Notice of Special Enrollment Provision

To: Blue Cross Blue Shield of Arizona (BCBSAZ) Employer Groups

Please distribute the following notice to each employee on or before the time the employee is offered the opportunity to enroll for BCBSAZ coverage under the employer group health plan.

Special Enrollment Provisions

If you or a dependent do not enroll for BCBSAZ coverage during your group's open enrollment period, you or your dependent may only apply for coverage outside of your group's open enrollment period if you meet the following criteria:

- The person at the time of the initial enrollment period was covered under a public or private health insurance policy or other health benefit plan and he/she lost coverage under the plan due to any of the following reasons, and the person requested coverage by completing an application and submitting it to BCBSAZ within thirty-one (31) days of the loss of other coverage:
    - dependent's termination of employment
    - dependent's termination of eligibility
    - dependent's reduction in the number of hours of employment
    - termination of the other plan's coverage
    - the death of an employed spouse
    - legal separation or divorce
    - exhaustion of COBRA
    - termination of the employer's contribution toward the coverage.

        - The person is employed by an employer that offers multiple health benefit plans and the person elects a different plan during an open enrollment.

        - The person becomes a dependent of a covered person through marriage, birth, adoption or placement for adoption and BCBSAZ received a completed application no later than thirty-one (31) days after becoming a dependent.

    - If you are not a participant in the group's health plan when a marriage, birth, adoption or placement for adoption occurs, you and your dependents are eligible to enroll in the group's health plan as a result of the marriage, birth, adoption or placement for adoption and not considered late enrollees so long as BCBSAZ receives a completed application no later than thirty-one (31) days after the family status change.

PREMIUM COST INFORMATION
Attachment to Accountable Health Plan Disclosure Form

Employer Group Name: **Town of Florence**

BCBSAZ Group Number: **30723**

BCBSAZ Benefit Plan: **PPO 500**

Effective Date: **07/01/2014**

The full premium cost of the plan:

Employee:	$656.50
Employee + Spouse:	$1,358.03
Employee + Child(ren):	$1,230.47
Employee + Family:	$1,932.00

Employer Group Name: Town of Florence
BCBSAZ Group Number: 30723
BCBSAZ Benefit Plan: PPO 500
Effective Date: 07/01/2014

ACCOUNTABLE HEALTH PLAN DISCLOSURE FORM
Blue Cross and Blue Shield of Arizona ("BCBSAZ")
Effective on and after January 1, 2014

This form applies to the following plans: BluePreferred 100/50, BluePreferred 90/70, BluePreferred 80/60, BluePreferred 70/50, BluePreferred HSA Plus 100, BluePreferred HSA Plus 90, BluePreferred HSA Plus 80, BluePreferred HSA Plus 70, BluePreferred Copay, BluePreferred Copay 100%, BluePreferred Saver 80%, BluePreferred Original, BluePreferred Basic, Blue Solutions and BlueEssential.

PLEASE READ THIS NOTICE CAREFULLY. IT HAS IMPORTANT INFORMATION YOU SHOULD KNOW BEFORE YOU ENROLL. IT IS ONLY A SUMMARY. YOU SHOULD REVIEW THE BENEFIT BOOK FOR DETAILED PROVISIONS GOVERNING COVERAGE.

A. PRIMARY CARE PHYSICIANS ROSTER

A provider directory listing primary care physicians, specialists, facilities and other PPO providers is available on request and online at the BCBSAZ web site, www.azblue.com.

B. PREMIUM

1. **State the full premium cost of the plan**:
   - Employer: Refer to the attached Premium Rate Information or Rate Issuance Sheet for the full premium cost of the plan.
   - Employee: Refer to the premium cost information supplied by your employer.

2. **State any reservations by the Plan to change premium:** With 60 days' prior written notice, or such longer period as required by BCBSAZ's contract with your employer, BCBSAZ may change a group's rates on the group's plan anniversary date and when the government imposes a new tax or fee on group health plans or insurers, or requires coverage of additional benefits.

C. HOW AND WHERE TO OBTAIN SERVICES

1. **Where and in what manner a member may obtain services:**

General Provisions

You may receive services from any licensed, eligible health care provider, both individuals and facilities. Eligible providers are listed in your plan benefit book, and do not include naturopathic or homeopathic physicians. PPO benefit plans have a network of hospitals and other health care providers that are contracted with BCBSAZ to provide health services. You can find PPO providers using the provider directory referenced in section (A) above. You do not have to pick a specific primary care physician (PCP) or notify BCBSAZ when changing PCPs. You do not need BCBSAZ approval to see specialists or registered nurse practitioners (RNPs).

You will usually have lower out-of-pocket costs when using PPO network providers. These providers will accept the BCBSAZ allowed amount for covered services and will file claims with BCBSAZ.

You can also receive services from noncontracted providers outside the PPO network. Noncontracted providers have not agreed to accept the BCBSAZ allowed amount, are not required to file claims for members, and may bill you for full billed charges, which can be much higher than the BCBSAZ allowed amount.

Referrals to Out-of-Network Providers
BCBSAZ does not guarantee that every specialist or facility will be included in the PPO network. When BCBSAZ determines that no PPO network provider is available to render covered services, BCBSAZ may precertify use of an out-of-network provider at in-network cost-sharing. This precertification is separate from any precertification already required for a particular procedure or service. A member's treating provider must obtain BCBSAZ precertification for both the procedure/service (if required), and for the in-network cost-sharing. "In-network cost-sharing" means the services will be subject to the in-network deductible (if there are separate deductibles) and paid at the in-network copay or coinsurance percentage. Also, coinsurance will count toward the in-network out-of-pocket maximum. **However, even if in-network cost share is approved, you are still responsible to pay for the difference between the provider's billed charges and the BCBSAZ allowed amount ("balance bill").**

Continuing Physician Care from an Out-of-Network Physician (MD or DO)
As required by Arizona law, you may be able to receive in-network level benefits for certain covered services by out-of-network doctors of medicine and osteopathy who are located in Arizona. This continuity of care benefit applies only when a member is in an active course of treatment for a life-threatening disease or in the third trimester of pregnancy. Continuity of care benefits are subject to all applicable provisions of the benefit plan. The out-of-network physician must agree to accept the BCBSAZ allowed amount and comply with BCBSAZ's applicable policies and procedures.

Continuity of care is not available for facility services. If the hospital or other facility at which your physician practices is not an in-network facility, out-of-network benefits will apply to the facility's services.

2. Whether services received outside of Arizona are covered and in what manner the services are covered:

This plan covers services outside of Arizona. If you receive covered services outside of Arizona from a provider that participates as a PPO provider with the local Blue Cross and/or Blue Shield ("Host Blue") plan, benefits are processed at the in-network level. Except for emergencies, covered services received outside of Arizona from a provider who does not participate as a PPO provider with the Host Blue plan are subject to out-of-network cost-share and balance billing. Out-of-state emergency services are covered at the in-network level of benefits, except you are responsible for the balance bill for emergency services from a noncontracted provider.

You can access PPO network providers in other states through the BlueCard Program by calling 1-800-810-BLUE or by checking the BlueCard Doctor and Hospital finder online at www.bcbs.com.

You can also call 1-800-810-BLUE when traveling outside of the United States for help in locating an international provider, to assist with foreign language translation and to submit claims.

3. **The locations of contracted hospitals and outpatient treatment centers:**

   Addresses for Arizona PPO providers are shown in the provider directory referenced in subsection (A) above, and at www.azblue.com.

D. PRE-AUTHORIZATION AND REFERRAL PROCEDURES

1. **The procedures a member must follow, if any, to obtain prior authorization for services:** Your benefit book shows what services require precertification. Precertification is required for all inpatient stays except emergencies and maternity. Precertification is also required for some medications. If precertification is required, your treating provider must call BCBSAZ (or the appropriate BCBSAZ contracted vendor acting on behalf of BCBSAZ) to get precertification before providing the service or treatment. BCBSAZ may require the provider to submit medical records or other information to support the request. You are responsible for making sure your provider gets precertification when required.

2. **The procedures to be followed by the member for consulting a physician other than the primary care physician and whether someone must first authorize the referral:** You are not required to get BCBSAZ authorization or referral before seeing any specialist who is an eligible provider as defined by BCBSAZ. Precertification is required to see an out-of-network specialist at in-network cost-sharing (see Subsection (C)(1) above).

3. **The necessity of repeating prior authorization if the specialist care is continuing:** Not required for ongoing specialist care. Additional precertification may be required for certain inpatient stays if the initial precertification was for a fixed period of time or a certain number of services.

4. **The circumstances under which the Plan may retroactively deny coverage for non-emergency treatment that had prior authorization under the Plan's written policies:** When your provider requests precertification, BCBSAZ reviews whether coverage is active, whether the treating provider or location of service is within the appropriate network and the applicability of other benefit plan provisions (limitations, exclusions, benefit maximums). Some of these provisions may not be readily identifiable at the time precertification is given, but will still apply if discovered later in the claim process after services have been provided. During the precertification process, BCBSAZ may review certain procedures or treatments for medical necessity, based on applicable medical coverage guidelines and other medical information.

   BCBSAZ may determine that precertification was made in error, and retroactively deny coverage if BCBSAZ received inaccurate or incomplete information about the services to be provided. Sometimes employers notify BCBSAZ that a member has lost eligibility after BCBSAZ precertifies a service. BCBSAZ may retroactively deny coverage if the member was not eligible at the time of service.

5. **Whether a Point of Service option is available and how it is structured:** BCBSAZ does not offer a Point of Service option.

E. EMERGENCY CARE

1. **Circumstances under which prior authorization is required for emergency medical care:** Precertification is not required for emergency services.

2. **Whether and where the Plan provides twenty-four hour emergency services:** Benefits are available for covered emergency services 24 hours a day at PPO network and noncontracted hospitals, both in and outside of Arizona.

3. **Procedures for emergency room, nighttime or weekend visits and referrals to specialist physicians:** Members who have emergencies should go to the nearest emergency room or call 911. No authorizations or referrals are necessary. Benefits for covered services received after initial emergency treatment are treated as non-emergency covered services.

   This plan also has an urgent care benefit. If you need treatment for a non-emergency condition that requires prompt medical attention, you can seek treatment during evenings and on weekends at a free-standing (not on a hospital campus) BCBSAZ-contracted Urgent Care (UC) Center. You will pay the UC cost-share amount for each visit to a contracted UC Center.

4. **The circumstances under which the Plan may retroactively deny coverage for emergency medical treatment that had prior authorization under the Plan's written policies:** Emergencies don't require precertification or prior authorization. BCBSAZ may deny coverage if the member was not eligible at the time of service.

F. PRESCRIPTION MEDICATIONS

1. **Whether the Plan physician is restricted to prescribing medications from a Plan list or Plan formulary:** Providers treating members with this benefit plan are not restricted to a prescription medication formulary.

2. **The extent to which a member will be reimbursed for the costs of a medication that is not on the Plan list or Plan formulary:** Most benefit plans have a tiered medication benefit so that most medications are available at tiered cost-share levels. Some plans require payment of deductible and coinsurance based on the medication allowed amount. BCBSAZ generally covers prescription medications that are FDA approved and meet BCBSAZ Pharmacy or Medical Coverage Guidelines and quantity, age and gender limitations, with limited exclusions for certain drugs such as weight loss drugs and drugs for sexual dysfunction. Medications that do not meet these criteria are denied as noncovered services. BCBSAZ does not reimburse members for the costs of medications that are not covered, with the exception of off-label use of certain medications when required by applicable Arizona law for the treatment of cancer.

G. APPEAL AND GRIEVANCE PROCEDURES

If you disagree with a denial of coverage or with the way BCBSAZ processed a claim, you may be able to appeal the decision or file a grievance. Members, their treating providers, and their authorized representatives may participate in all levels of the appeal and grievance processes. The procedures and specific timeframes for each level of review are described in a separate document called, "Guidelines and Procedures for Members Who Want to Appeal or Grieve an Adverse Benefit Determination." You may view this document at www.azblue.com or request it at any time.

An adverse benefit determination which may be appealed or grieved occurs when BCBSAZ makes any of the following decisions:

- denies your request for precertification of a service you haven't yet received;
- denies, reduces, or terminates your plan benefits;
- fails to provide or pay for a benefit covered under your plan;
- finds you ineligible for a benefit under your plan;
- finds you responsible for payment of cost share (copay, deductible, coinsurance, access fee, balance bill) for a plan benefit;
- finds that a service is not medically necessary;
- finds that a service is not covered because it is experimental or investigational;
- determines that you are not eligible for coverage under the benefit plan; or
- rescinds your coverage under the plan.

An adverse benefit determination can be issued in the form of an "Explanation of Benefits" (EOB) document, a monthly member health statement, or a letter. All of these documents will include information about your right to appeal or grieve the decision.

The process available to you, and the steps in that process, will vary, based on:

- Whether you are challenging a denial of an urgently needed service that you haven't yet received.
    - You may qualify for an expedited appeal if your provider certifies that proceeding under the time frames for a standard appeal will seriously jeopardize your life, health or ability to regain maximum function, cause a significant negative change in your medical condition, or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
- The type of decision you disagree with:
    - If we denied a claim or a precertification request for a service, you have 2 years from the date of denial to request an appeal.
    - If you disagree with how we paid the claim (i.e., copay, deductible, coinsurance, level of benefits, etc.), you have 1 year from the date of the notice to file a grievance. When your dispute is about how we applied cost share, we call it a "grievance".
- Whether you or your provider bears financial responsibility for the decision (BCBSAZ contracted providers are sometimes required to write off charges for certain services excluded from coverage under your benefit plan.)

Complaints about creditable coverage
If you believe that BCBSAZ has not properly credited you for prior coverage, you may contact BCBSAZ Enrollment services. If you are unable to resolve your complaint, you may file a grievance as described above.

Complaints about quality of care
Providers in the BCBSAZ network are independent contractors exercising independent medical judgment. However, if you are concerned about the quality of care you received from a PPO network provider, please contact customer service so we can refer your complaint for investigation by the BCBSAZ Clinical Quality Services Department.

H. PLAN PROVIDER REQUIREMENTS AND COMPENSATION

Specify whether provider compensation programs include any incentives or penalties that are intended to encourage plan providers to withhold services or

minimize or avoid referrals to specialists. Specify whether the Plan provider must comply with any specified numbers, targeted averages, or maximum duration of patient visits. If these types of incentives or penalties are included, provide a concise description of them:

BCBSAZ does not provide incentives or penalties to encourage providers to withhold services or limit specialist referrals. BCBSAZ does not require plan providers to comply with any specified numbers, targeted averages or maximum durations of patient visits.

I. EXPLANATION OR JUSTIFICATION FOR USE OF INCENTIVES AND PENALTIES

Not applicable.

J. DESCRIPTION OF BENEFITS

1. **Whether services outside the plan are covered and in what manner they are covered:** The attached Summary of Benefits and Coverage ("SBC") outlines your plan benefits, which include coverage of services by out-of-network providers for most plan benefits. See also response in Section C (1) above.

   To be covered, a service must be all of the following:
   - a benefit of the plan;
   - medically necessary, as determined by BCBSAZ or BCBSAZ's contracted vendor(s);
   - not excluded;
   - not experimental or investigational as determined by BCBSAZ or BCBSAZ's contracted vendor(s);
   - precertified where precertification is required;
   - provided while the benefit plan is in effect and while the person claiming benefits is eligible for benefits; **and**
   - rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ or BCBSAZ's contracted vendor(s). (You may call the BCBSAZ Customer Service Department for a provider's eligibility status.)

2. **Copayment, coinsurance or deductible requirements that a member or member's family may incur in obtaining coverage under the plan:** See the attached SBC for cost-sharing amounts. More cost-share information is in the plan benefit book.

3. **The health care benefits to which a member would be entitled:** See the attached SBC for an overview of benefits. The plan benefit book has a complete description of benefits, requirements, exclusions and limitations. Benefits may be modified during the term of the plan as specifically provided under the terms of group's contract and as permitted by law.

K. LIMITATIONS AND EXCLUSIONS THAT APPLY TO SERVICES AND BENEFITS

List all limitations and exclusions that have not already been disclosed in another section. Specifically include any pre-existing condition exclusions or limitations or any affiliation period requirements: This plan does not have pre-existing exclusions or limitations. See the attached SBC and separate exclusions list for information on conditions and services that are limited or excluded. Detailed information about benefits, limitations and exclusions is in the plan benefit book.

Town of Florence PPO 500

Blue Cross® Blue Shield® of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

Coverage Period: 07/01/2014-06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.azblue.com** or by calling 1-877-475-8440.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$500**/member Out-of-network: **$3,000**/member	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Your **deductible** is based on a calendar year and starts over each January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Unless a copay, fee or different percentage is shown, the coinsurance percentage of the **allowed amount** that you will pay for most services, after meeting any applicable **deductible**, is 10% in-network and 50% out of network. Copays, medications, access fees, balance bills, excluded services and precertification charges don't count toward **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$1,000**/member Out-of-network: **$8,000**/member	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses. If you have funds in an HRA or FSA, you may be able to use those funds to cover your out-of-pocket expense.
What is not included in the out–of–pocket limit?	Premiums, precertification charges, balance bills, and costs for health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. You must keep paying them even if you reach your out-of-pocket limit.
Does this plan use a network of providers?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your benefit book for more information about **excluded services**.

Questions: Call 1-877-475-8440 or visit us at **www.azblue.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at **www.cciio.cms.gov** or call 1-877-475-8440 to request a copy.

- **Copays** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use **in-network providers** by charging you a lower cost-share their services. A noncontracted provider can charge full billed charges, and the plan will reimburse you based only on the plan **allowed amount**, minus your cost share.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per member/provider/day	50% coinsurance & balance bill	Specialist copay applies to most chiropractic services. Plan doesn't cover acupuncture & services by naturopaths & homeopaths. In-network routine vision exam limited to 1 exam per calendar year; subject to $15 copay.
	Specialist visit	$25 copay per member/provider/day		
	Other practitioner office visit	10% coinsurance		
	Preventive care/ screening/immunization	No charge	Most services not covered out of network. If covered, 50% coinsurance (deductible waived) & balance bill	Provider's diagnosis and procedure codes determine whether service is preventive. Only mammography and foreign travel immunizations are covered out of network.
If you have a test	Diagnostic test (x-ray, blood work)	Office visit copay &/or 10% coinsurance for most professional services	50% coinsurance & balance bill	Cost share waived at contracted, freestanding, independent clinical labs. In-network cost share varies based on place of service and type of provider(s). Professional services by a radiologist, pathologist, and derma pathologist always subject to deductible and coinsurance.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription**	Level 1 prescription drugs	Retail: $10 copay Mail Order: $25 copay	Retail: $10 copay & balance bill	Some drugs require precertification and won't be covered without it. Retail copay covers up to a 30-day supply. Mail order copay covers up to 90-day supply. Specialty copay covers

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Level 2 prescription drugs	Retail: $30 copay Mail Order: $75 copay	Retail: $30 copay & balance bill	
	Level 3 prescription drugs	Retail: $60 copay Mail Order: $150 copay	Retail: $60 copay & balance bill	
	Specialty Medications	Level A: $30 copay Level B: $60 copay Level C: $90 copay Level D: $120 copay	Not covered	No coverage without precertification.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance & balance bill	Additional $1,000 access fee for all bariatric surgeries.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$150 access fee per member/facility/day, then 10% coinsurance	$150 access fee per member/facility/day, then 10% coinsurance & balance bill	Access fee is waived if you are admitted to the hospital.
	Emergency medical transportation	10% coinsurance		None
	Urgent care	$15 copay per member/provider/day	50% coinsurance & balance bill	Copay applies only to facilities specifically contracted for urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance & balance bill	Precertification required for out-of-network & $500 charge applies if not obtained. Additional $1,000 access fee for all bariatric surgeries.
	Physician/surgeon fee			
	Long-term acute care	10% coinsurance except 50% coinsurance for days 101-365	50% coinsurance & balance bill	Precertification required. Services not covered without precertification. Benefit limit of 365 total days of long term acute care per member.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Non-BSA: Physician office visit copay for services in provider's office or member's home. 10% coinsurance for all other outpatient services. BSA: $15 copay/visit	50% coinsurance & balance bill	Outpatient behavioral services have two in-network options: network with Behavioral Services Administrator (BSA) and non-BSA.
	Mental/Behavioral health inpatient services	10% coinsurance		Precertification required for out-of-network non-emergency admissions; $500 charge applies if not obtained.
	Substance use disorder outpatient services	Non-BSA: Physician office visit copay for services in provider's office or member's home. 10% coinsurance for all other outpatient services. BSA: $15 copay/visit		Outpatient behavioral services have two in-network options: network with Behavioral Services Administrator (BSA) and non-BSA.
	Substance use disorder inpatient services	10% coinsurance		Precertification required for out-of-network non-emergency admissions; $500 charge applies if not obtained.
If you are pregnant	Prenatal and postnatal care Delivery and all inpatient services	Physician: Office visit copay Hospital: 10% coinsurance	50% coinsurance & balance bill	In-network: Other than initial copay, cost-sharing is waived on physician's global delivery fee, but applies to all other covered services.
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	10% coinsurance	50% coinsurance & balance bill	Limited to 6 hours of care per member per day. Custodial care excluded. Certain drugs not covered without precertification.
	Rehabilitation services EAR = Extended Active Rehabilitation Facility PT/OT/ST = Physical therapy, occupational therapy, speech therapy	10% coinsurance except 50% coinsurance for days 61-120 EAR inpatient stay	50% coinsurance & balance bill	Precertification required for out-of-network & $500 charge applies if not obtained. Benefit limit of 120 days/member/calendar year for EAR inpatient stay. Plan doesn't cover group physical and occupational therapy.
	Habilitation services	Not covered		Excluded

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Skilled nursing care In skilled nursing facility (SNF)	10% coinsurance except 50% coinsurance for days 91-180	50% coinsurance & balance bill	Precertification required for out-of-network & $500 charge applies if not obtained. Benefit limit of 180 days/member/calendar year for SNF inpatient stay. Private duty nursing not covered.
	Durable medical equipment	10% coinsurance	50% coinsurance & balance bill	No coverage for rental or repair charges that exceed purchase price or for deluxe models that aren't medically necessary.
	Hospice service	No charge	No charge	None
If your child needs dental or eye care	Eye exam	$15 copay/visit. No charge for members under age 5.	50% coinsurance & balance bill. No charge for members under age 5.	Routine vision exam limited to 1 exam per calendar year.
	Glasses	Not covered		Excluded
	Dental check-up	Not covered		Excluded

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your benefit book for other excluded services.)

- Acupuncture
- Care that is not medically necessary
- Cosmetic surgery
- Dental care except dental accidents
- Experimental and investigational treatments
- Eye wear except after cataract surgery
- Habilitation care
- Hearing aids except as stated in benefit book
- Infertility treatment
- Long-term care (except long-term acute care)
- Massage therapy other than allowed under medical coverage guidelines
- Out-of-network mail order prescriptions and specialty self-medications
- Out-of-network preventive care except mammography and foreign travel immunizations
- Private-duty nursing
- Routine eye care except one exam per calendar year
- Routine foot care
- Services from naturopathic and homeopathic physicians
- Sexual dysfunction
- Smoking cessation programs, medications, aids and devices
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your benefit book for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic services	• Non-emergency care when travelling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-475-8440. You may also contact your state insurance department at (602) 364-2499 or (800) 325-2548, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-877-475-8440.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 602-864-4884.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 602-864-4884.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 602-864-4884.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-864-4884.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,680
- **Patient pays** $860

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$190
Coinsurance	$20
Limits or exclusions	$150
Total	**$860**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,320
- **Patient pays** $1,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$140
Copays	$860
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,080**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-877-475-8440 or visit us at www.azblue.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at **www.cciio.cms.gov** or call 1-877-475-8440 to request a copy.

Town of Florence PPO 500

Blue Cross® Blue Shield® of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

Coverage Period: 07/01/2014-06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual & Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.azblue.com** or by calling 1-877-475-8440.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$500**/member and **$1,500**/family Out-of-network: **$3,000**/member and **$9,000**/family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Your **deductible** is based on a calendar year and starts over each January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Unless a copay, fee or different percentage is shown, the coinsurance percentage of the **allowed amount** that you will pay for most services, after meeting any applicable **deductible**, is 10% in-network and 50% out of network. Copays, medications, access fees, balance bills, excluded services and precertification charges don't count toward **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$1,000**/member and **$3,000**/family Out-of-network: **$8,000**/member and **$24,000**/family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses. If you have funds in an HRA or FSA, you may be able to use those funds to cover your out-of-pocket expense.
What is not included in the out–of–pocket limit?	Premiums, precertification charges, balance bills, and costs for health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. You must keep paying them even if you reach your out-of-pocket limit.
Does this plan use a network of providers?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.

Questions: Call 1-877-475-8440 or visit us at **www.azblue.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at **www.cciio.cms.gov** or call 1-877-475-8440 to request a copy.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your benefit book for more information about **excluded services**.

- **Copays** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use **in-network providers** by charging you a lower cost-share their services. A noncontracted provider can charge full billed charges, and the plan will reimburse you based only on the plan **allowed amount**, minus your cost share.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per member/provider/day	50% coinsurance & balance bill	Specialist copay applies to most chiropractic services. Plan doesn't cover acupuncture & services by naturopaths & homeopaths. In-network routine vision exam limited to 1 exam per calendar year; subject to $15 copay.
	Specialist visit	$25 copay per member/provider/day		
	Other practitioner office visit	10% coinsurance		
	Preventive care/ screening/immunization	No charge	Most services not covered out of network. If covered, 50% coinsurance (deductible waived) & balance bill	Provider's diagnosis and procedure codes determine whether service is preventive. Only mammography and foreign travel immunizations are covered out of network.
If you have a test	Diagnostic test (x-ray, blood work)	Office visit copay &/or 10% coinsurance for most professional services	50% coinsurance & balance bill	Cost share waived at contracted, freestanding, independent clinical labs. In-network cost share varies based on place of service and type of provider(s). Professional services by a radiologist, pathologist, and derma pathologist always subject to deductible and coinsurance.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by logging into the BCBSAZ member portal at azblue.com/Rx.	Level 1 prescription drugs	Retail: $10 copay Mail Order: $25 copay	Retail: $10 copay & balance bill	Some drugs require precertification and won't be covered without it. Retail copay covers up to a 30-day supply. Mail order copay covers up to 90-day supply. Specialty copay covers up to a 30-day supply. Copays apply each time you fill a prescription supply. Mail order and specialty are not covered out of network.
	Level 2 prescription drugs	Retail: $30 copay Mail Order: $75 copay	Retail: $30 copay & balance bill	
	Level 3 prescription drugs	Retail: $60 copay Mail Order: $150 copay	Retail: $60 copay & balance bill	
	Specialty Medications	Level A: $30 copay Level B: $60 copay Level C: $90 copay Level D: $120 copay	Not covered	No coverage without precertification.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance & balance bill	Additional $1,000 access fee for all bariatric surgeries.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$150 access fee per member/facility/day, then 10% coinsurance	$150 access fee per member/facility/day, then 10% coinsurance & balance bill	Access fee is waived if you are admitted to the hospital.
	Emergency medical transportation	10% coinsurance		None
	Urgent care	$15 copay per member/provider/day	50% coinsurance & balance bill	Copay applies only to facilities specifically contracted for urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance & balance bill	Precertification required for out-of-network & $500 charge applies if not obtained. Additional $1,000 access fee for all bariatric surgeries.
	Physician/surgeon fee			
	Long-term acute care	10% coinsurance except 50% coinsurance for days 101-365	50% coinsurance & balance bill	Precertification required. Services not covered without precertification. Benefit limit of 365 total days of long term acute care per member.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Non-BSA: Physician office visit copay for services in provider's office or member's home. 10% coinsurance for all other outpatient services. BSA: $15 copay/visit	50% coinsurance & balance bill	Outpatient behavioral services have two in-network options: network with Behavioral Services Administrator (BSA) and non-BSA.
	Mental/Behavioral health inpatient services	10% coinsurance		Precertification required for out-of-network non-emergency admissions; $500 charge applies if not obtained.
	Substance use disorder outpatient services	Non-BSA: Physician office visit copay for services in provider's office or member's home. 10% coinsurance for all other outpatient services. BSA: $15 copay/visit		Outpatient behavioral services have two in-network options: network with Behavioral Services Administrator (BSA) and non-BSA.
	Substance use disorder inpatient services	10% coinsurance		Precertification required for out-of-network non-emergency admissions; $500 charge applies if not obtained.
If you are pregnant	Prenatal and postnatal care Delivery and all inpatient services	Physician: Office visit copay Hospital: 10% coinsurance	50% coinsurance & balance bill	In-network: Other than initial copay, cost-sharing is waived on physician's global delivery fee, but applies to all other covered services.
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	10% coinsurance	50% coinsurance & balance bill	Limited to 6 hours of care per member per day. Custodial care excluded. Certain drugs not covered without precertification.
	Rehabilitation services EAR = Extended Active Rehabilitation Facility PT/OT/ST = Physical therapy, occupational therapy, speech therapy	10% coinsurance except 50% coinsurance for days 61-120 EAR inpatient stay	50% coinsurance & balance bill	Precertification required for out-of-network & $500 charge applies if not obtained. Benefit limit of 120 days/member/calendar year for EAR inpatient stay. Plan doesn't cover group physical and occupational therapy.
	Habilitation services	Not covered		Excluded

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Skilled nursing care In skilled nursing facility (SNF)	10% coinsurance except 50% coinsurance for days 91-180	50% coinsurance & balance bill	Precertification required for out-of-network & $500 charge applies if not obtained. Benefit limit of 180 days/member/calendar year for SNF inpatient stay. Private duty nursing not covered.
	Durable medical equipment	10% coinsurance	50% coinsurance & balance bill	No coverage for rental or repair charges that exceed purchase price or for deluxe models that aren't medically necessary.
	Hospice service	No charge	No charge	None
If your child needs dental or eye care	Eye exam	$15 copay/visit. No charge for members under age 5.	50% coinsurance & balance bill. No charge for members under age 5.	Routine vision exam limited to 1 exam per calendar year.
	Glasses	Not covered		Excluded
	Dental check-up	Not covered		Excluded

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your benefit book for other excluded services.)

- Acupuncture
- Care that is not medically necessary
- Cosmetic surgery
- Dental care except dental accidents
- Experimental and investigational treatments
- Eye wear except after cataract surgery
- Habilitation care
- Hearing aids except as stated in benefit book
- Infertility treatment
- Long-term care (except long-term acute care)
- Massage therapy other than allowed under medical coverage guidelines
- Out-of-network mail order prescriptions and specialty self-medications
- Out-of-network preventive care except mammography and foreign travel immunizations
- Private-duty nursing
- Routine eye care except one exam per calendar year
- Routine foot care
- Services from naturopathic and homeopathic physicians
- Sexual dysfunction
- Smoking cessation programs, medications, aids and devices
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your benefit book for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic services	• Non-emergency care when travelling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-475-8440. You may also contact your state insurance department at (602) 364-2499 or (800) 325-2548, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-877-475-8440.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 602-864-4884.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 602-864-4884.

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,680
- **Patient pays** $860

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
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Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$190
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Limits or exclusions	$150
Total	**$860**

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(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,320
- **Patient pays** $1,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$140
Copays	$860
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,080**

This example shows the cost share for a policy covering only one person. If the policy covers a spouse and/or children, a member's cost share may be less than the amount shown if other members contribute to or satisfy the family deductible before the Plan receives claims for that one member.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

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Does the Coverage Example predict my future expenses?

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Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Exclusions and Limitations

This is a partial list of conditions and services that are excluded or limited. Detailed information about benefits, exclusions and limitations is in the benefit plan book and is available prior to enrollment upon request. In the event of a conflict between this list and the benefit book, the benefit book governs.

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

- **Abortions**, except as stated in the plan
- **Activity Therapy –** Activity therapy and milieu therapy, including community immersion, integration, home independence and work re-entry therapy; and any care intended to assist an individual in the activities of daily living; and any care for comfort and convenience, except for limited hospice benefits
- **Acupuncture**
- **Alternative Medicine –** 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.
  - **Exclusion applies only to group size 1-50.**
  - **For Group size 51+ ASD treatment is not excluded.**
- **Biofeedback and hypnotherapy,** except as may be available through the Behavioral Services Administrator
- **Body Art, Piercing and Tattooing –**and any related complications
- **Certain Types of Facility Charges –** Inpatient and outpatient facility charges for treatment provided by: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes.
- **Charges associated with the preparation, copying or production of health records**
- **Cognitive and Vocational Therapy**
- **Complications of Noncovered Services –** Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under the plan.
- **Computer Speech Training, Therapy Programs and Devices**
- **Cosmetic Services and any Related Complications –** Surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy
- **Counseling –** Counseling and behavioral modification services, except as stated in the plan
- **Court-Ordered Services**
- **Custodial Care**
- **Dental –** Except as stated in the plan
- **Dietary and Nutritional Supplements**
- **Expenses for services that exceed benefit limitations**
- **Experimental or Investigational Services**
- **Fees –** Fees for concierge medicine services
- **Fertility and Infertility Services –** Services to improve or achieve fertility (ability to conceive) or to diagnose and treat infertility (inability to conceive)
- **Flat Feet –** Services for treatment of flat feet, weak feet and fallen arches, except arch supports may be covered when medically necessary for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg
- **Foot Care –** Services for foot care, including trimming of nails or treatment of corns or calluses, except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg
- **Free Services –** Services you receive at no charge or for which you have no legal obligation to pay
- **Genetic and Chromosomal Testing, Screening and Therapy –** for an individual who is asymptomatic, unaffected or not displaying signs or symptoms of a disorder
- **Government Services –** Services provided at no charge to the member through a governmental program or facility
- **Growth Hormone –** Growth hormone, except as specified in the Medical Coverage Guidelines. Growth hormone to treat Idiopathic Short Stature (ISS) is expressly excluded**.**
- **Hearing Services and Devices,** except as stated in the plan
- **Inpatient or Outpatient Long Term Care,** except long-term acute care
- **Lifestyle Education and Management Services,** except as stated in the plan
- **Lodging and Meals –** except as stated in the 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 the plan
- **Manipulations under anesthesia,** except for reductions of fractures and/or dislocations done under anesthesia
- **Marijuana –**Medical marijuana, marijuana and any costs or fees associated with obtaining medical marijuana, even when prescribed and obtained in compliance with state law(s).
- **Massage Therapy –** Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines
- **Medications – Medications which are:**
  - Not FDA approved
  - Not required by the FDA to be obtained with a prescription
  - Not used in accordance with the Medical Coverage Guidelines
  - Used to treat a condition not covered by BCBSAZ
  - Off-label, unlabeled and orphan medications, except as stated in the plan
- **Medications Dispensed in Certain Settings –** Prescription medications given to the member, for the member's future use, by any person or entity that is not a licensed pharmacy, home health agency, specialty pharmacy or hospital emergency room
- **Neurofeedback**
- **Non-Medically Necessary Services**
- **Over-the-Counter Items**
- **Personal Comfort Services**
- **Private Duty Nursing**
- **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
- **Reversal of Sterilization**
- **Screening Tests**
- **Services for Idiopathic Environmental Intolerance**
- **Services for Weight Loss and Gain, except as stated in the plan**
- **Services from a Family Member**
- **Services from Ineligible Providers**
- **Services Paid for By Other Organizations**
- **Services prior to Member's Coverage Effective Date**
- **Services Provided After the Member's Coverage Termination Date,** except as stated in the plan
- **Services Related to or Associated with Noncovered Services**
- **Services Without A Prescription**
- **Sexual Dysfunction –** Services for sexual dysfunction, regardless of the cause, and medications for the treatment of sexual dysfunction

- **Smoking Cessation Programs**
- **Spinal Decompression or Vertebral Axial Decompression Therapy (VAX-D)**
- **Strength Training**
- **Telephonic and Electronic Consultations,** except as stated in the plan
- **Training and Education,** except as stated in the plan
- **Transportation –**and travel expenses, except as stated in the plan
- **Transsexual Treatment, Surgery, Medications and Related Services**
- **Vision –** Vision therapy; eye exercises; all types of refractive keratoplasties including but not limited to radial keratotomy and/or lasik surgery; any other procedures, treatments and devices for refractive correction; eyeglass frames and lenses, contact lenses and other eyewear; vision examinations for fitting of eyeglasses and contact lenses, except as stated in the plan
- **Vitamins**
- **Workers' Compensation –** Illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election