BLUECHOICE DISCLOSURE FORM
Blue Cross and Blue Shield of Arizona

PLEASE READ THIS NOTICE CAREFULLY. THIS NOTICE CONTAINS IMPORTANT INFORMATION YOU SHOULD KNOW BEFORE YOU ENROLL.

This Disclosure Form is only a summary. The Benefit Plan Booklet should be consulted to determine governing contractual provisions.

A. PRIMARY CARE PHYSICIANS ROSTER

A primary care provider (PCP) is a physician who specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, pediatrics, (certain pediatric specialists, e.g., pediatric cardiologists, pediatric allergists and pediatric surgeons are classified as specialists) and any other classification of provider approved as a PCP by BCBSAZ.

The BlueChoice HMO benefit plans do not require the use of a PCP, although subscribers are advised to establish a relationship with a PCP to coordinate care. Provider directories for primary care physicians and specialists are available to employer groups. An HMO provider directory is attached to this document.

B. PREMIUM

1. **State the full premium cost of the plan:** Refer to the attached Premium Rate Information Sheet for full premium cost of the benefit plan.

2. **State any reservations by the Company to change premium and any factors that may affect changes in premium:** Refer to the attached Premium Rate Information Sheet for full premium cost of the benefit plan.

3. State the minimum employer contribution and group participation rules: Refer to the attached Premium Rate Information Sheet.

C. HOW AND WHERE TO OBTAIN SERVICES

1. **Where and in what manner an enrollee may obtain services including the procedure for selecting or changing Primary Care Physicians:** BlueChoice benefit plans have a network of hospitals and other health care providers who are contracted with BCBSAZ to provide health services to HMO members. Except for emergency services, covered services must be rendered by network providers. The subscriber is responsible for any copayment, access fee, or coinsurance amounts that apply to his/her benefit plan. The subscriber is responsible for verifying that a provider is an HMO network provider. A provider directory is enclosed with this form or you can refer to the BCBSAZ web site, azblue.com, for our online provider directory.

   A subscriber is not required to choose a PCP to receive covered services, but BCBSAZ recommends subscribers establish a relationship with a PCP.

A PCP can become familiar with the subscriber's personal and family health history, and assist with coordination of care.

Referrals to Non-HMO Providers

BCBSAZ does not guarantee that every specialist or facility will be represented in the HMO network. Not all specialists or facilities will agree to contract with health insurance plans.

When there is no HMO network specialist of facility available to provide covered services, BCBSAZ may precertify the in-network level of benefits for services rendered by an out-of-network provider. This precertification is separate from any precertification already required for a particular procedure or service. For the subscriber to receive the in-network level of benefits, the subscriber's treating provider must obtain precertification from BCBSAZ for both the procedure or service and for the in-network level of benefits prior to a subscriber receiving services from an out-of-network provider. If services are precertified, expenses for covered services will be paid as if received from an in-network provider. If BCBSAZ does not precertify the out-of-network services, the services are not covered.

Continuing Physician Care from a Non-Network Physician (MD or DO)

If a subscriber new to BCBSAZ has a life-threatening disease or condition, or is in the third trimester of pregnancy on the date coverage becomes effective, the subscriber may continue an active course of treatment with the non-network physician in Arizona for a specific transitional period – thirty (30) days from the effective date of coverage in the case of a life-threatening disease or condition or, in the case of pregnancy, until delivery and for any care related to the delivery for up to six (6) weeks from the delivery date.

If BCBSAZ terminates a physician from the contracted network, except for reasons of medical incompetence or unprofessional conduct, a subscriber with a life-threatening disease or condition, or who is in the third trimester of pregnancy as of the effective date of the physician's termination, may continue an active course of treatment with the non-network physician in Arizona for a specific transitional period – thirty (30) days from the termination date in the case of a life-threatening disease or condition or, in the case of pregnancy, until delivery and for any care related to the delivery for up to six (6) weeks from the delivery date.

To obtain the above coverage, the subscriber's physician must agree in writing to accept the BCBSAZ allowed amount applicable to covered services provided by a network physician, subject to the coinsurance and copayment requirements of the benefit plan, comply with BCBSAZ's quality assurance and utilization review procedures, provide to BCBSAZ any necessary medical information related to the subscriber's care, and comply with BCBSAZ policies and procedures, including precertification, network referrals and claims processing, as applicable.

Services provided during an approved transitional period must be covered services under this benefit plan. Payment for covered services rendered during the continuity of care period will be paid at the in-network level of benefits described in the benefit plan, subject to applicable coinsurance and/or copayments. Services rendered during the continuity of care period are also subject to all other applicable provisions of the benefit plan,

including waiting periods, limitations, exclusions, and waivers or benefit maximums. Continuity of care applies only to out-of-network physician services. If the hospital at which the physician practices is not part of the BlueSelect network, the hospital services will not be covered.

To request continuity of care, a subscriber may contact BCBSAZ at 602-864-5841 or 1-800-232-2345, ext 5841.

2. **Whether services received outside of Arizona are covered and in what manner the services are covered:** HMO subscribers have coverage outside of Arizona in the case of an emergency or accident or through BlueCard Access for urgent and follow-up care only. To obtain the name of an HMO provider in another state through BlueCard Access, a subscriber can call BlueCard Access at 1-800-810-BLUE (2583) or by visiting the BlueCard Doctor and Hospital finder online at bcbs.com to be directed to a BCBS network provider. When the subscriber receives any urgent or follow-up care from a BlueCard provider, no claim forms are required. Covered services are subject to the usual out-of-pocket expenses (copayment, coinsurance). Precertification requirements and other benefit plan limitations apply to services received outside of Arizona. If precertification is required prior to receiving services, the subscriber is responsible for making sure the provider obtains precertification. When necessary precertification is not obtained, benefits may be denied.

3. **The locations of contracted hospitals and outpatient treatment centers:** Please see the HMO Provider Directory or consult our web site at azblue.com

4. **Map or list of areas served:** The BCBSAZ HMO network covers the state of Arizona. Please see the HMO Provider Directory for a list of locations of network providers.

D. PRE-AUTHORIZATION AND REFERRAL PROCEDURES

1. **The procedures an enrollee must follow to obtain prior authorization, if any, for services:** Precertification is required under the BlueChoice plan for certain services. Where precertification is required, the provider must call BCBSAZ to get precertification prior to service or treatment. The provider must call because he/she has the information and medical records BCBSAZ needs to make a benefits determination. The subscriber is responsible, however, for making sure the provider obtains precertification where required. Precertification is not a pre-approval or a guarantee of payment. Precertification made in error by BCBSAZ does not constitute a waiver of any right of BCBSAZ to deny payment for non-covered services. If precertification is not obtained when required, payment for the services may be denied.

2. **The procedures to be followed by the enrollee for consulting a physician other than the primary care physician:** BlueChoice subscribers are not required to get a referral from a PCP prior to seeing an in-network specialist. The specialist must be an eligible network provider as defined by BCBSAZ for covered services. A specialist office visit copay is higher than a PCP office visit copay. Please refer to the provider directory or the BCBSAZ web site for our online provider directory at azblue.com. Precertification is

required for covered services from an out-of-network specialist. Subscribers must follow the precertification procedure described above.

3. **Whether the enrollee's physician, the company's medical director or a committee must first authorize the referral:** Authorization of a referral to a specialist by BCBSAZ is only necessary when precertification is requested for covered services provided by an out-of-network specialist.

4. **The necessity of repeating prior authorization if the specialist care is continuing:** Not required.

5. **The circumstances under which the company may retroactively deny coverage for non-emergency treatment that had prior authorization under the company's written policies:** Precertification is the process BCBSAZ uses to determine eligibility for the requested procedure or service. At the time precertification is requested, 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 (waiting periods, limitations, exclusions, waivers, benefit maximums). Some of these provisions may not be readily identifiable at the time precertification is given, but they will still apply if discovered later in the claim process after services have been provided. Some procedures or treatments as specified by BCBSAZ, are also reviewed during the precertification process for medical necessity, according to BCBSAZ's periodic evaluation of clinical standards and other medical information. Precertification is not a pre-approval or a guarantee of payment. Precertification made in error by BCBSAZ does not constitute a waiver of any right of BCBSAZ to deny payment for non-covered services.

6. **Whether a Point of Service option is available and how it is structured:** BCBSAZ no longer offers Point of Service options to employer groups.

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 company provides twenty-four hour emergency services:** Benefits are available for covered services for an accident or emergency 24 hours a day.

3. **Procedures for emergency room, nighttime or weekend visits and referrals to a specialist physician:** Subscribers should proceed to the nearest emergency room or call 911 if emergency services are needed. No referrals are necessary. Initial treatment of an emergency is subject to the emergency access fee. Benefits for covered services received subsequent to initial emergency treatment are paid the same as non-emergency covered services. If subsequent services are received from a non-HMO provider, coverage will be denied, unless precertification has been approved for those services. Follow-up services must be provided by an HMO network provider. The subscriber should check the physician's or other provider's participation or network status with BCBSAZ or by checking the web site at azblue.com.

4. **The circumstances under which the company may retroactively deny coverage for emergency medical treatment that had prior authorization under the company's written policies:** BCBSAZ does not require precertification or prior authorization of emergency medical treatment.

F. PRESCRIPTION MEDICATIONS

1. **Whether the company physician is restricted to prescribing medications from a company list or company formulary:** BCBSAZ has no "company" physicians. Providers rendering services to BCBSAZ subscribers are not limited to a prescription medication formulary. Benefits for prescription medications are based upon whether the medication is covered under the benefit plan and its status on one of several cost sharing levels at the time the prescription is filled. Medications may change cost-sharing levels without notice.

2. **The extent to which an enrollee will be reimbursed for the costs of a medication that is not on the company list or company formulary:** Most medications covered under the benefit plan are included on one of the cost sharing levels and certain medications may require precertification. Some medications can only be obtained from a home health agency or specialty pharmacy. Benefits for prescription medications are based upon whether the medication is covered under the benefit plan and its status on one of the cost sharing levels at the time the prescription is filled. Medications may change cost sharing levels without notice.

   Prescriptions dispensed by pharmacies outside the U.S. are covered only when they are prescribed for an urgent or emergent medical situation while the subscriber is traveling outside of the U.S.

   Limitations apply to certain prescription medications obtained through the retail and mail order pharmacy benefit. 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.

   A per-copayment quantity limitation applies to certain prescription medications. These prescriptions will be subject to an additional copay each time the quantity limitation is exceeded. A process is available to subscribers and providers for requesting a review by BCBSAZ for coverage of a medication when the use of the medication exceeds or conflicts with BCBSAZ prescription medication limitations. There is no guarantee that requesting a review will result in coverage of a medication or an increase in quantity.

   Prescription Medications for the Treatment of Cancer: Arizona law requires coverage for off-label use of prescription medications and medically necessary services directly associated with the physical/actual administration of the prescription medications for the treatment of cancer. "Off-label prescription medication" for purposes of this provision means the medication a physician prescribed for the treatment of cancer has not been approved by the FDA for that specific medical condition and the medication meets all of the requirements set forth in Arizona law.

Claims for an off-label prescription medication will be processed and out-of-pocket expense calculated as any other eligible prescription medication based on where and by whom the medication is dispensed/administered. All other applicable benefit limitations and exclusions will apply.

G. GRIEVANCE PROCEDURES/APPEALS PROCESS

Grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care and access to care issues:

Subscribers and their treating providers may participate in the appeal process, which is described in detail in the Health Coverage Appeal Information Packet, a separate document provided to you. You may request an additional copy of the Health Coverage Appeal Information Packet from BCBSAZ at any time by contacting the BCBSAZ Supply Line. Below is a summary of those issues that can be appealed, and those that are not subject to the appeal process but can be reviewed through the BCBSAZ Grievance Process.

You Can Appeal the Following Decisions:

1. BCBSAZ does not approve a service that you have or your treating provider has requested, but that you have not yet received.
2. BCBSAZ does not pay for a service that you have already received.
3. BCBSAZ does not authorize a service or pay for a claim because it is not "medically necessary".
4. BCBSAZ does not authorize a service or pay for a claim because it is not covered under your insurance policy, and you believe it is covered.
5. BCBSAZ does not authorize a referral to a specialist.
6. Where preauthorization for a service is required by your benefit plan, BCBSAZ does not approve or deny your preauthorization request within ten (10) business days.

Under Arizona Law, You Cannot Appeal the Following Decisions:

Although the items listed below are not appealable under state law, you and/or your authorized representative may have the right to appeal some of the following types of decisions under federal law or the right to submit a grievance through the BCBSAZ Grievance Process. Please consult the section entitled "Additional Federal Rights for Groups Plans" for additional information regarding your appeal rights under federal law and/or the section entitled "Grievance Process".

1. You disagree with BCBSAZ's decision as to the amount of the BCBSAZ allowed amount.
2. You disagree with how BCBSAZ is coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how BCBSAZ has applied your claims to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with BCBSAZ's decision upon completion of a possible nondisclosure investigation.
6. You are dissatisfied with any rate increases you may receive under your insurance.
7. You believe BCBSAZ has violated any other parts of the Arizona Insurance Code.

Additional Federal Rights for Group Plans (Excluding Government Plans and Church Plans)

Levels 2 and 3 of Expedited Appeals and Standard Appeals and Level 2 of the Grievance Process are voluntary. If you choose to participate in Levels 2 or 3 of the Appeals Process or Level 2 of the Grievance Process, BCBSAZ will waive its right to assert that you have failed to exhaust administrative remedies. Any statute of limitations defense or other defenses based on timeliness will be stopped while your voluntary appeal or grievance is pending.

No fees or costs may be imposed upon you as part of any voluntary level of appeal or grievance. You also have the right to request the following information from BCBSAZ before deciding to submit your claim to Levels 2 & 3: (1) information about applicable rules of Levels 2 and 3, (2) your right to representation, (3) the process for selecting the decision maker, and (4) circumstances that may affect the impartiality of the decision maker, if any. If you wish to receive this information, please call or write to the following address and telephone number:

Dispute Resolution Coordinator
Formal Appeal A109
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85003-3466
Phone: (602) 864-5630
Fax: (602) 864-5858

You will have the opportunity to submit written comments, documents, or other information in support of your appeal or grievance, and you will have access to all documents that are relevant to your claim. Your appeal or grievance will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your appeal involves a medical judgment question, BCBSAZ will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, BCBSAZ will provide you with the identification of any medical expert whose advice was obtained on behalf of the plan in connection with your appeal.

These Appeal & Grievance rights are in addition to your rights to challenge BCBSAZ's decision in court including, but not limited to bringing legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). You and your ERISA plan may have other voluntary alternative dispute resolution options in addition to the Appeals and Grievance Processes described in the benefit plan booklet, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office. You may also be able to obtain information from your group benefits administrator.

Levels of Appeal

There are two types of appeals: (1) Expedited Appeal for urgent matters, and (2) Standard Appeal. Each type of appeal has three levels of review. The Expedited Appeals operate similarly to Standard Appeals, except that Expedited Appeals are processed much faster because of the patient's condition.

Expedited Appeal (for urgently needed services you have not yet received)	**Standard Appeal** (for non-urgent services or denied claims)
Level 1 – Expedited Medical Review Level 2 – Expedited Appeal Level 3 – Expedited External Independent Review	Level 1 – Informal Reconsideration Level 2 – Formal Appeal Level 3 – External Independent Review

Expedited Appeal

1. **Level 1 – Expedited Medical Review**

The first level of Expedited Appeal is Expedited Medical Review, which is available only when BCBSAZ or the behavioral services administrator (BSA) denies a request for a covered service that has not yet been provided (a precertification request). Expedited Medical Review requires your physician to certify orally or in writing that proceeding with the Standard Appeal process (Informal Reconsideration, Formal Appeal and External Independent Review) could seriously jeopardize your life, health or ability to regain maximum function or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. BCBSAZ or the BSA must notify you of its decision regarding an Expedited Medical Review as soon as possible in accordance with medical exigencies, but no later than one (1) business day.

In the event of a three or four day holiday weekend, BCBSAZ will notify you of its decision as soon as possible in accordance with medical exigencies, but no later than 72 hours after we receive your appeal request. For this Level 1 appeal, issues related to services provided by the BSA are handled by the BSA. If a service is denied, the BSA will process the Expedited Medical Review.

Level 2 – Expedited Appeal

An Expedited Appeal is available when; following an Expedited Medical Review, BCBSAZ or the BSA affirms a denial of a request for a covered service not yet provided (precertification request). To request an Expedited Appeal, immediately following the Expedited Medical Review, your treating provider will be required to submit to BCBSAZ a written appeal regarding the denial of the requested service not yet provided. BCBSAZ will notify you of its decision regarding an Expedited Appeal within three (3) business days.

Level 3 – Expedited External Independent Review

You may request an Expedited External Independent Review if, at the Expedited Medical Review and Expedited Appeal level, BCBSAZ affirms a denial of a request for a covered service not yet provided (precertification request). For cases involving coverage issues, the Arizona Department of Insurance (ADOI) must issue a decision within two (2) business days. For cases involving issues of medical necessity, the ADOI will select an Independent Review Organization (IRO), which will have five (5) business days to issue a decision.

Standard Appeal

Level 1 – Informal Reconsideration

If you are not eligible to participate in the Expedited Appeal process and wish to appeal the denial of a request for a covered service not yet provided (precertification request) or a denial of a claim for a service already provided, you may request an Informal Reconsideration. BCBSAZ or the BSA must notify you of its decision within thirty (30) days.

For this Level 1 appeal, issues related to services provided by the BSA are handled by the BSA. If a service is denied, the BSA will provide you with information on the Level 1 process applicable to its services.

Level 2 – Formal Appeal

You may proceed to a Formal Appeal if a denial is upheld by BCBSAZ or the BSA at the Informal Reconsideration level. BCBSAZ must notify you of its decision within thirty (30) days for an appeal of a covered service not yet provided (precertification request) and sixty (60) days for an appeal of a claim for a service already provided.

Level 3 – External Independent Review

You are not responsible for the costs of any External Independent Review.

You may request an External Independent Review following an Informal Reconsideration and Formal Appeal. For appeals involving medical necessity issues, the ADOI must select an Independent Review Organization (IRO), which has twenty-one (21) days to issue a decision regarding your appeal. For cases involving coverage issues, the ADOI must issue a decision within fifteen (15) business days.

If the ADOI finds that your appeal involves a medical issue, or if the ADOI is unable to determine issues of coverage, it must submit your case to an IRO.

Grievance Process

If you cannot resolve one of the issues that is not subject to the Appeal Process, you may direct a complaint or reconsideration request to BCBSAZ. Your complaint or reconsideration request must be made to BCBSAZ within one (1) year of the occurrence. These time limits may be extended by BCBSAZ in its sole and absolute discretion for good cause. Examples of good cause include a death in the immediate family or serious illness of you or someone in your immediate family. Good cause does not include travel for any reason other than death or serious illness, as noted.

BCBSAZ will then review the situation, including any new information brought to our attention. You will be notified of BCBSAZ's decision within thirty (30) days of receipt for pre-service issues and within sixty (60) days of receipt for claims and other post service issues.

The 30 or 60-day limit may be extended if necessary and in accordance with applicable law, and you will be notified if for any reason the 30 or 60-day time period will not be met.

If you do not find BCBSAZ's decision satisfactory, you may send a written grievance to BCBSAZ. The grievance must be filed within sixty (60) days of receiving BCBSAZ's decision regarding your complaint or reconsideration request. The written grievance must state your reason for the grievance, including the reason for dissatisfaction with the initial decision, and any additional information for review.

BCBSAZ will generally review your grievance and you will then be notified of BCBSAZ's final decision within sixty (60) days of the date BCBSAZ received your grievance.

H. COMPANY PROVIDER REQUIREMENTS AND COMPENSATION

Whether company 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. Whether the company 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 provider arrangements have no specific criteria, incentives or penalties intended to encourage providers to withhold any types of services or referrals to specialists. There are no requirements related to specific numbers, targeted averages or maximum durations of patient visits set forth in any of these arrangements.

BCBSAZ has negotiated varied reimbursement methods with network providers. BCBSAZ network providers have generally agreed to accept the lesser of billed charges or the BCBSAZ fee schedule, including any contractual arrangements. The BCBSAZ fee schedule for professional services is referred to as the Prevailing Fee. The BCBSAZ fee schedule for inpatient services is referred to as the Diagnosis Related Grouping (DRG). A DRG is a category of diagnoses or procedures used to reimburse hospitals specific dollar amounts depending on the category of reason for admission (diagnosis) or treatment (procedure). Some institutional providers are paid on a per diem basis.

All network providers are independent contractors and not employees, agents, or representatives of BCBSAZ. These independent providers have an agreement with BCBSAZ concerning reimbursement and administrative policies. Each medical provider exercises independent judgment. BCBSAZ's role is limited to administration of the benefits under this plan. A provider may recommend services or treatment not covered under the benefit plan. Whether to proceed with the service or procedure if benefits have been denied by BCBSAZ is an issue to be decided between a subscriber and his/her provider.

For many of its benefit plans, BCBSAZ contracts with a Behavioral Services Administrator (BSA) for inpatient and outpatient behavioral and mental health services. BCBSAZ pays a capitated amount per subscriber per month to the BSA. An additional specified amount per subscriber per month is placed into an inpatient risk fund from which inpatient claims are paid by BCBSAZ for services that have been approved by the BSA. The BSA makes medical necessity determinations for certain inpatient and outpatient mental health services based on its own medical necessity criteria. After reconciliation of the fund and claims paid, the BSA is responsible for 100% of any excess claims payment over the amount funded. If the amount funded exceeds claims paid, the

BSA is entitled to 100% of that excess. BCBSAZ provides the provider with data that reports the status of the fund.

Chiropractic Services

BCBSAZ contracts with a chiropractic services administrator to provide the chiropractic services covered under this benefit plan. BCBSAZ pays a capitated amount per subscriber, per month to the chiropractic services administrator.

Prescription Medication Rebates

BCBSAZ enters into contracts with pharmaceutical manufacturers to receive rebate payments based on the volume and/or market share of pharmaceutical products utilized by BCBSAZ subscribers. These rebate contracts are subject to renegotiation and/or termination from time to time at BCBSAZ's sole discretion. BCBSAZ's rebate contracts with pharmaceutical manufacturers generally work as follows: BCBSAZ submits data regarding utilization of specific medication(s) to the pharmaceutical manufacturer. The pharmaceutical manufacturer compares the data to the utilization level and/or market share required by the applicable rebate contract. If the utilization and/or market share meets the requirements of the rebate contract, the manufacturer issues a rebate payment to BCBSAZ. As utilization and/or market share increases, the amount of the rebate payable to BCBSAZ increases.

Rebates may be paid on medications that are covered under BCBSAZ retail and mail order pharmacy benefits. The BCBSAZ Pharmacy and Therapeutics Committee (P&T) decides which medications to place on the tiered pharmacy and specialty self-injectable medication levels. The P&T Committee is comprised of pharmacists, BCBSAZ employees, and other members as needed. The community physician members of the P&T are not informed of potential rebate contracts or rebate payments when deciding which medications to place on various cost sharing levels of the pharmacy benefit. Certain BCBSAZ employees are aware of the potential rebate contracts or rebate payments. P&T Committee decisions are not binding and can be overridden by BCBSAZ. Network providers are not aware of the rebate potential of a specific medication when it is prescribed.

Rebates BCBSAZ receives are not reimbursable to subscribers or providers. BCBSAZ retains the rebates as part of its overall compensation pursuant to its contract with employer groups. The rebates reduce BCBSAZ's costs and assist in limiting premium increases. Rebates received by BCBSAZ may result in the overall cost of a particular medication falling below the amount subscribers pay for such medication. Other discount programs offered by a pharmacy may result in members of the public paying a lower cost for some medications than you pay under this benefit plan.

The above does not apply to certain employer groups with alternative funding arrangements. For those eligible large groups, rebates are returned to the employer.

I. EXPLANATION OR JUSTIFICATION FOR USE OF INCENTIVES AND PENALTIES

Not Applicable.

J. DESCRIPTION OF BENEFITS – RENEWABILITY OF COVERAGE

1. **Whether services outside the plan are covered and in what manner they are covered:** Description of Benefits: See attached Benefit Summary for a description of benefits and cost sharing amounts. See also above response in Section C.2. Covered services are the services described as covered in the benefit plan booklet when performed by eligible providers within the scope of their practice, not excluded, precertified where precertification is required, and which are medically necessary as determined by BCBSAZ. Services provided in excess of a benefit maximum are not covered.

2. **In concise and specific terms, any copayment, coinsurance or deductible requirements that an enrollee or enrollee's family may incur in obtaining coverage under the plan**: See attached Benefit Summary for cost sharing amounts. Additional information is also available in the Benefit Plan Booklet provided at enrollment or prior to enrollment upon request.

3. **The health care benefits to which an enrollee would be entitled:** See attached Benefit Summary for a description of benefits and cost sharing amounts. Benefits of this plan are available only for covered services received while this benefit plan is in effect and the subscriber claiming benefits is eligible for coverage under this benefit plan and the group's contract with BCBSAZ. Benefits may be modified during the term of the plan as specifically provided under the terms of the group contract. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply to covered services processed on or after the effective date of the modification. There is no vested right to receive the benefits of the benefit plan.

4. **Renewability of coverage:** The group master contract controls the administration of the group coverage. Coverage terminates when the group master contract terminates. The group must renew the contract each year in order for coverage to continue. Failure of the group to return the Rate Acceptance Form, Intent to Renew or other required form, on or before the last day of the current contract will be deemed a rejection of an offer to renew the group master contract and the contract will terminate as of the date specified in the contract.

   It is the responsibility of the group to notify employees/dependents in the event that the group terminates the group master contract or if the group master contract is terminated for non-payment of premiums. BCBSAZ will notify employees if the group master contract is terminated for any other reason.

   BCBSAZ may terminate its contract with the group immediately at any time only for the reasons set forth in the Group Master Contract.

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 exclusions or limitations or any affiliation period requirements: Benefit plan limitations and exclusions, including any waiting period for pre-existing conditions, are listed on the attached Benefit Summary and Prescription

Medication Guide, if applicable and in the benefit plan booklet provided at enrollment or prior to enrollment upon request.