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SCHEDULE PAGE

YOUR BENEFIT BOOK INCLUDES EXCLUSIONS, LIMITATIONS, BENEFIT DESCRIPTIONS, AND DETAILS ABOUT COST SHARING. USE YOUR BENEFIT BOOK TOGETHER WITH THIS SCHEDULE PAGE TO SEE WHICH COST-SHARE TYPES APPLY TO EACH BENEFIT, AND THE AMOUNT OR PERCENTAGE OF YOUR PAYMENT. PLEASE KEEP YOUR CURRENT SCHEDULE PAGE WITH YOUR BENEFIT BOOK.

EFFECTIVE DATE OF THIS COVERAGE: 07/01/2010

BENEFIT PLAN MAXIMUM \$5,000,000

DESCRIPTION	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE (PER MEMBER)	\$750	\$1,500
ANNUAL FAMILY DEDUCTIBLE MAXIMUM	\$1,500	\$3,000
COVERED PERCENTAGE	80%	60%
CALENDAR-YEAR OUT-OF-POCKET COINSURANCE MAXIMUM PER MEMBER*	\$3,000	\$5,000
CALENDAR-YEAR OUT-OF-POCKET COINSURANCE MAXIMUM PER FAMILY*	\$6,000	\$10,000
PHYSICIAN OFFICE SERVICES - PCP IN-NETWORK: COPAY PER MEMBER, PER PROVIDER, PER DAY	\$35	
OUT-OF-NETWORK: COVERED PERCENTAGE		60%
PHYSICIAN OFFICE SERVICES - SPECIALIST IN-NETWORK: COPAY PER MEMBER, PER PROVIDER, PER DAY	\$45	
OUT-OF-NETWORK: COVERED PERCENTAGE		60%
LABORATORY SERVICES IN A PHYSICIAN'S OFFICE, PLAN PAYS 100% PHYSICIAN OFFICE VISIT COPAY IS WAIVED IF THE ONLY SERVICES RECEIVED DURING THE VISIT ARE LABORATORY SERVICES. AT CONTRACTED, FREESTANDING, INDEPENDENT CLINICAL LABS, PLAN PAYS 100% FOR COVERED SERVICES, DEDUCTIBLE AND COINSURANCE WAIVED. AT ALL OTHER FACILITIES, DEDUCTIBLE AND COINSURANCE APPLY. OUT-OF-NETWORK: COVERED PERCENTAGE AFTER MEETING DEDUCTIBLE		60%
URGENT CARE ** IN-NETWORK: COPAY PER MEMBER, PER PROVIDER, PER DAY	\$75	
OUT-OF-NETWORK: COVERED PERCENTAGE		60%
PRECERTIFICATION CHARGE PER HOSPITAL ADMISSION (IF PRECERTIFICATION IS NOT OBTAINED)***	\$300	\$300

EMERGENCY ROOM ACCESS FEE (PER MEMBER, PER PROVIDER, PER DAY; ACCESS FEE IS IN ADDITION TO IN-NETWORK DEDUCTIBLE AND COINSURANCE)	\$150	\$150
AMBULANCE COVERED PERCENTAGE DEDUCTIBLE WAIVED	80%	80%
BARIATRIC SURGERY ACCESS FEE (ACCESS FEE IS IN ADDITION TO DEDUCTIBLE AND COINSURANCE)	\$1,000	\$1,000
CHIROPRACTIC: IN-NETWORK: (COPAY PER MEMBER, PER PROVIDER, PER DAY) FOR MOST COVERED SERVICES PROVIDED IN A CHIROPRACTIC OFFICE. 80% FOR OTHER COVERED SERVICES, AFTER MEETING DEDUCTIBLE LIMITED TO 12 VISITS PER PER PERSON, PER CALENDAR YEAR.	\$45	
OUT-OF-NETWORK: COVERED PERCENTAGE AFTER MEETING DEDUCTIBLE. LIMITED TO 12 VISITS PER PERSON, PER CALENDAR YEAR.		60%
RETAIL MEDICATIONS IN-NETWORK: COPAY BASED ON LEVEL		
LEVEL 1 COPAY	\$7	
LEVEL 2 COPAY	\$30	
LEVEL 3 COPAY	\$50	
LEVEL 4 COPAY	\$100	
OUT-OF-NETWORK: COPAY PLUS BALANCE BILL		
MAIL ORDER MEDICATIONS IN-NETWORK: COPAY BASED ON LEVEL		
LEVEL 1	\$14	
LEVEL 2	\$60	
LEVEL 3	\$100	
LEVEL 4	\$200	
OUT-OF-NETWORK: NOT COVERED		
SPECIALTY SELF-INJECTABLE MEDICATIONS AT CONTRACTED SPECIALTY PHARMACY IN-NETWORK: COPAY BASED ON LEVEL		
LEVEL A COPAY	\$30	
LEVEL B COPAY	\$60	
LEVEL C COPAY	\$90	
LEVEL D COPAY	\$120	
OUT-OF-NETWORK: NOT COVERED		
BEHAVIORAL SERVICES ADMINISTRATOR (BSA) (COPAY PER MEMBER PER VISIT) BSA SERVICES AVAILABLE ONLY IN ARIZONA	\$15	

\*COINSURANCE PAYMENTS ARE BASED ON THE ALLOWED AMOUNT, AFTER DEDUCTIONS FOR ANY ACCESS FEES AND PRECERTIFICATION CHARGES. COINSURANCE IS NOT BASED ON A PROVIDER'S BILLED CHARGES. ONLY THE PORTION OF COINSURANCE PAID BY THE MEMBER, AS BASED ON THE ALLOWED AMOUNT, WILL ACCUMULATE TOWARDS THE OUT-OF-POCKET COINSURANCE MAXIMUM. MANY COST SHARE PAYMENTS DO NOT COUNT TOWARD THE OUT-OF-POCKET MAXIMUM, INCLUDING: DEDUCTIBLES, COPAYS, ACCESS FEES, CERTAIN OTHER CHARGES AMOUNTS PAID FOR NONCOVERED SERVICES, AND NONCONTRACTED PROVIDERS' BALANCE BILLS. TO DETERMINE WHETHER A SPECIFIC COST SHARE PAYMENT COUNTS TOWARD THE MAXIMUM, REFER TO THE BENEFIT BOOK. A MEMBER MUST CONTINUE TO PAY ALL THESE COST SHARE AMOUNTS EVEN AFTER MEETING THE MAXIMUM.

\*\*THE URGENT CARE COPAY APPLIES ONLY AT FACILITIES SPECIFICALLY CONTRACTED AS URGENT CARE FACILITY PROVIDERS. IN-NETWORK HOSPITALS AND HOSPITAL CLINICS ARE NOT CONTRACTED AS URGENT CARE FACILITIES.

\*\*\*THIS CHARGE APPLIES ONLY WHEN PRECERTIFICATION IS NOT OBTAINED FOR AN INPATIENT ADMISSION; WAIVED FOR EMERGENCIES AND MATERNITY. THERE ARE OTHER BENEFITS WHICH REQUIRE PRECERTIFICATION; LACK OF PRECERTIFICATION CAN RESULT IN LOSS OF BENEFITS. PLEASE SEE "PRECERTIFICATION" IN YOUR BENEFIT BOOK.

#### OTHER INFORMATION

THE IN-NETWORK OUT-OF-POCKET COINSURANCE MAXIMUM AND OUT-OF-NETWORK OUT-OF-POCKET COINSURANCE MAXIMUM ACCUMULATE SEPARATELY.

NONCONTRACTED PROVIDERS MAY CHARGE MEMBERS THEIR FULL BILLED CHARGES. AFTER INSURANCE REIMBURSEMENT BASED ON THE ALLOWED AMOUNT, LESS ANY DEDUCTION FOR THE MEMBER'S COST SHARE PORTION, MEMBERS ARE RESPONSIBLE TO PAY THE BALANCE BILL. THE OBLIGATION TO PAY THE BALANCE BILL CONTINUES EVEN AFTER THE MEMBER'S OUT-OF-POCKET COINSURANCE MAXIMUM IS MET.

BCBSAZ APPLIES LIMITATIONS TO CERTAIN PRESCRIPTION MEDICATIONS OBTAINED THROUGH THE RETAIL AND MAIL ORDER PHARMACY BENEFIT. A LIST OF THESE MEDICATIONS AND LIMITATIONS IS AVAILABLE ONLINE AT AZBLUE.COM OR BY CALLING BCBSAZ. THESE LIMITATIONS INCLUDE, BUT ARE NOT LIMITED TO, QUANTITY, AGE AND GENDER LIMITATIONS. BCBSAZ PRESCRIPTION MEDICATION LIMITATIONS ARE SUBJECT TO CHANGE AT ANY TIME WITHOUT PRIOR NOTICE.

#### NOTICE OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

IF YOU HAVE HAD OR ARE GOING TO HAVE A MASTECTOMY, YOU MAY BE ENTITLED TO TO CERTAIN BENEFITS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA). FOR INDIVIDUALS RECEIVING MASTECTOMY-RELATED BENEFITS, COVERAGE WILL BE PROVIDED IN A MANNER DETERMINED IN CONSULTATION WITH THE ATTENDING PHYSICIAN AND THE PATIENT, FOR: 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; PROSTHESES; AND TREATMENT OF PHYSICAL COMPLICATIONS OF THE MASTECTOMY, INCLUDING LYMPHEDEMA.

THESE BENEFITS ARE SUBJECT TO THE SAME DEDUCTIBLES AND COINSURANCE APPLICABLE TO OTHER MEDICAL AND SURGICAL BENEFITS PROVIDED UNDER YOUR BENEFIT PLAN, AS DESCRIBED ABOVE ON THIS SCHEDULE PAGE.

IF YOU WOULD LIKE MORE INFORMATION ON WHCRA BENEFITS, PLEASE REFER TO YOUR BENEFIT PLAN BOOKLET, TALK TO YOUR GROUP BENEFIT ADMINISTRATOR OR CALL THE CUSTOMER SERVICE NUMBER LISTED ON THE BACK OF YOUR BLUE CROSS BLUE SHIELD OF ARIZONA ID CARD.

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PPO \$750 BASE PLAN  
Effective 07/01/2010