

HIGH DEDUCTIBLE HEALTH PLAN
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
ANNUAL DEDUCTIBLE* (SELF-ONLY)	\$1,250
ANNUAL FAMILY DEDUCTIBLE* MAXIMUM	\$2,500

DESCRIPTION	IN-NETWORK	OUT-OF-NETWORK
COVERED PERCENTAGE	80%	60%
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM PER MEMBER**	\$4,000	\$6,000
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM PER FAMILY**	\$8,000	\$12,000
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)	\$100	\$100
AMBULANCE COVERED PERCENTAGE	80%	80%
BARIATRIC SURGERY ACCESS FEE (ACCESS FEE IS IN ADDITION TO DEDUCTIBLE AND COINSURANCE)	\$1,000	\$1,000

*DEDUCTIBLE MUST BE MET FOR ALL COVERED SERVICES UNLESS OTHERWISE STATED IN YOUR BENEFIT BOOK. UNLESS OTHERWISE STATED, SELF-ONLY DEDUCTIBLE MUST BE MET ON ONE-PERSON POLICIES AND FAMILY DEDUCTIBLE MUST BE MET ON FAMILY POLICIES BEFORE BCBSAZ WILL BEGIN TO PAY FOR COVERED SERVICES.

** 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 DEDUCTIBLE AND THE PORTION OF COINSURANCE PAID BY THE MEMBER, AS BASED ON THE ALLOWED AMOUNT, WILL ACCUMULATE TOWARDS THE OUT-OF-MAXIMUM. PRECERTIFICATION CHARGES, AMOUNTS PAID FOR NONCOVERED AND NONCONTRACTED PROVIDERS' BALANCE BILLS DO NOT COUNT TOWARD MEETING THE OUT-OF-POCKET MAXIMUM. A MEMBER MUST CONTINUE TO PAY ALL THESE COST SHARE AMOUNTS EVEN AFTER MEETING THE MAXIMUM.

***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 MAXIMUM AND OUT-OF-NETWORK OUT-OF-POCKET 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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HDHP \$1,250
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