Fund. If your coverage would otherwise terminate as a result of having insufficient hours in your Hour Bank and you have worked for a participating employer contributing to a health and welfare fund which also participates under the International Brotherhood of Electrical Workers Reciprocity Program, you may be provided continuation of coverage if the hours transferred are sufficient.

Termination of Eligibility.

Your eligibility will terminate on the last day of the Calendar Month for which you do not qualify under these rules.

Notwithstanding the foregoing, if you enter the uniformed military service of the United States, your Hour Bank can be held until you are released from military service and return to employment with a Participating Employer within ninety days following your release, if you requests it and it is approved by the Board of Trustees. If an Hour Bank is held under this provision, your eligibility will terminate on the last day of the Calendar Month in which you enter the uniformed military service.

The eligibility of your Dependent terminates on the earlier of the following dates:

1. The date your eligibility terminates.
2. In the event of your death, coverage shall terminate for your eligible Dependents of the last day of the Calendar Month in which your Hour Bank fell below 140 hours (120 hours for Pre-Journeymen).
3. The date of the Dependent's entrance into full-time active military duty.
4. The date the individual longer qualifies as a Dependent.

Establishment and Maintenance of Eligibility for Retired Employees

If you are a former Active Employee or former Non-Jobsite Employee (which former Non-Jobsite Employee was covered for Plan A benefits during the 36 consecutive months prior to retirement) who lost eligibility due to retirement you may elect, **in lieu of the self-payment benefits provided under Plan A** to continue eligibility for **PPO Medical, Outpatient Prescription Drug, Dental and Vision Benefits** for yourself and your eligible Dependents by making self-payments according to the following provisions, provided that you had work activity under Plan A which, if applied under the I.B.E.W. Local No. 640 and Arizona Chapter N.E.C.A. Pension, would have given rise to 10 years or more of Pension Credit, and you were eligible for coverage when you retired. In order to be eligible to make self-payments under this Section, you must have been an Active Employee covered by Plan A who failed to maintain that status because of retirement.

Notwithstanding the foregoing limitation, if you are a former Active Employee or former Non-Jobsite Employee who has the equivalent of 25 years of Pension Credit under Plan A and you are formally retired under the I.B.E.W. Local No. 640 and Arizona Chapter N.E.C.A. Pension Trust Fund, you and your eligible Dependents will be allowed coverage for Medical and Dental Benefits by making self-payments effective with the first month of your retirement.

Additionally, if you are the surviving spouse of a former Active Employee or former Non-Jobsite Employee who, at the time of death, would have, if retired, qualified for the Retired Employee coverage as described above, you and other eligible Dependents of such a former Employee may also elect, in lieu of COBRA self-payments under Plan A, coverage under this Retired Employee Plan.

Notice.

If you have retired, you will receive notice from the Administrative Office at the end of coverage under Plan A that you have lost eligibility because of insufficient Hour Bank hours. If you are the surviving spouse of an employee that would, if retired, have been eligible for Retired Employee coverage, you may request information from the Administrative Office concerning your eligibility for this Retired Employee Plan. If you are eligible to elect Retired Employee coverage, you will have until the time limits expressed under the Plan A COBRA provisions to elect **either** the COBRA self-payments **or** those described in this Section.

Self-Payment Amount – Coverage Available.

The amount(s) of the monthly self-payments for Retired Employees will be established by the Board of Trustees and will be subject to change in their discretion. The self-payments charged represent continuation of Medical and Dental Benefits.

Payment.

If you are eligible for pension payment deduction in accordance with the rules of the Pension Fund, you must have your self-payments automatically made by the Administrative Office under the Pension Fund provisions. Otherwise, payments must be made to the Administrative Office for monthly coverage. Such payments are due on the first day of the month for which coverage is intended. Payments received later than 30 days after their due date will not be accepted, and rights to self-pay for Retired Employee coverage will terminate.

Maximum Number of Self-Payments.

Your right to make self-payments will continue until the end of the month in which the **earliest** of the following events occurs:

- The Trust Fund ceases providing retiree benefits,
- The Trust Fund ceases providing any benefit to any participant
- Your death, or
- Your return to active employment under Plan A. The Trustees may suspend the operation of this provision when and if, in their discretion, industry conditions warrant.

Termination of Eligibility

Your eligibility will terminate on the last day of the Calendar Month for which you do not qualify under these rules. The eligibility of your Dependent will terminate on the earlier of the following dates:

- The date you eligibility terminates.
- The date of the Dependent's entrance into full-time active military duty.
- The date the individual no longer qualifies as a Dependent.

Enrollment

Required Enrollment

As an Eligible Employee or Retired Employee, you are considered enrolled for benefits coextensively with your eligibility date when information permitting contact from the Administrative Office is established.

Benefit eligibility for Dependents of an Eligible Employee or Retired Employee is co-extensive with your eligibility if the Dependents are properly enrolled in the Plan.

As an Eligible Employee or Retired Employee, all of your existing Dependents must be enrolled within 90 days of your initial eligibility or if applicable, reinstatement of eligibility, to gain eligibility as of the date of your eligibility. If a Dependent is not properly enrolled in this 90 day period (or becomes a Dependent thereafter) then eligibility for that Dependent will begin on the first day of the month following their proper enrollment, subject to the Special Rules below.

Enrollment Process

All of your Dependents are considered properly enrolled upon your completion of an enrollment form and the submission of the information required under the Proof of Dependent Status Provisions below.

- Special Rule for Newly-Acquired Spouse – A newly acquired spouse of an Eligible Employee or Retired Employee will be covered as of the date of the marriage to the Employee/Retired Employee, if properly enrolled within 90 days of the marriage. An enrollment form must be completed and submitted to the Plan including proof and identification data for the Dependent Spouse (if requested). If a newly acquired spouse is not properly enrolled with this 90 day period, then eligibility for that Dependent will begin on the first day of the month following their proper enrollment.
- Special Rule for Newborns – Newborn Dependent Children of an Eligible Employee or Retired Employee will be covered from the date of birth, if properly enrolled within 90 days of their birth. An enrollment form must be completed and submitted to the Plan including proof and identification data for the Dependent (if requested). If a newborn Dependent Child is not properly enrolled within this 90 day period, then eligibility for that Dependent will begin on the first day of the month following their proper enrollment.
- Special Rule for Adopted Children – Adopted Children, or children "Placed for Adoption" with an Eligible Employee or Retired Employee will be covered from the date of adoption, or the date of placement for adoption, if earlier, if properly enrolled within 90 days of the adoption or placement for adoption. A child is "Placed for Adoption" with the Employee or Retired Employee on the date they first become legally obligated to provide full or partial support of the child whom they plan to adopt. An enrollment form must be completed and submitted to the Plan including proof and identification data for the Dependent (if requested). If an adopted child is not properly enrolled within this 90 day period, then eligibility for the Dependent will begin on the first day of the month following their proper enrollment.

  If a child is Placed for Adoption and is properly enrolled, and if the adoption does not become final, coverage of that child will terminate as of the date the Employee or Retired Employee no longer has a legal obligation to support that child.

Proof of Dependent Status

Specific documentation to substantiate Dependent statue will be required by the Plan and may include proof that the Dependent is related to the Eligible Employee or Retired Employee and social security number of the Dependent(s) you wish to add to the Plan, and any of the following:

- Marriage: copy of the certified marriage certificate.
- Birth: copy of the certified birth certificate.
- Adoption or Placement for Adoption: court order papers signed by a judge.
- Stepchild: copy of the certified marriage certificate and the certified birth certificate.
- Legal Guardianship: a copy of your court-appointed legal guardianship documents and a copy of the certified birth certificate.
- Qualified Medical Child Support Order (QMCSO): valid QMCSO document or National Medical Support Notice
- Disabled Dependent Child: current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally retarded or mentally or physically disabled (as the term disabled is defined in this document) and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you and/or your Spouse for support and maintenance; and the disability existed before the child's attainment of the Plan's age limit. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a **temporary** extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the COBRA Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace at www.healthcare.gov. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA continuation coverage is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a Federal Law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Administrative Office (see the Reference Chart on page 3 of this booklet for contact information).

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced making you ineligible for group health coverage (including if you fail to work sufficient hours in a designated work period necessary to maintain plan eligibility), or
- Your employment ends for any reason (other than your gross misconduct).

If you are the spouse of an employee or Retired Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced making the employee ineligible for group health coverage;
- The parent-employee's employment ends for any reason (other than his or her gross misconduct);
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both) under Title XVIII;
- The parents become divorced or legally separated; or
- The child stops meeting the definition of a Dependent Child under the Plan.

When is COBRA Continuation Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator of the IBEW Local No 640 and Arizona Chapter NECA Health & Welfare Trust Fund has been notified that a qualifying event has occurred.

The following qualifying events **require notification from your employer**: end of employment; reduction of hours of employment making the employee ineligible for coverage; death of the employee.

IMPORTANT: You Or A Qualified Beneficiary Must Give Notice Of Some Qualifying Events: For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), **you must notify the Plan (by contacting the COBRA Administrator) within 60 days** after the Qualifying Event occurs (see notification steps below).

Notifying the Plan: Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must provide a written notice to the COBRA Administrator (whose address is listed at the end of this document). The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce decree or death certificate document. If mailed, your notice must be postmarked no later than the last day of the required notice period.

NOTE: If such a written notice is not received by the COBRA Administrator within the 60-day period you, the Qualified Beneficiary, will not be entitled to choose COBRA coverage.

The following documents are needed for their applicable event: death certificate; divorce decree; or Medicare card. You must provide this notice to the COBRA Administrator at:

IBEW Local No 640 and Arizona Chapter NECA Health & Welfare Trust Fund
ATTN: COBRA Administrator
2001 West Camelback Rd, Suite B-350
Phoenix, AZ 85015
1-602-248-8434

How Is COBRA Coverage Provided?

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

Duration of COBRA Coverage

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

When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months for the spouse and dependents who are qualified beneficiaries.

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

There are three ways in which COBRA coverage can last longer than 18 months:

1. **Secondary Qualifying Events**

   If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

2. **Medicare entitlement is not a Qualifying Event under this Plan** because it does not result in loss of coverage for an employee. As a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for spouses and dependents who are Qualified Beneficiaries.

3. **Disability Extension**

   If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event, provided the disability lasts at least until the end of the 18-month period of COBRA coverage.

   To qualify for the disability extension, all of the following requirements must be satisfied:

   - SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
   - **Notifying the Plan:** You or another family member must notify the Plan by sending a copy of the written SSA determination, which must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period. The written notice should be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA, the name of the disabled Qualified Beneficiary, the date the Qualified Beneficiary became disabled, and a copy of the written determination of disability from the Social Security Administration and that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.

Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage if the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. *For example*, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

1. the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
2. failure to pay the required premium within 30 calendar days after the due date;
3. after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both)
4. after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre- existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above (IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan).
5. any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).
6. the group health plan no longer provides health coverage to any of its employees.

Moving Out of Fund's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Fund's service area or the Fund eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Fund's service area. If the Fund offers another benefit option through BCBSAZ or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Fund's Notification Requirements

Your Fund is required to provide you and/or your Dependents with the following notices:

1. An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
2. A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
3. if the Plan provides that COBRA continuation coverage and the period within which a Fund must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
4. if the Plan provides that COBRA continuation coverage and the period within which a Fund must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
5. in the case of a multi-fund plan, no later than 14 days after the end of the period in which Funds must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan for coverage of a similarly situated active Member or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan for coverage of a similarly situated active Member or family member.

For example: If the Member alone elects COBRA continuation coverage, the Member will be charged 102% (or 150%) of the active Member premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Member premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

1. Your divorce or legal separation; or
2. Your child ceases to qualify as a Dependent under the Plan.
3. The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29- month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Member covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.

Newly Acquired Dependents

A Qualified Beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during an open enrollment period, etc. If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

Alternate Recipients Under Qualified Medical Child Support Orders (QMCSO).

A child of the covered employee, who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO) received by the COBRA Administrator during the employee's period of employment with the employer, is entitled the same rights under COBRA as a dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent.

Be sure to promptly notify the COBRA Administrator (in writing) if you need to make a change to your COBRA coverage.

The COBRA Administrator must be notified in writing within 31 days of the date you wish to make such a change (adding or dropping dependents, for example).

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Interaction With Other Alternatives

Employees with long service under this Plan (and the surviving spouse of such an employee) may be eligible to elect coverage for themselves and their dependents under the Retired Employee Plan of the Trust Fund instead of COBRA coverage as described above. Individuals interested in this alternative should contact the Administrative Office of the Fund, identified in the Quick Reference Chart at the front of this booklet, for additional details concerning this option, including the coverage available, which individuals are qualified to elect it, and the procedure for doing so.

Individuals who do not elect COBRA continuation benefits may also be able to secure health coverage from the exchanges established under the Affordable Care Act (ACA) the health reform legislation.

If You Have Questions.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator (contact information is below). For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov. You may also contact the COBRA Administrator at their address and phone number below.

Keep Your Plan Informed of Address Changes.

In order to protect your family's rights, **you should keep the COBRA Administrator informed of any changes in the addresses of family members.** You should also keep a copy, for your records, of any notices you send to the COBRA Administrator or COBRA Administrator.

Plan Contact Information.

Remember, while you can call the Plan for information, any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. See the procedures to notify the Plan in writing that have been outlined in this document.

COBRA Administrator
IBEW Local No 640 and Arizona Chapter NECA Health & Welfare Trust Fund
ATTN: COBRA Administrator
2001 West Camelback Rd, Suite B-350
Phoenix, AZ 85015
1-602-248-8434

UNDERSTANDING THE BASICS

Your Responsibilities

Before you receive services:

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

After you receive services:

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

BCBSAZ ID Card

Bring your ID card with you each time you seek healthcare services, and have your ID card available for reference when you contact BCBSAZ for information. BCBSAZ will mail you an ID card with basic information about your coverage:

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

Coverage Changes

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

Covered Services

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

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

Experimental or Investigational Services

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

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

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

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

Medically Necessary

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

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

Medical Necessity Guidelines and Criteria

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

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

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

MEDICAL PPO PLAN PROVIDERS

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

Provider Directory

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

Provider Eligibility and Network Status

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

Eligible Providers

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

Benefits may also be available from other healthcare professionals whose services are mandated by Arizona state law or federal law or who are accepted as eligible by BCBSAZ. The following are examples of ineligible providers: doctors of naturopathy and homeopathy. Other provider types may also be ineligible. The fact that a service is rendered by an eligible provider does not mean that the service will be covered. Not all eligible providers are contracted to participate in BCBSAZ networks.

ELIGIBLE PROVIDER LIST	
Professional	**Facility Ancillary**
• Board Certified Applied Behavioral Analyst (BCABA) • Certified Registered Nurse First Assist (CRNFA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Doctor of chiropractic (DC) • Doctor of dental surgery (DDS) • Doctor of medical dentistry (DMD) • Doctor of medicine (MD) • Doctor of optometry (OD) • Doctor of osteopathy (DO) • Doctor of podiatry (DPM) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner (NP) • Licensed professional counselor • Perfusionist • Physician Assistant (PA) • Psychologist (PhD, EdD and PsyD) • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational or physical therapist • Surgical Assist (SA) • Surgical Technician (ST)	• Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long-Term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Pain Management Clinics • Rehabilitation Treatment Centers (substance abuse centers) • Retail, mail order and specialty pharmacies • Skilled Nursing Facility • Sleep Lab • Specialty Laboratory • 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 BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for members of this Benefit Plan); and (2) Except as noted in this 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 BCBSAZ.

Except for Emergency Services, if the Provider submitting a laboratory, DME/medical supply, and/or air ambulance claim does not have a Plan Network contract with BCBSAZ (when the claim is submitted to BCBSAZ) or a PPO contract with the out-of-state Blue Cross and/or Blue Shield Plan to which the claim is submitted, the claim will be processed as an out-of-network claim**.** Members are responsible for in-network Cost Share and any applicable Balance Bill. See the *"Out-of-Network Providers"* section below.

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

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

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

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 members are responsible for in-network cost-share and any applicable Balance Bills (except for emergencies).

Out-of-Network Providers (Contracted and Noncontracted)

Out-of-network providers are: (1) Providers who are contracted with a Host Blue plan as "Participating" only providers; (2) Providers who are contracted with BCBSAZ but do not have a Plan Network contract (such as BCBSAZ PPO-only Providers); (3) Eligible providers who have no contract with BCBSAZ or a Host Blue plan (Noncontracted providers); (4) Providers who are contracted with Blue Cross Blue Shield Global® Core; and (5) Providers who submit a laboratory, DME/medical supply, or an 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 a Host Blue plan as "Participating" and are not contracted as PPO or Preferred providers. Participating-only providers are out-of-network providers. Participating-only providers will submit your claims to the Host Blue plan with which they are contracted. If you receive covered services from a Participating-only provider, you will pay out-of-network deductible and coinsurance and access fees. However, you will not have to pay the balance bill because the provider is contracted.

- **Providers contracted with BCBSAZ who are not in the Plan Network**

  Some BCBSAZ Providers are contracted with BCBSAZ for certain networks, but are not contracted as Plan Network Providers. For purposes of this Benefit Plan, they are considered noncontracted and will be treated like any other noncontracted Provider described below. For example, BCBSAZ PPO-only Providers are noncontracted Providers. They may, but are not required to submit your claims to BCBSAZ. If you receive Covered Services from a Provider who is contracted with BCBSAZ, but not contracted as a Plan Network Provider, you will pay out-of-network deductible and Coinsurance. BCBSAZ will send any claim payments to you, and you are responsible to pay the Provider. Because these Providers are considered noncontracted, they may Balance Bill you like any other noncontracted Provider.

- **Noncontracted Providers**

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

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

  Unless BCBSAZ agrees to pay the Provider directly, BCBSAZ will send payment to you for whatever benefits are covered under your plan, and you will be responsible for paying the out-of-network provider. A noncontracted provider will not receive a copy of your explanation of benefits (EOB) and will not know the amount this benefit plan paid you for the claim.

- **Providers Contracted with Blue Cross Blue Shield Global® Core**

  Providers who are contracted with Blue Cross Blue Shield Global Core are out-of-network providers. For covered services from these providers, you will pay out-of-network deductible and coinsurance and access fees (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 BCBSAZ Allowed Amount and Do Not Balance Bill**	**Payee for Reimbursement**
Providers contracted with BCBSAZ as Plan Network Providers*	In-network	Yes	Yes	BCBSAZ reimburses the **provider** the allowed amount, less any member cost-share
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue") as PPO providers*	In-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share
Providers contracted with Host Blue as Participating only providers*	Out-of-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share
Providers contracted with Blue Cross Blue Shield Global Core	Out-of-network	Yes	No	Blue Cross Blue Shield Global Core reimburses the **provider** the allowed amount less any member cost-share
Noncontracted providers (in Arizona and out-of-state, including providers who are contracted with BCBSAZ but not for your Plan Network) (must be eligible providers)*	Out-of-network	No (provider may elect to do so as courtesy to member)	No. May charge up to full billed charges. Difference between billed charges and BCBSAZ member reimbursement may be substantial.	BCBSAZ reimburses the **member** the allowed amount, less any member cost-share. Provider does not get copy of member's EOB or know reimbursement amount.

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 percent coinsurance for an in-network provider and 40 percent coinsurance for an out-of-network provider.

Billed Charges	Allowed Amount	Financial Responsibility	In-Network Providers 20% Coinsurance	Out-of-Network (Noncontracted) Providers 40% Coinsurance
$1,000	$400	This benefit plan pays:	$320	$240
		You pay:	$ 80 coinsurance amount	$160 coinsurance +600 balance bill $760 A Balance Bill means the amount a provider bills you for the difference between the provider's charge and the Allowed Amount. The Allowed Amount is the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost-share payment.

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.

Precertifications for Out-of-Network Providers

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

Continuing Care from an Out-of-Network Provider

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

Continuity of care only applies to otherwise covered services rendered by providers.

<table>
<tr><th>New Members</th><th>Current Members</th></tr>
<tr><td>A new member may continue an active course of treatment with an out-of-network physician during the transitional period after the member's effective date if:
The member has:
1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of coverage; or
2. Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; and</td><td>A current member may continue an active course of treatment with an out-of-network physician if BCBSAZ terminates the physician from the network for reasons other than medical incompetence or unprofessional conduct if:
The member has:
1. A serious and complex condition (serious and complex condition means an acute illness that is a condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm or in the case of chronic illness a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time), in which case the transitional period is not more than ninety (90) days from the effective date of the physician's termination; or
2. Entered the third trimester of pregnancy on the effective date of the physician's termination, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; and</td></tr>
<tr><td colspan="2">The member's physician agrees in writing to do all of the following:
1. Accept the BCBSAZ allowed amount applicable to covered services as if provided by an in-network physician, subject to the cost-share requirements of this benefit plan;
2. Provide BCBSAZ with any necessary medical information related to your care; and
3. Comply with BCBSAZ's policies and procedures, as applicable, including precertification, network referral, claims processing, quality assurance and utilization review.</td></tr>
</table>

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

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

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

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

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

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

Special Cases: Value-Based Programs

BlueCard Program

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

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

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

Nonparticipating Providers Outside BCBSAZ’s Service Area

1. **Liability Calculation**

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

2. **Exceptions**

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

Blue Cross Blue Shield Global Core Program

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

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

- **Inpatient Services:** In most cases, if you contact the Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. You must contact BCBSAZ to obtain precertification for non-emergency inpatient services.
- **Outpatient Services:** Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services.
- **Submitting A Blue Cross Blue Shield Global Core Claim:** When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. for institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider’s itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSAZ, the Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, 7 days a week.

Services Received on Cruise Ships

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

Precertification

When Is Precertification Required

Not all services require precertification. Precertification is not required for Emergency Services or Urgent Care Services. If it is required, your treating provider must obtain it on your behalf before rendering services. Precertification may be required for services to be covered when provided in certain settings. On the BCBSAZ website, you'll find a list of services that need to be precertified at www.azblue.com/individualsandfamilies/resources/forms, or call the Customer Service number on your ID card. BCBSAZ may change the services that require precertification by posting a revised listing of services that require precertification at www.azblue.com.

How to Obtain Precertification

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

Factors BCBSAZ Considers in Evaluating a Precertification Request for Services

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

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

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

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

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

If BCBSAZ Precertifies Your Service

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

If BCBSAZ Denies Your Precertification Request

Denial of precertification is an adverse benefit determination. As explained in the next section on Claims, BCBSAZ will send you a notice explaining the reason for the denial, and your right to appeal the BCBSAZ decision. Information on where to file an appeal is in the Claims and Appeal Procedures section beginning on page 71 of this booklet.

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

MEDICAL PPO PLAN BENEFITS

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

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

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.

The Qualifying Payment Amount, as defined by federal law, is the Allowed Amount for out-of-network provider emergency services, non-emergency services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services. 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.

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

Benefit Maximums

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

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.

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

Coinsurance

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

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

Copay

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

Out-of-Pocket Maximum (Individual & Family)

An out-of-pocket maximum is the amount each member must pay each year before the plan begins paying 100 percent of the allowed amount on covered services, for the remainder of the 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 precertification

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

Precertification Charges

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

DESCRIPTION OF MEDICAL PPO PLAN BENEFITS

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

A. ACUPUNCTURE SERVICES

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

Benefit-Specific Maximum: Benefits are limited to twelve (12) in- and out-of-network visits per calendar year. Please note: this limit is a separate limit from the chiropractic limit.

Benefit Description: Benefits are available for acupuncture services provided by a M.D., D.O., or a chiropractor who is also a licensed acupuncturist.

B. AMBULANCE SERVICES

Your Cost-Share: You pay in-network deductible and coinsurance.

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

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

Benefit-Specific Exclusions:

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

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

C.1.1 Inpatient Hospital

Your Cost-Share:

In-Network: You pay an access fee per admission, plus deductible and coinsurance.

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:

- Diagnostic testing
- Intensive care units and other special care units
- 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

C.1.2 Subacute Inpatient Behavioral Health Hospitalization (Including Residential Treatment) Your Cost-Share:

In-Network: You pay an access fee per admission, plus deductible and coinsurance.

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:

- Diagnostic testing
- Biologicals and solutions
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Treatment and recovery rooms and equipment for covered services

Benefits are available for inpatient behavioral and mental health services that meet all the following criteria:

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

Changing Types of Inpatient Care (applicable to C.1.1 and C.1.2 above): 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 precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit-Specific Exclusions:

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

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

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

C.2 Behavioral and Mental Health Services (Outpatient Facility and Professional Services)

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

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

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

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

D. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

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

Benefit-Specific Maximums:

- Benefits are limited to thirty-six (36) in- and out-of-network cardiac rehabilitation visits per calendar year. Evaluations **do** count toward the visit limit.
- Benefits are limited to sixty (60) in- and out-of-network combined pulmonary rehabilitation therapy, PT, OT, ST and CT visits per calendar year. Evaluations **do** count toward the visit limit.

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

E. CATARACT SURGERY AND KERATOCONUS

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

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

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

F. CHIROPRACTIC SERVICES

Your Cost-Share: 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 a maximum of twenty (20) in- and out-of-network visits per year. Physical medicine performed by a chiropractor **does** apply toward the visit limit.

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

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

- 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
- Food and Drug Administration (FDA) reviewed investigational new drug application
- The U.S. Department of Defense
- The U.S. Department of Veterans Affairs
- A panel of qualified, recognized clinical research experts within an Arizona academic health institution

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

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

Benefit-Specific Exclusions:

- Investigational medications and devices
- Any item, device or service that is the subject of the clinical study, or which is provided solely to meet the need for data collection and analysis
- Clinical Trials not required by law to be covered
- Costs and services customarily paid for by government, biotechnical, pharmaceutical and medical device industry sources
- Costs related to Clinical Trials that do not meet the applicable requirements
- Costs to manage the clinical trial research
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services not otherwise covered under this plan

H. DENTAL SERVICES BENEFIT – MEDICAL

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

H.1 Dental Accident 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: **"Accidental dental injury"** is an injury to the structures of the teeth that is caused by an external force or element such as a blow or fall. An injury to a tooth while chewing is not considered an accidental dental injury, even if the injury is due to chewing on a foreign object.

A **"sound tooth"** is a tooth that is:

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

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

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

Benefit-Specific Exclusions:

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

H.2 Dental Services Required for Medical Procedures

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

Benefit Description: Benefits are available for 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)

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

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

- Children 5 years or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office
- Dental extractions due to cancer related conditions
- Diabetes
- Heart problems
- Hemophilia
- Malignant hypertension
- Mental retardation
- 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 state or federal law to be covered**

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

Your Cost-Share: You pay applicable deductible and coinsurance. Your cost-share is waived for one 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. You also pay the balance bill for services provided by noncontracted providers.

Benefit-Specific Maximums:

- Benefits are limited to one (1) breast pump and breast pump supplies per member, per calendar year. This limit does not apply to claims submitted with a primary behavioral health and/or substance abuse diagnosis.
- Benefits are limited to $350 per member, per calendar year for wigs. This limit does not apply to claims submitted with a primary behavioral health and/or substance abuse diagnosis.

I.1 Durable Medical Equipment (DME)

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

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

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

Benefit-Specific Exclusions:

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

I.2 Medical Supplies

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

- Any device or supply required by applicable law or as otherwise permitted under current Evidence-based Criteria
- Blood glucose monitors
- Blood glucose monitors for the legally blind and visually impaired
- Diabetic injection aids and drawing-up devices (including drawing-up devices for the visually impaired)
- Diabetic syringes and lancets, including automatic lancing devices
- Insulin cartridges, including insulin cartridges for the legally blind
- Insulin preparations and glucagon
- Insulin pumps and insulin pump supplies
- Ostomy and urinary catheter supplies
- Peak flow meters
- Prescribed oral agents for controlling blood sugar that are included on the plan

- Supplies associated with oxygen or respiratory equipment
- Test strips for glucose monitors and visual reading and urine test strips
- Volume nebulizers
- **Other medical supplies required by federal or state law to be covered**

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

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 substance abuse or a behavioral health condition
  - For individuals with any other condition for which coverage is required under federal or state law
- Orthopedic shoes that are:
  - Attached to a brace; and
  - Depth inlay or custom-molded, along with inserts, for individuals with diabetes; and
  - Covered in accordance with BCBSAZ medical necessity criteria.
- Podiatric appliances for prevention of complications associated with diabetes, including foot orthotic devices and inserts (therapeutic shoes: including depth shoes or custom-molded shoes, as defined below.) Custom-molded shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and any of the following complications of diabetes involving the foot: peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. Depth shoes and custom-molded shoes are defined as follows:
  - **"Depth Shoes"** shall mean the shoe has a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of 3 widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.
  - **"Custom-Molded Shoes"** shall mean constructed over a positive model of the member's foot; made from leather or other suitable material of equal quality; have removable inserts that can be altered or replaced as the member's condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.
- **Other prosthetic appliance and orthotics required by federal or state law to be covered**

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

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

- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, corsets, cushions, dentures, diatherapy machines, disposable hygienic items, dressing aids and devices, elastic/support/compression stockings, (except TED hose), elevators, exercise equipment, foot stools, garter belts, grab bars, health spas, hearing aid batteries, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, mineral baths, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas, and vehicle or home modifications.
- 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 or substance abuse diagnosis.

J. EDUCATION AND TRAINING

J.1 Diabetes and Asthma Education and Training

Your Cost-Share: Cost-share is 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:

- Provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Conducted in person; **and**
- 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.

J.2 Nutritional Counseling and Training

Your Cost-Share: Cost-share is 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 six (6) nutritional counseling and training visits per member, per calendar year

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

- Cardiovascular Disease
- Coronary Artery Disease
- Diabetes
- Eating Disorders
- Food Allergies
- Gastrointestinal Disorders
- Heart Failure
- High Cholesterol
- Hypertension
- Behavioral Health
- 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 one copay per member, per facility, per day. In-network deductible and coinsurance are waived for professional services provided while in the emergency room.

Admission to the Hospital from the Emergency Room: The emergency room copay 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 Copay.

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.

Used to calculate your cost share on the Qualifying Payment Amount as defined by federal law, for out-of-network provider emergency services, non-emergency services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services, 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. For all non-emergency services following the emergency treatment and stabilization, you pay applicable cost-share. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which may be substantial.

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

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

L. EOSINOPHILIC GASTROINTESTINAL DISORDER

<u>Your Cost-Share:</u> You pay applicable deductible, then 20 percent of the Cost for Formula.

<u>Benefit-Specific Definitions:</u> "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.

<u>Benefit Description:</u> Benefits are available for Formula for members who are:

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

M. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

<u>Your Cost-Share:</u>

***In-Network*:**

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

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

<u>Hormonal Contraceptive Methods:</u> Your cost-share is waived for patches, rings and contraceptive injections. See the "Physician Services" section for benefits.

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

<u>Barrier Contraceptive Methods</u>: Your cost-share is waived for diaphragms, cervical caps, cervical shields, female 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.

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

<u>Benefit-Specific Exclusion</u>: All prescription and over-the-counter contraceptive devices for male members.

N. HEARING AIDS AND SERVICES

<u>Your Cost-Share:</u>

Hearing Exams: 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.

Hearing Aids: You pay applicable deductible. Once your deductible has been met, the Plan pays 100 percent of the cost, up to a maximum of $750 per hearing device, per ear. 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.

<u>Benefit-Specific Maximum</u>: There is a maximum benefit of one (1) unit or pair of hearing devices per member, per every five (5) calendar years, including repair and replacement of existing hearing aids.

<u>Benefit Description</u>: Routine hearing exams, (except hearing screenings performed as part of a routine well exam) Hearing Aids, new or replacement Hearing Aids no longer under warranty, cleaning and repair of Hearing Aids, and dispensing fees for Hearing Aids. Benefits are available up to the Allowed Amount only for a prescribed hearing aid meeting specifications for your need. BCBSAZ determines the covered model.

<u>Benefit Specific Exclusions</u>:

- Assistive listening devices, including but not limited to, hearing aids that sync wirelessly with MP3 players, laptops, televisions and/or other wireless devices
- Disposable hearing aids
- Batteries or battery replacement for hearing aids

- Additional warranties for hearing aids
- Replacement of lost, stolen or damaged hearing aids when the member has already met the benefit maximum of one (1) unit or pair of hearing devices per member, per ear, per every five (5) calendar years
- Earmolds
- Direct audio input, Bluetooth capability or other additional features
- Return or exchange fees for hearing aids that are returned or exchanged
- Follow-up visits in addition to the original hearing exam

O. 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 Definition: **"Sole source of nutrition"** is defined as the inability to orally receive more than 30 percent of daily caloric needs.

Benefit-Specific Maximum: Benefits are limited to any combination of skilled nursing services necessary to provide home infusion medication administration, enteral nutrition and/or other services requiring skilled nursing care, up to a maximum of six (6) hours per member, per day. 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:

- Enteral nutrition (tube feeding) when it is the sole source of nutrition
- Home infusion medication administration therapy, including:
  - Blood and blood components
  - Hydration therapy
  - Intravenous catheter care
  - Intravenous, intramuscular or subcutaneous administration of medication
  - Specialty medications, as defined by BCBSAZ
  - Total parenteral nutrition
- Physical therapy, occupational therapy, and speech therapy
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition, and other services that require skilled nursing care.
- Other home health services required by federal or state law to be covered

Each service must meet all of the following criteria:

- A 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 services in excess of the 6 hour per member, per day maximum, except as stated in this section
- Custodial care
- Domiciliary care
- Private duty nursing
- Respite care

P. HOSPICE SERVICES

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.

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.

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

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 precertification, you will also need to obtain a new precertification for the different level of care.**

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

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

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

Q. INPATIENT AND OUTPATIENT DETOXIFICATION 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 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.

R. INPATIENT HOSPITAL

Your Cost-Share:

In-Network: You pay an access fee per admission, plus deductible and coinsurance, for all inpatient admissions, including for all bariatric surgeries. See your SBC for the amount of the applicable access fees. Your bariatric access fee applies toward professional charges for the 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.

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 Maximum: Benefits are limited to one (1) bariatric surgery per lifetime.

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 precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description:

- Adjustments to bariatric surgery provided while the member was covered under another plan
- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including radiology and laboratory services
- General, spinal and caudal anesthetic provided in connection with a covered service
- 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
- Biologicals and solutions
- Operating, recovery and treatment rooms and equipment for covered services
- Radiation therapy or chemotherapy, except in conjunction with a noncovered transplant
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Other inpatient services required by state or federal law to be covered

Benefit-Specific Exclusions:

- Bariatric surgery received from out-of-network providers
- Medications dispensed at the time of discharge from a hospital.

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

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

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

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 precertification, you will also need to obtain a new precertification for the different level of care.**

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

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

Benefit-Specific Exclusions:

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

T. LONG-TERM ACUTE CARE (INPATIENT)

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

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

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 precertification, you will also need to obtain a new precertification for the different level of care.**

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

Benefit-Specific Exclusions:

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

U. MATERNITY

Your Cost-Share:

Inpatient Services:

In-Network: You pay an access fee per admission, plus deductible and coinsurance.

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.

Outpatient Services: The Plan pays 100 percent of the provider's global charge. You pay applicable deductible and coinsurance for all other covered services. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided 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 will 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 defined as a fee charged by the delivering provider that may include certain prenatal, delivery and postnatal services.

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

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

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

This adopted child maternity benefit is secondary to any other coverage available to the birth mother. Contact Customer Services at the number on your ID card to receive a BCBSAZ adoption packet.

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

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

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

In addition, a plan or issuer may not, under federal law, require that a physician or other 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 precertification. For information on precertification, call the Customer Service number on your ID card.

V. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Your Cost-Share: You pay applicable deductible, then 20 percent 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 BCBSAZ.

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

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

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

Benefit-Specific Exclusions:

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

Claim submission for Medical Foods

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

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

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

Medical Foods also may be covered under the *"Home Health Services"* benefit.

W. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

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

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

Benefit-Specific Exclusion: Any treatment for developmental delay following an initial evaluation of a developmental delay, regardless of the cause of the delay. The only benefits available to cover treatment of the delay are Physical Therapy, Occupational Therapy, and Speech Therapy.

X. OUTPATIENT SERVICES

Your Cost-Share: You pay deductible and applicable 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. You pay an access fee for all bariatric surgeries, in addition to applicable deductible and coinsurance. 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.

Benefit-Specific Maximum: Benefits are limited to one (1) bariatric surgery per lifetime.

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

- Adjustments to bariatric surgery provided while the member was covered under another plan
- Allergy testing, antigen administration, and desensitization treatment
- Blood transfusions, whole blood, blood components, and blood derivatives
- Diagnostic testing, including laboratory and radiology services
- Dialysis
- End-stage renal disease services
- Epidural and facet injections and radio frequency ablation for pain management
- Infusion/IV therapy in an outpatient setting
- 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
- Administration of medications, in an outpatient setting
- Orthognathic treatment and surgery, including but not limited to dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)
- Outpatient and ambulatory cardiac testing, angiography, sleep testing (including sleep studies and polysomnography), and video EEG
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant
- Surgery and other invasive procedures
- Treatment of Temporomandibular Joint Disorders (TMJ)

Benefit-Specific Exclusion: Bariatric surgery provided by out-of-network providers

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

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

Benefit-Specific Maximum: Benefits are limited to sixty (60) in- and out-of-network combined pulmonary rehabilitation therapy, PT, OT, ST and CT visits per calendar year. Evaluations **do** count toward the visit limit.

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

Benefit-Specific Exclusions:

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

Z. PHYSICIAN SERVICES

Your Cost-Share:

In-Network:

PCMH Providers: You pay one copay, per member, per provider, per day for office, home and walk-in clinic visits. You pay in-network deductible and coinsurance for non-preventive physician services provided in locations other than an office, home or walk-in clinic.

All Other Providers: You pay in-network deductible and coinsurance.

If you receive preventive services during one of these visits, your cost-share may be waived, as described in the *"Preventive Services"* section of this 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" section for cost-share for emergency professional services.

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

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
- 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
- Inpatient medical visits
- Administration of medications in a physician's office
- Second diagnostic surgical opinions
- Services for FDA-approved patches, rings, and contraceptive injections; FDA-approved diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides; and FDA-approved emergency contraception
- Services for FDA-approved sterilization procedures
- Services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices
- Services for FDA-approved implanted contraceptive devices
- Sleep studies
- Surgical procedures (including assistance at surgery). Call customer service at the number on your ID card to verify that the surgical assistant chosen by your physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your physician are in-network providers.
- Treatment of TMJ

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

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

AA. POST-MASTECTOMY SERVICES

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

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

Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving the mastectomy-related benefits described above under "Benefit

Description," coverage will be provided in a manner determined in consultation between the attending physician and the member being treated. These benefits are subject to the same cost-share generally applicable to other medical and surgical benefits provided under this plan, as described in the "Member Cost-share" section of your SBC. If you would like more information on WHCRA benefits, call BCBSAZ Customer Service at the number listed on your ID card.

BB. PREGNANCY, TERMINATION

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

Benefit Description: Benefits are available for elective and non-elective abortions.

CC. 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; **and**
- The diagnosis codes, procedure codes, or combination of procedure and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive.

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

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

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

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

Benefits are also specifically available for the following services:

- Mammograms for routine breast cancer screening, including:
  - A single baseline mammogram for members ages 35-39; and
  - One mammogram per year for members age 40 and older
  - More frequent mammograms based on the physician's recommendation
- Prostate specific antigen (PSA) testing and digital rectal examination (DRE) for members age 40 and older, or for members under age 40 who are at high risk due to:
  - Family history (such as multiple first-degree relatives diagnosed at an early age);
  - African-American race; or
  - Previous borderline PSA levels
- Well-baby/child care up to 47 months; childhood immunizations

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

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

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

Benefit-Specific Exclusions:

- Abortifacient medications
- All prescription and over-the-counter contraceptive medications and devices for male members

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

DD. RECONSTRUCTIVE SURGERY AND SERVICES

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

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

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

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

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

EE. TELEHEALTH SERVICES

Your Cost-Share: You pay applicable copay.

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

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

Benefit-Specific Exclusions:

- Emergency services
- Preventive services
- Services not provided through the TSA

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

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

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

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

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

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

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

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

Benefit-Specific Exclusions:

- Expenses related to a noncovered transplant
- Expenses related to donation of an organ to a recipient who is not covered by BCBSAZ
- Transplants that do not meet current Evidence-based Criteria

GG. TRANSPLANT AND GENE THERAPY TRAVEL AND LODGING

Your Cost-Share: Waived.

Benefit-Specific Maximums: 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 per transplant maximum.

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

Benefit Description: Coverage is available for reimbursement of the transplant and gene therapy travel and lodging expenses as listed below during evaluation, transplant, post-transplant care, and complications directly related to the transplant when all the following criteria are met:

- BCBSAZ has precertified the transplant or, if BCBSAZ did not precertify the transplant, the transplant met the requirements of this Benefit Plan;
- The distance from the member's, donor's, or caregiver's residence must be more than 60 miles from the transplant facility
- The expenses are incurred by the member, donor, or the member's caregiver; and
- The expenses are for any of the following:
  - Meal expenses;
  - Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; bus; train or air fare; **and**
  - Room charges from hotels, motels and hostels or apartment rental.

Benefit-Specific Exclusions:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or Internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of the benefit-specific maximums stated above
- Ambulance transportation (ground or air)
- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with transplant services that do not qualify for coverage under this Benefit Plan
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Travel and lodging expenses for transplants other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service
- Travel and lodging expenses for members, donors, or Caregivers when the member, donor, or Caregiver does not travel more than sixty (60) miles for an authorized transplant or transplant-related services
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement:

To request reimbursement of eligible transplant travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to BCBSAZ. The address for claims submission is listed in the Customer Service section at the front of this book. To request a claim form, call the Customer Service number on your ID card.

HH. URGENT CARE

Your Cost-Share: You pay one urgent care copay per member, per provider, per day. If you receive services from a noncontracted provider, you also pay the balance bill.

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

Benefit Description: Benefits are available for urgent care services rendered by a free-standing urgent care provider contracted with the Plan Network. These providers are listed on the BCBSAZ website at www.azblue.com under "Urgent Care Centers."

Please be aware that the Plan Network includes some providers, such as hospitals, that offer urgent care services, but which are not specifically contracted with the Plan Network as urgent care providers. 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.

PPO MEDICAL BENEFITS

The Schedule

For You and Your Dependents

PPO Medical Benefits provide coverage for care In-Network and Out-of-Network. You and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

Coinsurance

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

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.

Deductible

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

Out-of-Pocket Expenses - For In-Network Charges Only

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Out-of-Pocket Expenses - For Out-of-Network Charges Only

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.
- Plan Deductible.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Any copayments and/or benefit deductibles.
- Provider charges in excess of the Allowed Amount.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will accumulate in one direction (that is, Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

Precertification Charges

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

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.
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.
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. The Qualifying Payment Amount, as defined by federal law, is the Allowed Amount for out-of-network provider emergency services, non-emergency services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services. 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 have no obligation to accept the allowed amount for other claim. You are responsible to pay a noncontracted provider's billed charges, even though the Fund will reimburse your claims based on the allowed amount. Any amounts paid for balance bills do not count toward deductible, coinsurance or the out-of-pocket maximum.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	80%	50% of the Allowed Amount
Calendar Year Deductible Individual Family Maximum Family Maximum Calculation **Individual Calculation:** 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. 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.	$250 per person $500 per family	$2,000 per person $4,000 per family

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket Maximum for Medical Expenses An out-of-pocket maximum is the amount each member must pay each year before the plan begins paying 100 percent of the allowed amount on covered services, for the remainder of the 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 precertification If you have family coverage, there is an out-of-pocket maximum for your family. Amounts applied to each member's out-of-pocket maximum also apply to the family out-of-pocket maximum. The family maximum is applied in the same way as the individual maximum described above and is subject to the same rules. When the family has met its family out-of-pocket maximum, it also satisfies the out-of-pocket maximum requirements for all the individual members.	$4,400 per person $10,000 per family	$10,000 per person Unlimited per family
Out-of-Pocket Maximum for Pharmacy	$1,000 per person $2,000 per family See Prescription Drug Benefit Schedule	$10,000 per person Unlimited per family See Prescription Drug Benefit Schedule
Physician's Services		
PCMH Provider Office Visits	$20 copay; deductible does not apply	
Other Providers:		
Primary Care Physician's Office Visit	80% after plan deductible	50% after plan deductible
Specialty Care Physician's Office Visits	80% after plan deductible	50% after plan deductible
Consultant and Referral Physician's Services **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.		
Surgery Performed in the Physician's Office	80% after plan deductible	50% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	80% after plan deductible	50% after plan deductible
Allergy Treatment/Injections	80% after plan deductible	50% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	80% after plan deductible	50% after plan deductible
Preventive Care **Note:** Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Routine Preventive Care - all ages	No charge	50% after plan deductible
Immunizations - all ages	No charge	50% after plan deductible
Mammograms, PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	No charge	50% after plan deductible
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service	Subject to the plan's x-ray & lab benefit; based on place of service

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital - Facility Services	$200 per admission copay, then 80% after plan deductible	50% after plan deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Standard Private Room if the hospital only has private rooms	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	80% after plan deductible	50% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	80% after plan deductible	50% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible	50% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible	50% after plan deductible
Emergency and Urgent Care Services		
Physician's Office Visit	80% after plan deductible	80% after plan deductible
Hospital Emergency Room	No charge after $300 per visit copay* and plan deductible *waived if admitted	No charge after $300 per visit copay* and plan deductible *waived if admitted
Outpatient Professional Services (radiology, pathology and ER Physician)	No charge after plan deductible	No charge after plan deductible
Urgent Care Facility or Outpatient Facility	No charge after $100 per visit copay* and plan deductible *waived if admitted	No charge after $100 per visit copay* and plan deductible *waived if admitted
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge after plan deductible	No charge after plan deductible
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge after plan deductible	No charge after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	No charge after plan deductible	No charge after plan deductible
Ambulance	80% after plan deductible	80% after plan deductible
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub- Acute Facilities Calendar Year Maximum: 60 days combined	80% after plan deductible	50% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	80% after plan deductible	50% after plan deductible
Outpatient Hospital Facility	80% after plan deductible	50% after plan deductible
Independent X-ray and/or Lab Facility	80% after plan deductible	50% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office Visit	80% after plan deductible	50% after plan deductible
Inpatient Facility	$200 per admission copay, then 80% after plan deductible	50% after plan deductible
Outpatient Facility	80% after plan deductible	50% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 60 days for all therapies combined Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	80% after plan deductible	50% after plan deductible
Outpatient Cardiac Rehabilitation Calendar Year Maximum: 36 days	80% after plan deductible	50% after plan deductible
Chiropractic Care Calendar Year Maximum: 20 days Physician's Office Visit	 80% after plan deductible	 50% after plan deductible
Home Health Care Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	80% after plan deductible	50% after plan deductible
Hospice Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	 80% after plan deductible 80% after plan deductible	 50% after plan deductible 50% after plan deductible
Bereavement Counseling Services provided as part of Hospice Care Inpatient Outpatient Services provided by Mental Health Professional	 80% after plan deductible 80% after plan deductible Covered under Mental Health Benefit	 50% after plan deductible 50% after plan deductible Covered under Mental Health Benefit
Maternity Care Services Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either as a PCP or Specialist depending on how the provider contracts with the Insurance Company. All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist Delivery - Facility (Inpatient Hospital, Birthing Center)	 80% after plan deductible 80% after plan deductible 80% after plan deductible $200 per admission copay, then 80% after plan deductible	 50% after plan deductible 50% after plan deductible 50% after plan deductible 50% after plan deductible
Abortion Includes elective and non-elective procedures Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	 80% after plan deductible $200 per admission copay, then 80% after plan deductible 80% after plan deductible 80% after plan deductible	 50% after plan deductible 50% after plan deductible 50% after plan deductible 50% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Women's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling **Note:** Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.	No charge	50% after plan deductible
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Physician's Office Visit	No charge	50% after plan deductible
Inpatient Facility	No charge	50% after plan deductible
Outpatient Facility	No charge	50% after plan deductible
Physician's Services	No charge	50% after plan deductible
Men's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	**PCMH Providers:** $20 copay; deductible does not apply. **Other Providers:** 80% after plan deductible	50% after plan deductible
Surgical Sterilization Procedures for Vasectomy (excludes reversals)		
Physician's Office Visit	80% after plan deductible	50% after plan deductible
Inpatient Facility	$200 per admission copay, then 80% after plan deductible	50% after plan deductible
Outpatient Facility	80% after plan deductible	50% after plan deductible
Physician's Services	80% after plan deductible	50% after plan deductible
Infertility Treatment Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered	Not Covered
Organ Transplants		
Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	80% after plan deductible	In-Network coverage only
Compatibility testing, organ removal and organ transport.	80% after plan deductible	In-Network coverage only
Inpatient Facility	80% after plan deductible	In-Network coverage only
Post-Transplant follow up	80% after plan deductible	In-Network coverage only
Travel Maximum: $10,000 per transplant; coverage is based upon distance from member residence to the facility. Includes coverage for one of non-member caregiver. **Note:** Coverage for a non-Member donor to a plan member recipient. There is no coverage for a plan member donor to a non-member recipient.	80% after plan deductible	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment Calendar Year Maximum: Unlimited	80% after plan deductible	50% after plan deductible
Breast Feeding Equipment and Supplies **Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	No charge	50% after plan deductible
External Prosthetic Appliances Calendar Year Maximum: Unlimited	80% after plan deductible	50% after plan deductible
Nutritional Evaluation Calendar Year Maximum: 6 visits per person		
Physician's Office Visit	80% after plan deductible	50% after plan deductible
Inpatient Facility	$200 per admission copay, then 80% after plan deductible	50% after plan deductible
Outpatient Facility	80% after plan deductible	50% after plan deductible
Physician's Services	80% after plan deductible	50% after plan deductible
Dental Accident Services Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office Visit	80% after plan deductible	50% after plan deductible
Inpatient Facility	$200 per admission copay, then 80% after plan deductible	50% after plan deductible
Outpatient Facility	80% after plan deductible	50% after plan deductible
Physician's Services	80% after plan deductible	50% after plan deductible
Bariatric Surgery **Note:** Subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.		
Physician's Office Visit	80% after plan deductible	In-Network coverage only
Inpatient Facility	$200 per admission copay, then 80% after plan deductible	In-Network coverage only
Outpatient Facility	80% after plan deductible	In-Network coverage only
Physician's Services	80% after plan deductible	In-Network coverage only
Lifetime Maximum: 1 surgery		
Acupuncture Calendar Year Maximum: 12 days	80% after plan deductible	50% after plan deductible
Hearing Aids **Note:** $750.00 limit per device - 1 time every 5 years	80% after plan deductible	In-Network coverage only
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Mental Health		
Inpatient	$200 per admission copay, then 80% after plan deductible	50% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	80% after plan deductible	50% after plan deductible
Outpatient Facility	80% after plan deductible	50% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Abuse		
Inpatient	$200 per admission copay, then 80% after plan deductible	50% after plan deductible
Outpatient (Includes Individual and Intensive Outpatient)		
Physician's Office Visit	80% after plan deductible	50% after plan deductible
Outpatient Facility	80% after plan deductible	50% after plan deductible

PRESCRIPTION DRUG BENEFITS

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, MedImpact will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, excluding Specialty Medications, at a retail Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at retail Pharmacy or a home delivery Participating Pharmacy, unless limited by the drug manufacturer’s packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to MedImpact to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for your, or your Dependent’s convenience, a Copayment will apply to each Prescription Drug.

In no event will the Copayment or Coinsurance for the Prescription Drug or Related Supply exceed the amount paid by the plan to the Pharmacy, or the Pharmacy’s Usual and Customary (U&C) charge. Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers regardless of the customer’s payment source.

Exclusions

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law unless state or federal law requires coverage of such drugs;
- any drug that is a pharmaceutical alternative to an over-the- counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in the standard reference compendia (AHFS or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- prescription vitamins (other than prenatal vitamins), dietary supplements unless state or federal law requires coverage of such drugs;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;
- any drugs that are experimental or investigational as described under the Medical “Exclusions” section of your certificate.

Other limitations are shown in the Medical “Exclusions” section of your certificate.

PRESCRIPTION DRUG BENEFITS

The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

Charges

The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.

Copayments

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY**	Non-PARTICIPATING PHARMACY
Lifetime Maximum	Unlimited	
Out-of-Pocket Maximum Individual Family	$1,000 per person $2,000 per family	$10,000 per person Unlimited per family
Retail Prescription Drugs	**The amount you pay for each 30-day supply**	**The amount you pay for each 30- day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1 Generic* drugs on the Prescription Drug List	The greater of 10% or $10, then the plan pays 100%	40%
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent. If a Brand-Name* drug designated as preferred has a Generic equivalent, you must try the Generic first.	The greater of 20% or $20, then the plan pays 100% If a brand name drug is dispensed in place of a generic when a generic drug is available, you will pay the brand cost-sharing plus the difference in cost between the generic and brand name drug.	40%
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	The greater of 50% or $50, then the plan pays 100% If a brand name drug is dispensed in place of a generic when a generic drug is available, you will pay the brand cost-sharing plus the difference in cost between the generic and brand name drug.	40%
*Designated as per generally-accepted industry sources and adopted by the Insurance Company		
**Specialty Medications are covered through home delivery only.		

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY**	Non-PARTICIPATING PHARMACY
Retail Prescription Drugs or Home Delivery Prescription Drugs	**The amount you pay for each 90-day supply**	**The amount you pay for each 90- day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1 Generic* drugs on the Prescription Drug List	No charge after $20 copay	In-network coverage only
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $40 copay If a brand name drug is dispensed in place of a generic when a generic drug is available, you will pay the brand cost-sharing plus the difference in cost between the generic and brand name drug.	In-network coverage only
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $90 copay If a brand name drug is dispensed in place of a generic when a generic drug is available, you will pay the brand cost-sharing plus the difference in cost between the generic and brand name drug.	In-network coverage only
*Designated as per generally-accepted industry sources and adopted by the Insurance Company		
**Specialty Medications are covered through home delivery only.		

EXCLUSIONS, EXPENSES NOT COVERED AND GENERAL LIMITATIONS

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

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

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

Autism Spectrum Disorders (ASD) – Services related to treatment of ASD

Bariatric Surgeries, excluded by current Evidence-based Criteria

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

Biofeedback

Blood Administration for the purpose of general improvement in physical condition

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

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

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

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

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

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

Computer Speech Training, Therapy Programs and Devices

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

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

Cosmetics and health and beauty aids

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

Court-Ordered Services – Court-ordered testing, treatment and therapy, unless such services are otherwise covered under this plan as determined by BCBSAZ 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, 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. This exclusion does not apply to arch supports when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg.

Foot Care – Services for foot care, including trimming of nails or treatment of corns or calluses. This exclusion does not apply when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg.

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

Genetic and Chromosomal Testing, Screening and Therapy – Genetic and chromosomal testing, screening and therapy for an individual who is asymptomatic, unaffected or not displaying signs or symptoms of a disorder for which the test, screening or therapy is performed, except as stated in this plan

Gender Transition Surgery

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

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

Habilitation Services

Hearing Aids and Associated Services, except as stated in this plan.

Hypnotherapy

Inpatient or Outpatient Long-Term Care

Laboratory Services Provided Without an Order From an Eligible Provider

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

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

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

Manipulation of the Spine Under Anesthesia

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

Massage Therapy – Massage therapy, except in limited circumstances as described in current Evidence-based Criteria

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

Medications – Medications which are:

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

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

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

Neurofeedback

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

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

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

Payments for exclusions imposed by any certification requirement

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

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

Phase 3 Cardiac Rehabilitation

Private Duty Nursing

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

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

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

Respite Care, except as covered in the Hospice Services benefit

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

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

Sensory Integration and Music Therapy

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

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

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

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

Services from Ineligible Providers

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

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

Services Prior to Member's Coverage Effective Date

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

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

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

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

Specialty Medications

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

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

Telemedicine Services

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

Therapy Services, except as stated in this plan

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

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

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

Vision – Routine vision exams, except for preventive vision screenings for members under age 5; vision therapy; eye exercises; all types of refractive keratoplasties including but not limited to radial keratotomy and/or lasik surgery; any other procedures, treatments and devices for refractive correction; eyeglass frames and lenses, contact lenses and other eyewear; vision examinations for fitting of eyeglasses and contact lenses, except as stated in this plan

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

Vocational Therapy – Services related to reinforcing or re-establishing previously learned thought processes, compensatory training, sensory integrative activities and services related to employability

Wigs and hairpieces, except as stated in this plan

Workers' Compensation – Services to treat illnesses and injuries which are (1) covered by Workers' Compensation; and (2) expressly identified as workers' compensation claims when submitted to BCBSAZ. This exclusion does not apply if the member has made a statutory opt-out election and/or is exempt from Workers' Compensation coverage.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Allowed Amounts.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your or your Dependent's family.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.

PAYMENT OF BENEFITS

To Whom Payable

Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; any such assignment shall be null and void; however, any Eligible Employee may direct that benefits due him/her be paid to an institution in which he/she or his/her Dependent is hospitalized, or to any provider of medical, dental or vision care services or supplies in consideration for Hospital, medical, dental or vision care services rendered or to be rendered.

Notwithstanding the foregoing, the Fund will honor any "qualified medical child support order" as defined by ERISA Section 609, received with respect to the Fund, and will make any payment required by ERISA Section 609 to a State which has acquired rights under that Section.

BCBSAZ may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of BCBSAZ is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, BCBSAZ may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, BCBSAZ may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Calculation of Covered Expenses

BCBSAZ, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology,
- the methodologies as reported by generally recognized professionals or publications.

Rescissions

Your coverage may not be rescinded (retroactively terminated) by BCBSAZ or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Providers

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

Provider Directory

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

Provider Eligibility and Network Status

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

Eligible Providers

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

Benefits may also be available from other healthcare professionals whose services are mandated by Arizona state law or federal law or who are accepted as eligible by BCBSAZ. The following are examples of ineligible providers: doctors of naturopathy and homeopathy. Other provider types may also be ineligible. The fact that a service is rendered by an eligible provider does not mean that the service will be covered. Not all eligible providers are contracted to participate in BCBSAZ networks.

DEFINITIONS FOR MEDICAL BENEFITS

Allowed Amount

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

Type of Provider	Type of Claim	Basis for Allowed Amount
Providers contracted with BCBSAZ as Plan Network providers	Emergency and non-emergency	Lesser of the provider's billed charges or the applicable fee schedule, with adjustments for any negotiated contractual arrangements and certain claim editing procedures and pricing guidelines
Providers contracted with a vendor	Emergency and non-emergency	Generally, the lesser of the provider's billed charges or the vendor's fee schedule, with adjustments for any negotiated contractual arrangements
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue")	Emergency and non-emergency	Lesser of the provider's billed charges or the price the Host Blue plan has negotiated with the provider
Noncontracted providers in Arizona, including Providers contracted with another BCBSAZ network but not as a Plan Network Provider for this Benefit Plan	Non-emergency claims and emergency ground ambulance claims	Lesser of the provider's billed charges or the applicable BCBSAZ fee schedule, with adjustments for certain claim editing procedures and pricing guidelines. For emergency ground ambulance claims, the allowed amount is based upon the ambulance provider's billed charges.
Noncontracted providers outside Arizona	Non-emergency claims and emergency ground ambulance claims	We compare the provider's Billed Charges to the amount the Host Blue normally pays for a local nonparticipating Provider. The Allowed Amount will be the lower of these two amounts. If the Host Blue has not set an amount it normally pays for a nonparticipating Provider, we may then base the Allowed Amount on the applicable Fee Schedule. For emergency ground ambulance claims, 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 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 (in Arizona and out-of-state)	Emergency	The Qualifying Payment Amount, as defined by federal law, is the allowed amount.
Noncontracted air ambulance providers	Emergency and non-emergency	The Qualifying Payment Amount, as defined by federal law, is the allowed amount.

Bariatric Surgery

The term Bariatric Surgery means a surgical procedure to promote weight loss for the treatment of morbid obesity. Bariatric surgery also includes any revisions to a bariatric surgical procedure.

BCBSAZ

The term BCBSAZ means Blue Cross Blue Shield of Arizona, when acting as the administrator of a group benefit plan.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Benefit Plan

The term Benefit Plan means the document describing the benefits. **Billed Charges**

The term 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 Cross® Blue Shield® of Arizona

Blue Cross Blue Shield of Arizona is an independent licensee of the Blue Cross and Blue Shield Association. BCBSAZ is a not-for-profit corporation organized under the laws of the state of Arizona as a hospital, medical, dental, and optometric services corporation and is authorized to operate a health care services organization as a line of business.

Blue Distinction®

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

Chiropractic Benefits Administrator

The term Chiropractic Benefits Administrator means the independent company that administers chiropractic benefits for BCBSAZ. The Chiropractic Benefits Administrator develops and manages the BCBSAZ network of chiropractic providers, processes chiropractic claims, determines medical necessity and handles utilization management, grievances and appeals related to chiropractic services.

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Contract Holder

The term 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

The term 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 state or federal 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

The term Cost-Share means the member's financial obligation for a covered service. Depending on the plan type, cost-share may include one or more of the following: deductible, copay, access fee, coinsurance, and precertification charges.

Custodial Care

The term Custodial Care means health services and other related services that meet any one or more of the following criteria:

1. Are for comfort or convenience;
2. Do not seek to cure;
3. Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition or other self-care; **or**
4. Are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as a licensed practical nurse (LPN), registered nurse (RN), or licensed therapist.

Diagnosis Related Grouping or DRG

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

Domiciliary Care

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

Emergency Medical Condition

A medical condition, including mental health or substance use disorder conditions, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine could

reasonably believe he or she is in need of immediate medical care and could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part, or place the health of a woman or her unborn child in serious jeopardy.

Emergency Services

Emergency services means:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition exists; and
2. Such further medical examination and treatment as are required to stabilize the individual (regardless of the department of the hospital in which such further examination or treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable.

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Evidence-Based Criteria

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

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

FDA

The term FDA means the federal Food and Drug Administration.

Fee Schedules

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

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

1. it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
2. it maintains at least two operating rooms and one recovery room;
3. it maintains diagnostic laboratory and x-ray facilities;
4. it has equipment for emergency care;
5. it has a blood supply;
6. it maintains medical records;
7. it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
8. it is licensed in accordance with the laws of the appropriate legally authorized agency.

Hospice Care Program

The term Hospice Care Program means:

1. a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
2. a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
3. a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:
1. primarily provides care for Terminally Ill patients;
2. is accredited by the National Hospice Organization;
3. meets standards established by BCBSAZ; and
4. fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:
1. an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
2. an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
3. an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:
1. a registered bed patient in a Hospital upon the recommendation of a Physician;
2. receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
3. receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

Injury

The term Injury means an accidental bodily injury.

Maintenance Treatment

The term Maintenance Treatment means treatment rendered to keep or maintain the patient's current status.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary

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

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

Medical Necessity Guidelines and Criteria

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

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

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

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Other Health Care Facility/Other Health Professional

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

Participating Pharmacy

The term Participating Pharmacy means a retail Pharmacy with which MedImpact has contracted to provide prescription services to insureds, or a designated home delivery Pharmacy with which MedImpact has contracted to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with BCBSAZ to provide covered services with regard to a particular plan under which the participant is covered.

Participation Date

The term Participation Date means the later of:
1. the Effective Date of the policy; or
2. the date on which your Fund becomes a participant in the plan of insurance authorized by the agreement of Trust.

Patient Protection and Affordable Care Act of 2010 ("PPACA")

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Pharmacy

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

Pharmacy & Therapeutics (P & T) Committee

A committee of MedImpact Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician

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

Plan Network

The term 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

Precertification

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

Prescription Drug

Prescription Drug means; a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

Primary Care Provider (PCP)

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

Provider

The term 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.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

Rehabilitation Services

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

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

Respite Care

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.

Review Organization

The term Review Organization refers to an affiliate of BCBSAZ or another entity to which BCBSAZ has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

Service

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

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

1. physical rehabilitation on an inpatient basis; or
2. skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

Specialist

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

Specialty Medication

The term Specialty Medication means high cost medications which are used to treat rare and chronic conditions which include, but are not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis.

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Summary of Benefits and Coverage (SBC)

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

Telehealth Services Administrator (TSA)

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

Telehealth Services

The term Telemedicine Services means Services delivered through interactive audio-video electronic media to treat certain covered conditions.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by BCBSAZ, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

CLAIM AND APPEAL PROCEDURES

The following complies with federal law.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The booklet describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the booklet, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the booklet, in your provider's network participation documents, and in the determination notices.

Filing Claims

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

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

Time Limit for Claim Filing

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

- Medicare or another carrier was the primary payer on a claim where BCBSAZ was secondary payer, and the delay was caused by the need to coordinate benefits with the primary payer.
- The member can show good cause for delay. BCBSAZ determines good cause in its sole discretion. Examples of good cause:
  - BCBSAZ gave the member wrong information about the filing date;
  - The member had an extended illness that prevented the member from filing the claim; or
  - Other similar situations outside the member's reasonable control.

Complete Claims

Claim forms are available from BCBSAZ. Go to the "Forms" section of the "Member" area of www.azblue.com or call the Customer Service number on your ID card. BCBSAZ may reject claims that are filed without complete information needed for processing. If BCBSAZ rejects a submitted claim due to lack of information, BCBSAZ will notify you or the provider who submitted the claim. Lack of complete information may also delay processing. A complete claim includes, at a minimum, the following information:

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

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

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

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

After your claim is processed, BCBSAZ and/or any contracted vendors that process claims will send you an EOB. Most EOBs are consolidated and sent to you in a monthly Member Health statement rather than as single EOBs. Your BCBSAZ EOBs also will be available through the member portal on www.azblue.com. An EOB shows services billed, whether the services are covered or not covered, the allowed amount and the application of cost-sharing amounts. Carefully review your EOB for any discrepancies or inconsistencies with the amounts your provider actually collects from you or bills to you. If you paid more cost share than required for a covered service, BCBSAZ may refund that amount to a network provider, and the provider will be responsible for refunding you. Your EOB will show any refunds for cost-share overpayments. BCBSAZ and/or any contracted vendors will also send your in-network provider the information that appears on your EOB. This information is not sent to out-of-network providers. Out-of-network providers do not receive any written information on how much was paid on a claim or the reasons for how the claim processed. Save the EOB for your personal records. BCBSAZ or any contracted vendor may charge a fee for duplication of claims records.

Notice of Determination

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

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

Preservice Determinations

When you or your representative requests a required prior authorization, BCBSAZ will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond BCBSAZ's control, BCBSAZ will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to BCBSAZ within 45 days after receiving the notice. The determination period will be suspended on the date BCBSAZ sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, BCBSAZ will make the preservice determination on an expedited basis. BCBSAZ's Physician will defer to the determination of the treating Physician, regarding whether an expedited determination is necessary. BCBSAZ will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, BCBSAZ will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to BCBSAZ within 48 hours after receiving the notice. BCBSAZ will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow BCBSAZ's procedures for requesting a required preservice determination, BCBSAZ will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent coverage determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, BCBSAZ will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Determinations

When you or your representative requests a coverage determination after services have been rendered, BCBSAZ will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond BCBSAZ's control BCBSAZ will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to BCBSAZ within 45 days after receiving the notice. The determination period will be suspended on the date BCBSAZ sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Medical - When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf; unless otherwise noted.

"Physician Reviewers" are licensed Physicians depending on the care, service or treatment under review.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeals Procedure

BCBSAZ has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to BCBSAZ or the appropriate claims administrator within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask BCBSAZ to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Appropriate Claims Administrator For Appeals Chart	
Medical	**BCBSAZ** (602) 864-4400 (Local) (800) 232-2345 (Long Distance) Blue Cross Blue Shield of Arizona P.O. Box 13466 Phoenix, AZ 85002-3466
Dental	**Delta Dental Plan of Arizona (DDPAZ)** (602) 938-3131 or (800) 352-6132 P. O. Box 43000 Phoenix, AZ 85080-3000

Appropriate Claims Administrator For Appeals Chart	
Vision	**Vision Service Plan** (800) 877-7195 P.O. Box 385018 Birmingham, AL 35238
Prescription	**MedImpact** (833) 229-3589 10181 Scripps Gateway Court San Diego, CA 92131

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

BCBSAZ's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, BCBSAZ will respond orally with a decision within 72 hours, followed up in writing.

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal for required preservice and concurrent care coverage determinations, follow the same process required for a level-one appeal. For post service claims, send this appeal to Zenith American Solutions who will administer the level-two process for such claims. To be considered timely, your level-two appeal of a post service claim must be submitted within 60 days of notice of denial at level-one.

Zenith American Solutions
Attn: Kathy Wade, Client Service Executive
2001 W. Camelback Road, Suite B350
Phoenix, Arizona 85015-7404
P 602.200.2483 1.800.553.2801 Ext. 432483
Fax 602.248.8301.

For post service claims, the Board of Trustees or their designee (hereafter, "Committee") will make a second level appeal determination according to the following timeframes:

- If an appeal is filed with the Plan more than 30 days before the next Board meeting, the review will occur at the next Board meeting date.
- If an appeal is filed with the Plan within 30 days of the next Board meeting, the review will occur no later than the second meeting following receipt of the appeal.
- If special circumstances (such as the need to hold a hearing) require a further extension of time the review will occur at the third meeting following receipt of the appeal. If such an extension is necessary the Committee will provide to you a Notice of Extension describing the special circumstances and the date the benefit determination will be made.
- After the Committee makes a decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

In the event any new or additional information (evidence) is considered, relied upon or generated by the Committee in connection with the level-two appeal, the Committee will provide this information to you as soon as possible and sufficiently in advance of the Committee's decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Committee, the Committee will provide the rationale to you as soon as possible and sufficiently in advance of the Committee's decision so that you will have an opportunity to respond.

You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the level two appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. BCBSAZ's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, the decision-maker will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of the level- two appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by BCBSAZ HealthCare, or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. BCBSAZ will abide by the decision of the Independent Review Organization.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of the level-two appeal review denial. BCBSAZ or the Committee will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by BCBSAZ's Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitle to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against BCBSAZ or the Plan until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action. However, no action may be brought at all unless brought within three years after exhaustion of the Plan's Appeals Procedure.

COORDINATION OF BENEFITS

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

If you are eligible for benefits under another group health plan, and the other group plan is the primary payer, then the combined benefit payments from all coverages will not exceed the greater of the primary payer's or BCBSAZ's allowed amount.

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

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

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

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

Non-Duplication of Benefits

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

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

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan.

- If you are eligible for benefits under another group health plan, and the other group plan is the primary payer, then the combined benefit payments from all coverages will not exceed the greater of the primary payer's or BCBSAZ's allowed amount.
- If your other group health insurance does not include a coordination of benefits provision, the other group coverage pays first. If your other group health insurance provides for coordination of benefits, the following rules will be used to determine which coverage will pay first:
- If the person who received care is covered as an active employee under one benefit plan and as a dependent under another, the employee coverage pays first.
- If the person who receives care is covered as an active employee under one benefit plan and as an inactive employee under another, the coverage through active employment pays first.
- If the person who receives care is a dependent child, then the plan benefits of the parent whose birthday occurred earlier in a calendar year shall cover the child first.
- If both parents have the same birthday, the benefits of the plan that covered a parent longer shall cover a dependent child first.
- If one of the plans determines the order of benefits based upon the gender of a parent and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rule shall determine the order of benefits.
- If the dependent child's parents are legally separated or divorced, the following applies:
  - If a court decree specifies the parent who is financially responsible for the child's healthcare expenses, the specified parent's coverage pays first.
  - If there is no applicable court decree, the custodial parent's coverage pays first. If the custodial parent has remarried, the stepparent's coverage pays second. The non-custodial parent's coverage pays last.
  - If the parents have joint custody, the plan benefits of the parent whose birthday occurred earlier in a calendar year pays first.

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

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

Right to Receive and Release Information

BCBSAZ, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

BCBSAZ will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

1. a former Member who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
2. a former Member's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
3. a Member whose Fund and each other Fund participating in the Fund's plan have fewer than 100 Members and that Member is eligible for Medicare due to disability;
4. the Dependent of a Member whose Fund and each other Fund participating in the Fund's plan have fewer than 100 Members and that Dependent is eligible for Medicare due to disability;
5. a Member or a Dependent of a Member of a Fund who has fewer than 20 Members, if that person is eligible for Medicare due to age;
6. a Member, retired Member, Member's Dependent or retired Member's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

BCBSAZ will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Member and his Dependent or any former Member and his Dependent unless he is listed under (a) through (f) above.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

In addition to the Behavioral Health Benefits, the Plan offers all eligible Active Employees and their Dependents up to 6 free visits per issue to an EAP counselor.

- The EAP counselors provide confidential information, counseling, assessment and referral services when a person is experiencing a personal, family or work problem.
- Typical concerns called into the EAP counselor include relationship problems, marital problems, anxiety, depression, substance abuse, grief and loss, parent/child problems, domestic violence, work/family balance challenges, work performance problems or coworker conflicts.

A brochure describing the EAP benefits and identifying the provider will be made available to eligible Active Employees. The contact information for the EAP is set forth in the Quick Reference Chart at the front of this booklet.

DENTAL PPO PLAN BENEFITS

For You and Your Dependents

Dental PPO Plan benefits are designed to constitute and to be administered as "excepted benefits," as defined by federal law. In accordance with Health Reform regulations, you have the option to decline the Plan's dental coverage.

Benefits

If you are an Active Employee or a Retired Employee, dental benefits are provided by a fully insured contact issued by Delta Dental. For details on dental benefits, refer to your certificate or contact Delta Dental (see the Reference Chart on page three of this booklet for contact information).

The dental benefits are provided through Delta Dental Plan of Arizona (DDPAZ), a network of dental providers that offer discounts off the fees they charge for their services. Questions regarding the dental program may be presented to DDPAZ at the telephone number in its brochure, which will be provided to Active Employees and Retired Employees.

For purposes of determining payable amounts under this Plan refer to the definition of Allowable Amount set forth below.

Covered Dental Expenses

Covered Dental Expenses include Allowable Amounts for necessary dental care and treatment of any disease, defect or accidental Injury, or for preventive dental care as prescribed by a Dentist or Physician, as noted below:

A. **Routine Services**
   1. *Diagnostic:* The necessary procedures to assist the Dentist in evaluating the existing conditions to determine the required dental treatment.
   2. *Preventive:* The necessary procedures to prevent the occurrence of oral disease.

B. **Basic Services**
   1. *Oral Surgery:* The necessary procedures for extractions and other oral surgery including pre- and post-operative care and general anesthesia.
   2. *Fillings*: Silver amalgam and for front teeth only, synthetic tooth color fillings. One per surface every two years.
   3. *Stainless Steel Crowns*: For primary (baby) teeth only.
   4. *Endodontics:* The necessary procedures for pulpal therapy and root canal filling on infected teeth.
   5. *Periodontics:* The necessary procedures for treatment of the tissues supporting the teeth. – Non-surgical once every two years. Surgical once every three years.
   6. *Sealants:* Topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay. For children up to age 19 – Once in a 3-year period for permanent molars and bicuspids.
   7. *Emergency Services:* Benefits will be provided for emergency palliative care.

C. **Major Services**
   1. *Prosthodontics:* The necessary procedures for construction of bridges, partial and complete dentures. 5 Year waiting period for replacement last performed.
   2. *Restorative Crowns &Onlays:* The necessary procedures for provision of crowns (except preformed stainless steel crowns which are covered under Basic Services above) when teeth cannot be restored with amalgam, composite resin or plastic materials for treatment of decay or fractures.
   3. *Implant*- Implants are only a benefit to replace a single missing tooth bounded by teeth on each side.
   4. *Bridge and Denture Repair*: Repair of such appliances to their original condition, including relining of dentures.

Exclusions

DDPAZ excludes those services that may be classified as:

A. Services for injuries or conditions which can be compensated under workers' compensation or employers' liability laws; services which are provided the Eligible Individual by any federal or state government agency or are provided without cost to the Eligible Individual by a municipality, county or other political subdivision or community agency.
B. Services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and anodontia.
C. Benefits are not provided for prosthodontic appliances or devices (including crown and bridge) or any single procedure started prior to the date the Eligible Individual became eligible for such services under this contract.
D. General anesthesia, except when administered for a covered oral surgery procedure performed by a Dentist and when Medically Necessary.
E. Prescription drugs.
F. Orthodontic services.
G. Treatment for the disturbances of the temporomandibular joint.
H. Hypnosis.
I. All other services not specified as covered dental services.
J. Dietary instruction.
K. Charges for Hospital services.
L. Myofunctional therapy.

Extended Dental Benefits

Expenses for root canals, crowns, fixed bridges, partial and dentures will be covered after loss of eligibility for up to 60 days, provided the service was actually started before loss of eligibility. "Started" means that, with a root canal, the tooth was opened; with a crown or bridgework, that the teeth were prepared and impressions were taken; and with partials and dentures, that final impressions were taken. In addition, services that have been pre-approved by DDPAZ as part of its predetermination mechanism at a time at which the individual was eligible will be covered for the period indicated on the Predetermination Voucher forwarded by DDPAZ to the Dentist. Other services provided after loss of eligibility will not be covered.

Coordination of Benefits

Dental expense benefits are subject to the Coordination of Benefits provisions as described in the section of this Booklet describing Medical Benefits.

Dental Definitions

The following are definitions of terms used in this Article:

A. "Allowable Amount" means the Allowed Charge amount considered less any applicable deductibles provided for by the Plan.

B. "Dentist" is a person holding a valid license to practice dentistry in Arizona or, in the event of services received in another state, in that state. In no event shall any person not licensed to practice in the United States or its territories or possessions be considered a Dentist for purposes of this coverage.

C. "Non-Participating Dentist" is a Dentist, as defined, who has not entered into an agreement with DDPAZ to provide dental services to its subscribers in accordance with its rules and regulations.

D. "Participating Dentist" is a Dentist, as defined, who has entered into an agreement with DDPAZ to provide dental service to its subscribers in accordance with its rules and regulations and fee allowances. Any expenses in excess of the DDPAZ fee allowances will not be considered as covered expenses and the Eligible Individual will not be responsible for the excess amounts.

How to File A Claim for Dental Benefits—Appeal Procedures

A brochure prepared by the Dental PPO Network will be provided to you, detailing how to access the Plan's Dental Benefits. Contact information for the Network is on the Quick Reference Chart at the front of this Booklet.

DENTAL BENEFITS

The Schedule

For You and Your Dependents

This plan provides Dental benefits as shown in this Schedule. To receive Dental Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of Charges for covered Dental Services that you or your Dependent are required to pay under this plan.

Charges

The term Charges means the amount charged by the Dental Provider to the plan.

Copayments

Copayments are expenses to be paid by you or your Dependent for Dental Services.

BENEFIT HIGHLIGHTS	IN-NETWORK	NON-NETWORK
Annual Dental Maximum Benefit	$1,000 per person per calendar year	
Deductible	$100 per person per calendar year $300 per family per calendar year	
Routine Diagnostic and Preventative Services Includes exams, routine cleanings, fluoride (for children to age 18), x-rays, and space maintainers.	100% of discounted fees	100% of the Allowed Charge
Basic Services Includes oral surgery, fillings, endodontics (root canal), periodontics (treatment of gum disease), stainless steel crowns, emergency treatment, and sealants (for children up to age 19)	80% of discounted fees	80% of the Allowed Charge
Major Services Includes prosthodontics (bridges, dentures, partial dentures), implants and crowns and onlays	60% of discounted fees	60% of the Allowed Charge

VISION PPO PLAN BENEFITS

For You and Your Dependents

Vision benefits are designed to constitute and to be administered as "excepted benefits," as defined by federal law. In accordance with Health Reform regulations, you have the option to decline the Plan's vision coverage.

Benefits

This Vision PPO Plan is designed to provide standard vision examinations and eyewear materials such as eyeglasses or contact lenses. Regular vision exams can help detect individuals who have chronic diseases that can affect the eye, such as diabetes, high blood pressure (hypertension), glaucoma, and cataracts.

Vision PPO Plan Benefits are administered by an independent Vision PPO Plan Claims Administrator whose name and address are listed in the Quick Reference Chart in the front of this document.

Eligibility for Vision PPO Plan Benefits

All Active Employees, Retired Employees, and eligible Dependents are eligible to participate in the Vision PPO Plan. Vision PPO Plan Benefits are effective on the date your medical Plan Benefits are effective unless you decline Vision PPO Plan Benefits.

Vision PPO Network

The Vision PPO Plan contract with an independent network of vision providers who extend a discount to you for covered vision services. Covered vision expenses are noted in the Schedule of Vision PPO Plan Benefits in this chapter and refer to payment for covered services up to the Allowed Charge for in-network providers or non-network providers.

PPO Providers: Network Providers (licensed ophthalmologist, optometrist, or dispensing optician) have a contract to provide discounted fees to you for services covered under this Vision PPO Plan. By using the services of an In-Network Vision PPO Provider, both you and the Plan pay less.

A current list of PPO network vision providers is available free of charge when you call the Vision PPO Plan Claims Administrator whose name, address and telephone number are listed on the Quick Reference Chart in the front of this document. **To receive services, simply call a PPO network vision provider and identify yourself as a member of this Vision PPO Plan.** <u>You must identify yourself as a member of this Vision PPO Plan at the time that you make the appointment with the In-Network PPO provider or you may not receive the In-Network discounted rates.</u>

Non-Network (Non-PPO) Providers: Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician; however, when non-network providers are used, this Plan will pay at the Non-Network benefit level as noted in the Schedule of Vision PPO Plan Benefits. The itemized paid bill reflecting the Non-Network provider's fees can be submitted to the Vision PPO Plan Claims Administrator for consideration for reimbursement. If the service is a covered benefit, you will be reimbursed according to the lesser of billed charges or the Plan's Allowed Charge (outlined in the Schedule of Vision PPO Plan Benefits).

Non-Network Providers may bill a Plan Participant for any balance that may be due in addition to the Allowed Amount payable by the Plan, also called balance billing.

Balance billing occurs when a healthcare provider bills a patient for charges (other than Copayments, Coinsurance, or Deductibles) that exceed the plan's payment for a covered service. **<u>You can avoid balance billing by using In-Network providers</u>.**

Definition of Terms Related to Vision PPO Plan

A **vision exam** includes a professional eye examination (vision analysis) and an eye refraction to determine the prescription for corrective eyewear where indicated (refraction billed without an exam is not covered). The exam typically includes:

1. an assessment of your health history that is relevant to your vision,
2. external exam of the eyes for pathological abnormalities of the eyes including but not limited to the pupil, lens, eyelashes and eyelids,
3. internal exam including but not limited to an assessment of the lens and retina along with tonometry (measurement of the fluid pressure in the eye to help detect signs of glaucoma), visual field testing (checking peripheral visual capabilities), biomicroscopy (retina examination) and inspection of the retina with an ophthalmoscope, visual acuity (the ability to see clearly at all distances) and refraction (testing the eyes ability to focus light rays on the retina from a distance and close-up).

A **contact lens exam** includes the comprehensive exam covered under the exam benefit along with the assessment of the optical and physical characteristics of the eye and the surface of the eye such as power, size, curvature, flexibility, gas-permeability, moisture/tear content, along with prescription of contact lens, fitting, evaluation, modification and dispensing of the contacts. Contact lens services may be provided by a doctor or optician. Contact lens exams are designed to ensure the proper fit of contacts and to evaluate vision with the contacts. Although the vision may be clear and a person may feel no discomfort from their lenses, there are potential risks with improper wearing or fitting of contact lenses that can affect the overall health of the eyes. The regular "vision exam" does not include a contact lens exam. A contact lens exam is in addition to a regular eye exam.

Optician means a person qualified to manufacture and dispense eyeglasses and/or contact lenses.

Optometrist means a person licensed to practice optometry. Optometrists examine the internal and external structure of the eyes to diagnose eye diseases like glaucoma, cataracts and retinal disorders; systemic diseases like hypertension and diabetes; and vision conditions like nearsightedness, farsightedness, astigmatism and presbyopia.

<table>
<tr><th colspan="4">SCHEDULE OF VISION PPO PLAN BENEFITS

YOUR SCHEDULE WITH A VSP PROVIDER</th></tr>
<tr><td>WELLVISION EXAM</td><td>Focuses on your eyes and overall wellness</td><td>$10</td><td>Every calendar year</td></tr>
<tr><td>ESSENTIAL MEDICAL EYE CARE</td><td>• Retinal screening for members with diabetes

• Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.

Coordination with your medical coverage may apply. Ask your VSP doctor for details.</td><td>$0 per screening

$20 per exam</td><td>Available as needed</td></tr>
<tr><td colspan="2">PRESCRIPTION GLASSES</td><td colspan="2">$10</td></tr>
<tr><td>FRAME</td><td>• $195 featured frame brands allowance
• $175 frame allowance
• 20% savings on the amount over your allowance
• $95 Costco® frame allowance</td><td>Included in Prescription Glasses</td><td>Every calendar year</td></tr>
<tr><td>LENSES</td><td>Single vision, lined bifocal, and lined trifocal lenses</td><td>Included in Prescription Glasses</td><td>Every calendar year</td></tr>
<tr><td>LENS ENHANCEMENTS</td><td>• Standard progressive lenses
• Premium & Custom progressive lenses Impact-resistant lenses
• Scratch-resistant coating
• Average savings of 30% on other lens enhancements</td><td>$0
$40

$0
$0</td><td>Every calendar year</td></tr>
<tr><td>CONTACTS (INSTEAD OF GLASSES)</td><td>$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)</td><td>Up to $60</td><td>Every calendar year</td></tr>
<tr><td>LIGHTCARE</td><td>$175 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts</td><td>$25</td><td>Every calendar year</td></tr>
<tr><td rowspan="3">EXTRA SAVINGS</td><td colspan="3">Glasses and Sunglasses
• Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details.
• 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</td></tr>
<tr><td colspan="3">Routine Retinal Screening
No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam</td></tr>
<tr><td colspan="3">Laser Vision Correction
Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</td></tr>
</table>

<table>
<tr><th colspan="3">Out-of-Network Coverage Reimbursement</th></tr>
<tr><td>Exam ………………………...up to $45
Frame………………………...up to $70
Single Vision Lenses………...up to $30</td><td>Lined Bifocal Lenses…………..up to $50
Lined Trifocal Lenses…………up to $65</td><td>Progressive Lenses……..….up to $50
Contacts…………………….up to $105</td></tr>
</table>

WEEKLY DISABILITY INCOME BENEFITS
(Not Available To Retired Employees)

For Eligible Active Employees, these benefits are not offered to Retired Employees.

Benefits

If while an Active Employee you become Totally Disabled as a result of a non-occupational bodily Injury or Illness while covered hereunder, and as a result of the Injury or Illness you are prevented from performing your regular or customary occupation, the Fund will, subject to the provisions hereinafter set forth, pay to you up to $150 per week. If an Active Employee is Totally Disabled due to pregnancy, then, subject to the provisions set forth herein, you may be eligible for up to $600 a week for the first 6 weeks from the date of delivery if the Active Employee undergoes a vaginal delivery and for the first 8 weeks from the date of delivery if the Active Employee undergoes a Cesarean delivery. If any period for which benefits are payable is less than a full week, payments will be made at the rate of 1/7 of the weekly benefit for each day in such period. Applicable Federal taxes will be deducted from this amount and reported to the Internal Revenue Service on your behalf. No benefits are payable in any month in which you receive retirement benefits from the companion I.B.E.W. Local No. 640 and Arizona Chapter N.E.C.A. Pension Trust Fund.

Payment of Benefits

Payments begin with the fifteenth day of disability due to Illness; however, as to accidental Injuries, the benefit will be payable retroactively to the first day of disability. Benefits due to disability from pregnancy will be payable from the date of delivery. Payments will continue for the period of disability up to a maximum of 13 weeks for each disability.

Period of Disability

Successive periods of disability will be considered as one period of disability unless acceptable evidence is furnished that:

A. The causes of the latest disability absence cannot be connected with the causes of any of the prior disability absences and the latest disability absence occurs after you return to work on a fulltime basis.

B. A connection with prior disability absences can be established, but between the last of the previous disability absences which are connected and the latest one, you have returned to work on a fulltime basis for at least two consecutive weeks.

The foregoing benefit will only be provided for:

A. Those days on which you are under the care of a legally qualified Physician. A period of disability will be considered to have started on the date your disability has been determined to have occurred by competent medical opinion satisfactory to the Board of Trustees. However, this date may not be earlier than the date when you were first seen and treated personally by a Physician for the disability.

B. Those days on which you are not performing work for compensation or profit.

C. Disabilities which commence while you were covered as an Active Employee for Fund benefits.

D. Disabilities resulting from an Injury or Illness to which the Workers' Compensation Act of Arizona or any similar law of any other jurisdiction is not applicable.

E. Disabilities which do not result from:
   1. Self-inflicted Injury; or
   2. Your alcohol and/or drug abuse

   For this purpose, your sanity or mental status is irrelevant.

How to File a Claim for Weekly Disability Income Benefits (Disability Claim Process)

A claim for disability benefits is a request for disability plan benefits made by you or your authorized representative in accordance with the Plan's disability claims procedures, described below.

Eligible employees who become totally disabled from a non-occupational illness should apply (file a claim) for disability benefits within 30 calendar days after the date on which the illness or injury began, according to the following steps:

1. Obtain a disability claim form from the Administrative Office. Complete the patient portion of the form. Then give the form to your physician to complete the health care provider section of the form. Return the completed disability claim form to the Administrative Office. **Disability claims will be determined no later than 45 calendar days after receipt of the claim for disability benefits by the Appropriate Claims Administrator.**

2. You will be notified if you did not follow the disability claim process or if you need to submit additional medical information or records to prove a disability claim and provided 45 calendar days in which to obtain this additional information.

   - Proof of disability must be provided to the Plan (to the Administrative Office) no later than 90 calendar days after the end of the period for which disability benefits are payable. If you do not provide proof of disability within the time specified, you can still claim full benefits if you can show that proof was furnished as soon as reasonably possible.

   - The Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending or payable.

3. The Administrative Office determines if employees are eligible to receive disability benefits under this Plan. The Plan will review your disability claim and notify you or your authorized representative in writing (or electronically, as applicable) no later than 45 calendar days from the date the Appropriate Claims Administrator receives the claim.
   - This 45-day period may be **extended for up to 30 calendar days** provided the Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period, that additional time is needed to process the claim, the special circumstances for this extension and the date by which it expects to render its determination.
   - If, prior to the end of this first 30 day extension, the Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.
   - A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. If the Administrator needs additional information from you to make its decision, you will have at least 45 calendar days to submit the additional information.
   - If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
4. Disability benefits begin when the claim for disability benefits has been determined to meet the definition of total disability under this Plan and it is determined that Plan disability exclusions do not apply to the claim.
5. **If the claim for disability benefits is approved**, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.
6. **If the claim for disability benefits is denied** in whole or in part, a notice of this initial denial (adverse benefit determination) will be provided to the employee in writing (or electronically, as applicable). This notice of initial denial will:
   - give the specific reason(s) for the denial;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's appeal procedure along with time limits;
   - contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal; and
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.
7. **If you disagree with a denial of a disability claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.
8. **Informal Review:** A claimant may request an informal review of a post-service claim by the Administrative Office. Such a request for informal review may be in writing or presented orally and need only specify the claim in question and why the claimant feels the adverse benefit determination was erroneous. Upon presentation of a request for informal review, the Administrative Office will reexamine the claim that is the subject of the request and will notify the claimant in writing of the results of the informal review within 30 days. If the result of the informal review is to uphold the original adverse determination, the notice to the claimant will set forth the right of the claimant to pursue a formal appeal. Formal appeals must be requested in writing within the 180-day timeframe for appeal review noted above unless that timeframe is expressly extended by the Administrative Office.

Appeal of a Denial of a Disability Claim

1. Appeals must be in writing to the Board of Trustees. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

2. The Plan will make a determination as follows:
   - no later than the date of the Board of Trustees meeting that immediately follows the Plan's receipt of a request for review, when the request for appeal review is filed **within** 30 calendar days preceding the date of such meeting. If the **appeal is filed more than 30 days** before the next meeting, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of the request for review.
   - If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be made no later than the third meeting of the Board following the Plans' receipt of the request for review.
   - If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
   - The Plan will notify you of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.
3. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA section 502(a) following the appeal;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

WEEKLY DISABILITY INCOME BENEFITS

The Schedule

Active Employees: Disability benefits are payable up to $150 per week to a maximum of 13 weeks

Active Employees, Disability benefits due to pregnancy are payable up to $600 per week for the first 6 weeks from the date of delivery if the baby is delivered vaginally, and $600 per week for the first 8 weeks from the date of delivery if the baby is delivered by cesarean section.

DEATH AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Death Benefits for Active Employees and Self-Pay Active Employees (Excluding Retired Employees and Plan B participants)

If you, as an Active Employee or Self-Pay Active Employee (excluding Retired Employees and Plan B participants) die from any cause, Union Labor Life Insurance Company will pay, subject to the terms and conditions of Group Policy No. G-2911, and as amended from time to time, an amount equal to the amount set forth in the aforementioned policy. A certificate of such policy, noting coverages and limitations, will be provided to Active Employees.

Death Benefits for Dependents of Active Employees and Self-Pay Active Employees (Excluding Retired Employees and Plan B participants)

If an Active Employee's or Self-Pay Active Employee's (excluding Retired Employees and Plan B participants) Dependent dies from any cause, Union Labor Life Insurance Company will pay, subject to the terms and conditions of Group Policy No. G-2911, and as amended from time to time, an amount equal to the amount set forth in the aforementioned policy, as noted in the Schedule, above.

Accidental Death and Dismemberment Benefits for Active Employees and Self-Pay Active Employees (Excluding Retired Employees Plan B participants)

If you, as an Active Employee or Self-Pay Active Employee (excluding Retired Employees and Plan B participants) die or lose one or both hands or feet, or eyesight in one or both eyes, as the result of accidental means and within 90 days of the accident, Union Labor Life Insurance Company will pay, subject to the terms and conditions of Group Policy No. C-4202, and as amended from time to time, an amount equal to the amount set forth in the aforementioned policy as noted in the Schedule, above. A certificate of such policy, noting coverages and limitations, will be provided to Active Employees.

Accelerated Life Insurance Benefit (Excluding Retired Employees and Plan B participants)

If a determination is made that you, as an Active Employee or Self-Pay Active Employee (excluding Retired Employees and Plan B participants) have a life expectancy of 12 months or less as the result of a medical condition caused by injury or illness, a lump sum accelerated benefit equal to 50 percent of the life insurance amount may be payable to you or to the party designated by you. The balance of the life insurance amount shall be payable to the designated beneficiary upon your death. The conditions for which this benefit is payable are fully described in Group Policy No. G-2911.

Retired Employees and Plan B participants (Pre-Journeymen)

Retired Employees and Plan B participants and their Eligible Dependents are **not** covered for Death and Accidental Death and Dismemberment Benefits.

Payment

All employee Death Benefits will be paid to you or your Beneficiary. Dependent Death Benefits and Dismember Benefits will be paid to you. You may not assign Death nor Accidental Death and Dismemberment Benefits.

Life Insurance Claim Filing And Appeal Procedure

Life Insurance claims are managed by the Union Labor Life Insurance Company ('Union Labor Life') Life Insurance and Accidental Death and Dismemberment Internal Appeals Procedure. Those procedures are outlined here.

Group Life Insurance Certification and Benefit Amounts

A group life insurance claim must be submitted first to the Administrative Office for eligibility certification, then the entire claim (which includes the proof of death completed by both the beneficiary and policyholder, a certified copy of the death certificate and the enrolment card indicating the beneficiary) can be submitted to the Life Claims office of Union Labor Life.

The Life Claims office reviews the claim to determine if the designations of benefit amount and class of insureds (i.e., active workers, retirees or dependents) are in accordance with the policy provisions. Any discrepancies are brought to the attention of the policyholder for clarification or justification. Since the policyholder controls the records regarding benefit eligibility, benefit amount and classification of insured, any issues related to those subjects raised by insured or beneficiaries will be referred to the group policyholder.

Life Insurance Policies Issued Pursuant to Conversion Rights

- **Eligibility and Issuance:** A group policyholder is responsible for the notification of rights and the initial application process when an insured may be eligible for a life insurance policy pursuant to conversion rights set forth in the group life insurance policy. If a dispute involves conversion rights or administration of the group life insurance policy as it relates to conversion terms, the dispute shall be referred to the group policyholder. Issues arising after the conversion policy has been issued are handled by Union Labor Life.

Appeals to Union Labor Life

Issues related to rival claimant for proceeds are referred to the Legal Department for handling through interpleader actions in state or federal courts. Otherwise, a claim determination, benefit denial, or other matters related to the administration of the policy may be appealed if disputed by an insured or beneficiary or representative of such persons. The claim examiner immediately shall forward the claim file and an explanation of the dispute to the Manager of Contracts. If the Manager is unable to resolve the matter, the claim will then be reviewed by the Vice President of Group Administration, the Vice President for Underwriting, the Legal Department, and if necessary, the Medical Director to determine appropriate action. The consensus recommendation of those individuals shall be provided to the Manager for implementation within 10 business days of their receipt of the claim information.

A final denial by the Company can be further appealed by the insured or beneficiary in accordance with any claims appeals procedures available through the group policyholder.

LIFE (DEATH) INSURANCE

The Schedule

Life (Death) Insurance Benefit	$10,000 per eligible employee
Dependent Life Insurance	
• Spouse	$1,000
• Child Ages 15 days to 19 years (or 23 if a fulltime student)	$1,000

ACCIDENTAL DEATH & DISMEMBERMENT (ADD&D) INSURANCE

The Schedule

Principal Sum	$10,000
Loss of Life, Two Hands, Two Feet, Sight of Two Eyes, One Hand and One Foot, One hand or Foot and Sight of One Eye	The Principal Sum
One Hand or One Foot, Sight of One Eye	One half the Principal Sum

EXPENSES FOR WHICH A THIRD PARTY MAY BE RESPONSIBLE

This plan does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

1. Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
2. Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

1. grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
2. agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
3. agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

1. No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
2. No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
3. The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
4. No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
5. The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
6. The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
7. In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
8. Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief
9. Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

INFORMATION REQUIRED BY ERISA
(EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974)

The following information concerning the Welfare Plan is being provided to you in accordance with Government regulations:

The name and type of administration of the Plan.

Plan A of the I.B.E.W. Local No. 640 and Arizona Chapter N.E.C.A. Health and Welfare Trust Fund is a welfare benefit plan providing medical expense, prescription drug expense, dental expense, vision expense, short-term (weekly) disability and life and accidental death and dismemberment benefits to participants and beneficiaries. It is administered by a joint Board of Trustees, consisting of four Union representatives and four Employer representatives.

Plan B of the I.B.E.W. Local No. 640 and Arizona Chapter N.E.C.A. Health and Welfare Trust Fund is a welfare benefit plan providing medical expense, prescription drug expense, dental expense, vision expense, and short-term (weekly)_disability benefits to participants and beneficiaries. It is administered by a joint Board of Trustees, consisting of four Union representatives and four Employer representatives.

The name and address of the Plan Administrator is the Board of Trustees

I.B.E.W. Local No. 640 and Arizona Chapter N.E.C.A. Health and Welfare Trust Fund
c/o Zenith American Solutions
2001 W. Camelback, Suite B350
Phoenix, AZ 85015
Phone: (602) 248-8434 or 1-800-553-2801
Fax: (602) 248-8301

The Trustees have engaged the independent contractor named below to perform the routine administration of the Trust:

Zenith American Solutions
2001 W. Camelback, Suite B350
Phoenix, AZ 85015
Phone: (602) 248-8434 or 1-800-553-2801
Fax: (602) 248-8301

The Trustees have also engaged the carriers named below, on their behalf, to process and pay medical, dental, vision, behavioral health, and prescription claims:

BCBSAZ
(800) 232-2345 (Long Distance)
(602) 864-4400 (Local)
(800) 770-8973, TTY: 71 (Hearing Impaired)
www.azblue.com
Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ 85002-3466

MedImpact
(833) 229-3589
10181 Scripps Gateway Court
San Diego, CA 92131

Delta Dental Plan of Arizona (DDPAZ)
602-938-3131 or 800-352-6132
P. O. Box 43000 Phoenix, AZ 85080-3000
www.deltadentalaz.com

VSP, Inc.
P.O. Box 385018
Birmingham, AL 35238
Phone: 1-800-877-7195
www.vsp.com

The names and business addresses of the Trustees are:

Employer Trustees

Debra Margraf
Arizona Chapter N.E.C.A.
4315 N. 12th Street, Ste 100
Phoenix, AZ 85014

Amy Ortiz
Rosendin Electric
1375 W. Drivers Ln.
Tempe, AZ 85284
602.723.7842

Larry Howard
C/O Arizona Chapter NECA
4315 N. 12th Street, Ste 100
Phoenix, AZ 85014

John Gannon
Jessco Electric
P.O. Box 1793
Cave Creek, AZ 85327

Union Trustees

Dean Wine
I.B.E.W. Local No. 640
5808 N. 7th Street
Phoenix, AZ 85014

Delbert Hawk
I.B.E.W. Local No. 640
5808 N. 7th Street
Phoenix, AZ 85014

Lionel Webb
I.B.E.W. Local No. 640
5808 N. 7th Street
Phoenix, AZ 85014

Jason Dempsey
I.B.E.W. Local No. 640
5808 North 7th Street
Phoenix, AZ 85014

In addition to the Board of Trustees, the following person has been designated as agent for the service of legal process:

J. Kenny Kelley
Ryan, Rapp Underwood & Pacheco, PLC
3200 N. Central Ave, Suite 2250
Phoenix, AZ 85012

The Employer Identification Number assigned by Internal Revenue Service to the Board of Trustees is 86-6052414. The Plan Number assigned by the Board of Trustees is 501.

For purposes of maintaining the Fund's fiscal records, the year-end date is December 31.

Funding Medium:

Benefits are provided from the Trust Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

The Fund contracts with an independent Behavioral Health Program (whose name is listed on the Quick Reference Chart in this document) to provide an Employee Assistance Program (EAP).

Death and Accidental Death and Dismemberment benefits are provided through an insurance policy. The Death benefits are underwritten by Union Labor Life Insurance Company, Policy Number G-2911. The Accidental Death and Dismemberment benefits are underwritten by Union Labor Life Insurance Company, Policy Number C-4202.

Dental benefits are provided through an insurance policy. The Dental benefits are underwritten by Delta Dental Group Number 4957.

Vision benefits are self-funded group health plan benefits provided through VSP – Policy Number 30110467.

Financial Information

Contribution Source:

Contributions to the Plan are made by Employers in accordance with collective bargaining agreements between Local No. 640 of the International Brotherhood of Electrical Workers, AFL-CIO and the Arizona Chapter of the National Electrical Contractors Association, and in accordance with certain non-jobsite agreements accepted by the Trustees.

The collective bargaining agreements require contributions to the Plan at a fixed rate per hour worked; the non-jobsite agreements require contributions at a fixed monthly rate.

The Administrative Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Plan on behalf of Participants working under the collective bargaining agreement, or otherwise.

See the section entitled "Plan Documents" in Section O below if you wish to obtain additional information about the collective bargaining agreement.

Organizations Accumulating Fund Assets:

The Fund's assets and reserves are held in custody by Bank of Montreal (BMO) and invested in various collective investment vehicles.

See the section entitled "Plan Documents" below if you wish to obtain additional information concerning the Fund's investment of assets and checking accounts.

PLAN INFORMATION

Eligibility:

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are fully described in the eligibility sections of this Booklet.

Plan Regulations:

All of the types of benefits provided by the Plan are set forth in the Benefits Sections.

Statement of ERISA Rights:

As a participant in the Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, 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 (formerly known as the Pension and Welfare Benefits Administration).

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents it there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Receive reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if your request it up to 24 months after losing coverage. Without evidence of credible coverage, you may be subject to pre-existing condition exclusion for 12 months after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhaustion of available appeals.

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 (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration).

ADDITIONAL INFORMATION

Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Of course, a longer stay will be allowed if the needs are such that a longer stay is medically necessary.

Women's Health and Cancer Rights Act (WHCRA)

Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery on the other breast to produce a symmetrical appearance;
- Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

This coverage is subject to the Plan's normal co-payments, annual deductibles and coinsurance provisions. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Claim Procedures:

The procedures to follow for filing a claim for benefits are set forth in the Benefits Sections of this booklet. All claims for benefits must be submitted on claim forms made available by providers. Claims submitted must be accompanied by all information or proof requested and reasonably required to process such claims.

Review and Appeals Procedures:

The procedures to follow for appealing an adverse claim determination are also set forth in the Benefits Sections this booklet.

Plan Documents and Reports:

You may examine the following documents at the Administrative Office during regular business hours, Monday through Friday, except holidays:

- Trust Agreement;
- Collective Bargaining Agreement;
- Plan Documents, policies and all amendments;
- Form 5500 or full Annual Report filed with the Internal Revenue Service and Department of Labor; and
- List of Contributing Employers.

You may also obtain copies of the documents by writing for them and paying the reasonable cost of duplication. You should find out what the charges will be before requesting copies. If you prefer, you can arrange to examine these reports, during business hours, at your Union Office. To make such arrangements, call or write the Administrator at the Administrative Office. A summary of the annual report which gives details of the financial information about the Fund's operation is furnished free of charge to all Participants.

Spanish Language Assistance:

Pongase en contacto con la oficina de administracion si no entiende los beneficios del Plan al numero (602) 248-8434 or 1-800-553-2801.

This booklet contains a summary in English of your Plan rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Administrative office at Zenith American Solutions, 2001 W. Camelback, Suite B350, Phoenix, AZ 85015; Phone: (602) 248-8434 or 1-800-553-2801.

The office hours are from 8:30 a.m. to 4:30 p.m., MST, Monday through Friday. You may also call the Administrative office at (602) 248-8434 or 1-800-553-2801 for assistance.

The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant.

Discretionary Authority for Medical Claims

The Plan Administrator delegates to BCBSAZ the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of medical claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to BCBSAZ the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative, except for second level post-service appeals.

Plan Modification, Amendment and Termination

The Trustees reserve the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Administrative Office for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Fund and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for extending coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

Privacy

The Trustees shall have adopted the following Privacy rules to fulfill their obligations under the Health Insurance Portability and Accountability Act (HIPAA). The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the Plan's Board of Trustees (the "Trustees") for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

Disclosure of PHI to the Trustees.

<u>Disclosures by Plan</u>. The Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administrative functions that qualify as Payment or Health Care Operations. The Plan may, pursuant to 42 C.F.R. § 423.884(b), provide to the Trustees and/or the Centers for Medicare and Medicaid Services and/or its contractors, including but not limited to the Retiree Drug Subsidy Center, in the manner and in the form directed by the Trustees, the information required for the Trustees to comply with their obligations, if any, under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and its implementing regulations, including subpart R of Part 423 of Title 42 of the Code of Federal Regulations.

<u>Disclosures by Business Associates</u>. The Plan's Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:

- The Plan's Payment activities,
- Those Health Care Operations designated in 45 C.F.R. Section 164.506(c)(4) with respect to the Plan, and
- All of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

Uses and Disclosures of PHI by the Trustees. The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as Payment or Health Care Operations. The Plan does not use or disclose PHI that is genetic information as defined in 45 CFR § 160.103 for underwriting purposes as set forth in 45 CFR § 164.502.

Privacy Safeguards. The Trustees agree to:

- Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;
- Ensure that any subcontractors or agents to whom the Trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;
- Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;
- Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;
- Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
- Make available the information required to provide and accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
- Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;
- If feasible, return or destroy all PHI that the Trustees maintain in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and
- Ensure that adequate separation between the Plan and the Trustees is established, as described below.

Adequate Separation. The Trustees may use PHI only for Plan administration activities. The Trustees may not use PHI for employment-related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.

Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Board of Trustees will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
- Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

No Participant Right to Assets

No person other than the Trustees of the Trust shall have any right, title or interest in any of the income, property or funds received or held by or for the account of the Plan, and no person shall have any right to benefits provided by the Plan except as expressly provided herein. Amounts paid erroneously to any person, including any Eligible Individual whether through the misconduct of the recipient or the mistake or oversight of the Trustees or their representatives, shall be held in trust by the recipient, and the Trust and its Trustees shall have an equitable lien thereon in addition to any other remedy provided by the Plan, by law, or otherwise.