2015 SCHEDULE OF MEDICAL BENEFITS

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Deductible • The amount you must pay each calendar year before the Plan pays benefits. • The family deductible applies if you are covering one or more dependents.	• All covered services from providers are combined to meet your annual deductible amount. • The deductible applies to all benefits in this schedule including outpatient prescription drugs except where stated otherwise.	None			None			In-Network $1,500 Single $3,000 Family Out-of-Network $2,500 Single $5,000 Family		
Health Savings Account (HSA) • SLHN will match your per pay period contributions up to $31.25 for single and $62.50 for family into your HSA on your behalf if you are making contributions and enrolled in the HSA Plan. Contributions will cease once you no longer are an active participant in the health plan.	• The per pay period contribution will be prorated to newly eligible participants, not to exceed the annual contribution of $750 for single or $1,500 for family.	None			None			SLHN annual contribution amount to your Health Savings Account $750 Single $1,500 Family		
Out-of-Pocket Maximum • The maximum amount of co-pays and coinsurance you are responsible for each calendar year before the Plan pays 100% of your covered eligible medical expenses. Includes deductibles and prescription drug costs.	• Some out-of-pocket expenses do not apply to this maximum. Refer to the Medical Expense Benefits and Networks chapter for details. • **Coordinated Care and Standard Plan**: one member is not required to meet the individual out-of-pocket maximum before the annual family out-of-pocket maximum can be satisfied. • **Health Savings Account Plan**: The family out-of-pocket maximum applies if you are covering one or more dependents. Deductibles accumulate to the out-of-pocket maximum under the HSA Plan.	In-Network $5,000 Single $10,000 Family Out-of-Network No maximum limit unless specified (Unlimited except where stated)			In-Network $6,450 Single $12,900 Family Out-of-Network No maximum limit unless specified (Unlimited except where stated)			In-Network $6,450 Single $12,900 Family Out-of-Network No maximum limit unless specified (Unlimited except where stated)		

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Hospital Services (Inpatient) Hospital Inpatient services including: • Room & board facility fees in a semiprivate room with general nursing services. • Observation room stays will be considered on a per day co-pay • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/X-ray/diagnostic services. • Related medically necessary ancillary services (e.g., prescriptions, supplies). • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, active, progressive Rehabilitation Services that cannot be provided in an outpatient or home setting.	• Hospitalization is subject to precertification and concurrent review. See the Utilization Management chapter for details. • Under certain circumstances the Plan will pay for the facility fees and anesthesia associated with medically necessary dental services covered by the Dental Plan if the utilization management firm determines that hospitalization or outpatient surgery facility care is medically necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or any assistant dental provider fees under this Plan. • Hospital transfers include the overall maximum of five co-pays. • Hospital facility fees when caused by an emergency admission, as determined by the Plan Administrator or its designee, are payable at higher coinsurance. • Pre-Admission testing including laboratory test x-rays and other medically necessary tests performed on an outpatient basis prior to a scheduled hospital admission will be included with the facility charges. • 120 day maximum per person per calendar year for inpatient rehabilitation services.	Elective Admission: $150 co-pay per day up to 5 days per admission, then plan pays 100% Emergency Admission: $150 co-pay per day up to 5 days per admission, then plan pays 100%	Elective Admission: Not covered Emergency Admission: $400 co-pay per day up to 5 days per admission, then plan pays 90%	Elective Admission: Not covered Emergency Admission: $400 co-pay per day up to 5 days per admission, then plan pays 90%	Elective Admission: $200 co-pay per day up to 5 days per admission, then plan pays 100% Emergency Admission: $200 co-pay per day up to 5 days per admission, then plan pays 100%	Elective Admission: $400 co-pay per day up to 5 days per admission, then plan pays 50% Emergency Admission: $400 co-pay per day up to 5 days per admission, then plan pays 80%	Elective Admission: Not covered Emergency Admission: $400 co-pay per day up to 5 days per admission, then plan pays 80%	Elective Admission: Play pays 90% Emergency Admission: Plan pays 90%	Elective Admission: Play pays 50% Emergency Admission: Plan pays 80%	Elective Admission: Plan pays 40% Emergency Admission: Plan pays 80%

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Hospital Services (Outpatient Facility) Facility fees associated with outpatient services such as (but not limited to): • Chemotherapy treatment • Radiation treatment • Infusion treatment • Biopsies • Cath lab procedures • Dialysis	• See the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits for information on how professional fees are covered. •Certain services performed in a hospital are subject to precertification. See the Utilization Management chapter for details. •Refer to the Laboratory Services (Outpatient) section for covered lab services and fees.	Plan pays 90%	Not covered	Not covered	Plan pays 85%	Plan pays 50%	Not covered	Plan pays 90%	Plan pays 50%	Plan pays 40%
Services Not Available at a SLHN Facility and/or BCBSAZ Facility •When covered services are not available by Scottsdale Lincoln Health Network and/or Blue Cross Blue Shield of Arizona facility, benefits will be paid by the Plan for out-of-network facilities per this schedule up to the Allowed Charge.	• Hospitalization is subject to precertification and concurrent review. See the Utilization Management chapter for details. • The out-of-pocket maximum will apply to covered expenses paid for services not provided. • Refer to the Benefit Coverage section of the covered service for applicable SLHN Facility column co-pay. •Refer to the Out-of-Area Services section for out-of-area coverage (e.g. out of state travel, full-time students temporarily residing out of state).	Not available	Not available	Applicable co-pay, then plan pays 75%	Not available	Not available	Applicable co-pay, then plan pays 75%	Not available	Not available	Applicable co-pay, then plan pays 75%

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Physician and Other Healthcare Practitioner Services • Benefits are covered when provided by a Physician or other covered Healthcare Practitioner in an office, hospital, emergency room, or other covered healthcare facility location. •Under this Plan, there is no requirement to select a primary care Physician (PCP) or to obtain a referral or prior authorization before you receive services by a specialist. • Covered Physicians and Healthcare Practitioner professional fees include: • Consultation; • Surgeon; Assistant surgeon (if medically necessary); • Anesthesia provided by Physicians and Certified Registered Nurse Anesthetists (CRNA); • Pathologist; Radiologist • Podiatrist; • Physician Assistant; • Nurse Practitioner; • Hospitalist •Breastfeeding/Lactation Educator	•Several Physician and Healthcare Practitioner Services are subject to precertification. See the Utilization Management chapter for details. • See the definition of "Office Visit", "Physician" and "Healthcare Practitioner" in the Definitions chapter. • The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery" in the Definitions chapter. • Assistant Surgeon fees will be reimbursed for medically necessary services, subject to limitations, to a max of 20% of the eligible expenses covered to the primary surgeon. Certified Surgical Assistants (as that term is defined by this Plan) are covered if the use of an assistant surgeon was medically necessary to a max of 10% of the eligible expenses covered to the primary surgeon. • No coverage is provided for Prophylactic Surgery or Treatment as defined in the Definitions chapter and as explained in the Exclusions chapter. • General Physician means a primary care provider, family practitioner, pediatrician, internist or general practitioner physician. • Specialist means physicians who are not General Physicians as defined above. • Anesthesia services associated with tubal ligation are covered 100% (deductible waived).	Family Physician: $10 co-pay, then plan pays 100% for an Office Visit Specialist: $30 co-pay, then plan pays 100% for an Office Visit All other covered services: 90%	Family Physician: Not covered Specialist: $40 co-pay, then plan pays 100% for an Office Visit if specialty not included within SLHN $100 co-pay, then plan pays 100% for an Office Visit if specialty is included within SLHN All other covered services: 70%	Family Physician: Not covered Specialist: Not covered All other covered services: Not covered	Family Physician: $20 co-pay, then plan pays 100% for an Office Visit Specialist: $50 co-pay, then plan pays 100% for an Office Visit All other covered services: 85%	Family Physician: $40 co-pay, then plan pays 100% for an Office Visit Specialist: $60 co-pay, then plan pays 100% for an Office Visit if specialty not included within SLHN $100 co-pay, then plan pays 100% for an Office Visit if specialty is included within SLHN All other covered services: 70%	Family Physician: Not covered Specialist: Not covered All other covered services: Not covered	Office visit from Family Physician or Specialist: 90% All other covered services: 90%	Office visit from Family Physician or Specialist 80% All other covered services: 70%	Office visit from Family Physician or Specialist 40% All other covered services: 40%

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician. • Desensitization injections are covered only when provided by a licensed Healthcare Practitioner.	90%	70%	Not covered	85%	70%	Not covered	90%	80%	40%
Alternative Healthcare Services (Chiropractor, Acupuncture, Naturopath) • Spinal Manipulation Services (from a Doctor of Osteopathy (DO) or Chiropractor) including these related ancillary services: office visit/consultation, X-rays, diagnostic tests performed along with spinal manipulation is covered subject to the limitations shown in the Explanations and Limitations column. •Biofeedback. •Advanced Allergy Therapeutics. • Naturopaths, Non-MD. • Naturopaths, MD not part of the BCBSAZ network. • Not all Alternative Healthcare Services are covered. See the exclusions of Alternative Healthcare Services in the Exclusions chapter for details.	•When benefits for acupuncture are covered by this Plan, such services may be rendered by a Physician (MD or DO) with proper credentials to perform acupuncture in the state in which they are licensed or by an Acupuncturist who is properly licensed by the state in which he or she is practicing and is performing services within the scope of that license, or, where licensing of an acupuncturist is not required, is certified by the National Certification Commission for Acupuncturists (NCCA). • Services are covered only if the Plan Administrator or its designee determines that the practitioner is licensed or duly authorized to practice in the jurisdiction in which the services are provided. • Supplements are excluded.	75% up to $750, then plan pays 10% (All services combined)			75% up to $750, then plan pays 10% (All services combined)			75% up to $750, then plan pays 10% (All services combined)		

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Ambulance Services • **Ground vehicle transportation** to the appropriate facility as medically necessary for treatment of a medical emergency, acute illness or inter-healthcare facility transfer. • **Air/sea transportation** only as medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.	• Expenses for ambulance services are covered only when those services are for an Emergency as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care," or for medically necessary inter-facility transport. • No coverage for ambulance response charges when the covered participant is not transported by ambulance.	90%	75%	75%	85%	75%	75%	90%	75%	75%
Asthma Education Services • Education services for individuals and parents of children diagnosed with asthma.	• Covered only when ordered by a Physician.	$10 co-pay, then plan pays 100%	Not covered	Not covered	$20 co-pay, then plan pays 100%	Not covered	Not covered	90%	50%	Not covered
Blood Transfusions (Outpatient) • Blood transfusions and blood products and equipment for its administration. • Inpatient blood transfusions are covered according to the hospital facility section (see the Hospital Services (inpatient) row of this Schedule of Medical Benefits).	• Covered only when ordered by a Physician. • Expenses related to autologous blood donation (patient's own blood) are covered.	90%	Not covered	Not covered	85%	70%	Not covered	90%	80%	40%

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental) • Coverage is provided for medically necessary devices when ordered by a Physician or Healthcare Practitioner as follows: • Rental (but only up to the allowed purchase price of the device). • Purchase of standard model. • Repair, adjustment or servicing of the device or replacement of the device due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired. • Duplicate services not covered. • Colostomy, ostomy or orthotic supplies. • Prosthetic devices are covered for the temporary and definitive (permanent) appliance, including necessary supplies. Replacement only as determined to be medically necessary. • Cochlear implant and related supplies. • Refer to the Hearing Aid Benefit row in this Schedule of Medical Benefits. • To help determine what prosthetic or orthotic devices are covered, see the definition of "Prosthetic Appliances" and "Orthotics" in the Definitions chapter.	• Prosthetic devices over $1,000/device require precertification. See the Utilization Management chapter for details. • Orthotic devices over $1,000/device require precertification. See the Utilization Management chapter for details. Covered orthotics includes the device with necessary supplies, repair and servicing. Foot orthotics do not require precertification. • Foot Orthotics (orthopedic or corrective shoes and other supportive appliances for the feet) are covered only when custom made and at the following frequency: 1 time per calendar year for adults and 2 times per calendar year for children under age 19 when replacement is required due to growth. • Hair loss replacement toward a single wig, toupee or hairpiece if required to replace hair lost as a result of treatment of an illness such as cancer therapy. • The Plan covers up to 4 anti-embolism or vascular support garments (e.g., Jobst) per person per calendar year. • See the exclusions related to Corrective Appliances in the Exclusions chapter.	90% 90% up to $250, then plan pays 10% for hair loss replacement	70% 70% up to $250, then plan pays 10% for hair loss replacement	Not covered	85% 85% up to $250, then plan pays 10% for hair loss replacement	70% 70% up to $250, then plan pays 10% for hair loss replacement	Not covered	90% 90% up to $250, then plan pays 10% for hair loss replacement	80% 80% up to $250, then plan pays 10% for hair loss replace-ment	40% 40% up to $250, then plan pays 10% for hair loss replacement
Diabetes Counseling/Education • Education services for individuals and parents of children diagnosed with diabetes.	• Covered only when ordered by a Physician.	$10 co-pay, then plan pays 100%	Not covered	Not covered	$20 co-pay, then plan pays 100%	Not covered	Not covered	90%	50%	Not covered

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Diagnostic Testing (Outpatient Facility) Facility fees associated with diagnostic testing such as (but not limited to): • EKG/EEG • Stress Test • Peripheral Vascular Test	• Covered only when ordered by a Physician or Healthcare Practitioner. • See the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits for information on how professional fees are covered.	$10 co-pay, then plan pays 100%	75%	Not covered	$15 co-pay, then plan pays 100%	75%	Not covered	90%	50%	40%
Durable Medical Equipment (DME) • Coverage is provided for: • Rental (but only up to the allowed purchase price of the Durable Medical Equipment). • Purchase of standard model. • Repair, adjustment or servicing or medically necessary replacement of the Durable Medical Equipment due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired. • Coverage is provided for medically necessary oxygen, along with the medically necessary equipment and supplies required for its administration. • Coverage is provided for delivery and set-up fees associated with the covered DME equipment.	• Precertification required for all DME rentals or purchases costing over $1,000. See the Utilization Management chapter of this document for details. • See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions chapter. • To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter. • Durable Medical Equipment is covered only when its use is medically necessary and it is ordered by a Physician or Healthcare Practitioner. • For coverage of external breast prostheses, see the Corrective Appliances row of this Schedule of Medical Benefits. • Coverage is provided for breast pumps and related supplies. Precertification is not required.	90% 100% for breast pumps and related supplies	75% 100% for breast pumps and related supplies	Not covered	85% 100% for breast pumps and related supplies	75% 100% for breast pumps and related supplies	Not covered	90% 100% for breast pumps and related supplies (Deductible waived)	75% 100% for breast pumps and related supplies (Deductible waived)	40%

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Emergency Room (ER) Facility Services • Hospital emergency room (ER)/emergency department (ED) for a medical Emergency and ancillary charges (such as lab or X-ray) performed during the ER visit. • See also the Ambulance Services row section of this Schedule of Medical Benefits. • See the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits for information on how professional fees are covered. • See also the Urgent Care Facility row of this Schedule of Medical Benefits.	• Emergency is defined in the Definitions chapter of this document under the heading of "Emergency Care and Emergency Services." • If you use an out-of-network ER facility in an emergency, the co-pay and coinsurance will apply toward your annual out-of-pocket maximum. • If you use any out-of-network ER facility and it is not for an emergency, the co-pay and coinsurance will not apply toward your annual out-of-pocket maximum. • Emergency room services are subject to the co-pay per visit (when applicable) which will be waived if subsequent immediate hospitalization or observation is required. • Emergency Room physicians' services only are included in the co-pay or coinsurance. •There is no requirement to pre-certify a hospital-based emergency room visit. The Plan will pay a reasonable amount for hospital-based emergency services performed out-of-network in compliance with health reform.	Non Emergency: $250 co-pay, then plan pays 50% Emergency: $250 co-pay, then plan pays 100%	Non Emergency: $250 co-pay, then plan pays 50% Emergency: $250 co-pay, then plan pays 100%	Non Emergency: $250 co-pay, then plan pays 50% Emergency: $250 co-pay, then plan pays 100%	Non Emergency: $300 co-pay, then plan pays 50% Emergency: $300 co-pay, then plan pays 100%	Non Emergency: $300 co-pay, then plan pays 50% Emergency: $300 co-pay, then plan pays 100%	Non Emergency: $300 co-pay, then plan pays 50% Emergency: $300 co-pay, then plan pays 100%	Non Emergency: 50% Emergency: 80%	Non Emergency: 50% Emergency: 80%	Non Emergency: 50% Emergency: 80%

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Enteral Therapy Services •Enteral nutritional therapy provides nourishment directly (e.g. feeding tube) to the digestive tract of a person who cannot ingest an appropriate amount of calories and nutrients to maintain an acceptable nutritional status. Enteral nutritional formula is payable when medically necessary and pre-certified and meets all the following criteria: •When the formula is the primary source of nutrition (i.e., 60% or more of caloric nutritional intake) and ALL of the following criteria are met: •Without enteral feedings, the individual would be unable to obtain sufficient nutrients to maintain an appropriate weight by dietary adjustment and/or oral supplements, and •The individual has one of the following conditions that is expected to be permanent or of indefinite duration: •An anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel; disease of the small bowel that impairs absorption of an oral diet; • A central nervous; or system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.	•Enteral therapy services are covered only when ordered by a Physician. • Home Healthcare Services and Home Infusion Therapy Services may be limited to a 60-day max per person per calendar year. •Coverage for a home enteral infusion pump (and associated necessary supplies) is considered payable when the use of the pump is medically necessary because the individual cannot tolerate gravity or syringe feedings or requires a controlled rate of infusion of the enteral formula. •Enteral nutritional formula that is not payable by the Plan includes: •Standardized or specialized infant formula (e.g., Alimentum, Elecare, Neocate, and Nutramigen), or baby food for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerance; gluten-free formula for gluten-sensitivity, or formula for protein, soy or fat digestive problems. • Food thickeners, dietary and food supplements including but not limited to puddings, powders, mixes, vitamins and minerals; lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like. •Weight-loss or weight-gain foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and minerals.	90%	70%	Not covered	85%	70%	Not covered	90%	80%	40%

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Family Planning • Surgical sterilization • Prescription contraceptives such as generic oral pills, patch, injectables (e.g.,Depo-Provera, Lunelle), intrauterine device (IUD), cervical cap, contraceptive ring, diaphragm, implantable birth control device/service (e.g., Implanon). • See the specific exclusions related to Drugs, Medicines & Nutrition and Maternity Services in the Exclusions chapter. • Excludes all over-the-counter male birth control products.	• Sterilization procedures for females (e.g., tubal ligation) are covered 100% (co-pay and deductible waived). No coverage for reversal of sterilization procedures. • Sterilization procedures for males (e.g., vasectomy) are covered 100%. No coverage for reversal of sterilization procedures. • FDA approved generic contraceptive drugs for females are covered 100%, deductible waived when in-network providers used. See the Schedule of Outpatient Prescription Drug Benefits. •FDA approved over-the-counter female birth control products are covered 100%, deductible waived with a prescription. See the Schedule of Outpatient Prescription Drug Benefits.	100%	100%	Not covered	100%	100%	Not covered	100% (Deductible waived)	100% (Deductible waived)	Not covered

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Fertility, Reproductive and Erectile Dysfunction Services • Fertility and infertility treatment for the Employee, Spouse or Domestic Partner only up to $1,500 then plan pays 10%. • Outpatient prescription drugs for the treatment of fertility and infertility are limited to four 30-day fills per person per calendar year.	• Fertility and infertility coverage includes evaluation, diagnosis and treatment. • No coverage for erectile dysfunction. • See the specific exclusions related to Drugs & Medicines; Fertility & infertility; and Erectile Dysfunction Services in the Exclusions chapter.	Family Physician: $10 co-pay, then plan pays 100% for an Office Visit Specialist: $30 co-pay, then plan pays 100% for an Office Visit All other covered services: 90%	Family Physician: Not covered Specialist: $40 co-pay, then plan pays 100% for an Office Visit if specialty not included within SLHN $100 co-pay, then plan pays 100% for an Office Visit if specialty is included within SLHN All other covered services: 70%	Family Physician: Not covered Specialist: Not covered All other covered services: Not covered	Family Physician: $20 co-pay, then plan pays 100% for an Office Visit Specialist: $50 co-pay, then plan pays 100% for an Office Visit All other covered services: 85%	Family Physician: $40 co-pay, then plan pays 100% for an Office Visit Specialist: $60 co-pay, then plan pays 100% for an Office Visit if specialty not included within SLHN $100 co-pay, then plan pays 100% for an Office Visit if specialty is included within SLHN All other covered services: 70%	Family Physician: Not covered Specialist: Not covered All other covered services: Not Covered	90% All other covered services: 90%	80% All other covered services: 70%	40% All other covered services: 40%

2015 SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits covered by the Plan up to the Allowed Charge. See also the Exclusions and Definitions chapters of this document for important information.
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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Genetic Testing Lab Fees and Counseling Services • Genetic testing and counseling for mutations associated with multifactorial diseases and only if medically necessary as determined by the Plan Administrator or its designee. Precertification is required. • Genetic testing for fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafeto- protein (AFP) analysis in covered pregnant women and only if the procedure is medically necessary as determined by the Plan Administrator or its designee. • Genetic counseling covered under this Plan when provided to discuss the test results and implications of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis as described above. •BRCA testing and counseling is covered under this plan. See the Wellness & Preventive Healthcare Services section of this schedule.	• Professional fees for genetic counseling and testing covered under the Physician services section (see the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits). • See the definitions of "Genetic Counseling", "Genetic Testing" and "Prophylactic Surgery" in the Definitions chapter. • See the Exclusions chapter for exclusions relating to Genetic Testing, Counseling and Treatment of Prophylactic Surgery.	90%	75%	Not covered	85%	75%	Not covered	90%	75%	40%
Hearing Aid Benefit • Coverage is limited to each ear every three years for hearing aids, hearing aid repairs, hearing aid batteries and related supplies.	• Cochlear implant devices and related surgical procedures are not limited by this hearing aid benefit. • An audiology exam does not accumulate under this benefit and is covered under the Physician services (see the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits). • Out-of-pocket maximum applies for OON services.	75% up to $2,000, then plan pays 10% per ear every three years	75% $2,000, then plan pays 10% per ear every three years	75% up to $2,000, then plan pays 10% per ear every three years	75% up to $2,000, then plan pays 10% per ear every three years	75% up to $2,000, then plan pays 10% per ear every three years	75% up to $2,000 then plan pays 10% per ear every three years	75% up to $2,000, then plan pays 10% per ear every three years	75% up to $2,000 then plan pays 10% per ear every three years	75% up to $2,000 then plan pays 10% per ear every three years

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Home Healthcare Services • Part-time, intermittent Skilled Nursing Care services and medically necessary supplies to provide Home Healthcare. • Home services other than Skilled Nursing Care are not covered. • Home Hospice coverage is covered under Hospice benefits. Home Physical Therapy services coverage is covered under the Rehabilitation Services benefits.	• Precertification and ongoing medical review is required for home health care except when provided by SHC/JCL locations. • 60-day maximum per person per calendar year (combined with Home Infusion Therapy Services). • Home Healthcare services are covered only when ordered by a Physician or Healthcare Practitioner and provided by a licensed home healthcare agency. • See the exclusions related to Home Healthcare and Custodial Care (including personal care and child care) in the Exclusions chapter of this document.	90%	75%	Not covered	85%	70%	Not covered	90%	80%	40%
Home Infusion Therapy Services • Part-time, intermittent Skilled Nursing Care services and medically necessary supplies and infusion medications in order to provide home infusion services. •See also the Enteral Therapy row. • Certain medications that require precertification by the Outpatient Prescription Drug Program (such as drugs to treat multiple sclerosis, rheumatoid arthritis, hepatitis as well as growth hormone) and are ordered by, or administered by Physicians and Health Care Practitioners in an office or outpatient setting must also be precertified by contacting the Utilization Management Program.	• Precertification and ongoing medical review is required for home infusion therapy and outpatient infusion of drugs. See the Utilization Management chapter. • 60-day maximum per person per calendar year (combined with Home Healthcare Services). • See the exclusions related to Home Healthcare and Custodial Care (including personal care and child care) in the Exclusions chapter of this document. • Home Infusion Therapy services are covered only when ordered by a Physician or Healthcare Practitioner and provided by a licensed home infusion therapy agency and are medically necessary.	90%	75%	Not covered	85%	70%	Not covered	90%	80%	40%
Hospice • Hospice services include inpatient hospice care and outpatient home hospice when the patient meets the definition of “Hospice” in the Definitions chapter.	• Bereavement counseling beyond that included as part of the Hospice program is covered under the Behavioral Health benefits of this Plan.	90%	75%	Not covered	85%	75%	Not covered	90%	80%	40%

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Laboratory Services (Outpatient) •Facility Fees associated with lab work •Physician fees are covered under the Physician services section (see the Physician and Other Healthcare practitioner Services row of this Schedule of Medical Benefits). • See Genetic Testing for additional information.	• Covered only when ordered by a Physician or Healthcare Practitioner. • Some laboratory services are covered under the preventative benefits in this Schedule of Medical Benefits. • Co-pay is per visit, not per lab service.	$10 co-pay, then plan pays 100%	$10 co-pay, then plan pays 100%	Not covered	$15 co-pay, then plan pays 100%	$15 co-pay, then plan pays 100%	Not covered	90%	90%	Not covered

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Maternity Services • Hospital, Birth (Birthing) Center charges, Physician and Midwife fees for medically necessary maternity services. •In conjunction with birth, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a trained provider during pregnancy and/or in the postpartum period, at 100%, no deductible when provided by an in-network provider. Under this plan a trained provider is a Breastfeeding/Lactation Educator as defined in the Definitions chapter. • Deductible, Coinsurance and Co-pay waived for well newborn(s) that are discharged with mother. • Only medically necessary ultrasound(s) are covered • To obtain coverage for a newborn, you must add a newborn within 31 days of the date of birth. Refer to the Eligibility chapter for details. • Termination of pregnancy is covered only in cases of rape/incest, or complications arise from an abortion from rape/incest, or when the attending Physician certifies that the female's health would be endangered if the fetus were carried to term. •Breastfeeding equipment and supplies are payable as noted in the Durable Medical Equipment row of this Schedule.	• See the exclusions related to Maternity Services in the Exclusions chapter. • Hospital Length of Stay for Childbirth: This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hrs following a normal vaginal delivery, or less than 96 hrs following a cesarean section, or requiring a Healthcare Practitioner (HP) to obtain authorization from the Plan or its Utilization Management Company for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending HP, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hrs (or 96 hrs, if available). •There is no requirement to obtain prior authorization from provider. • Prenatal/postnatal visits obtained from an in-network provider are payable at no cost to you. Normal plan cost-sharing still applies to all other maternity related services including ultrasounds and delivery fees. When a provider submits a bill to the plan with a global CPT code for the combination of pre/postnatal visits and delivery expenses, the Plan's claim administrator will process the claim applying no cost-sharing to 40% of the charges representing prenatal/postnatal expenses, and normal cost-sharing to 60% of the charges representing the delivery expenses.	Facility: $150 co-pay per day up to 5 days, then plan pays 100% (for mother and baby) Physician: 90% Delivery charges 100% Pre-natal and post-natal visits	Facility: Not covered Physician: 70% Delivery charges 100% Pre-natal and post-natal visits	Facility: Not covered Physician: Not covered	Facility: $200 co-pay per day up to 5 days, then plan pays 100% (for mother and baby) Physician: 85% Delivery charges 100% Pre-natal and post-natal visits	Facility: $400 co-pay per day up to 5 days, then plan pays 50% (for mother and baby) Physician: 70% Delivery Charges 100% Pre-natal and post-natal visits	Facility: Not covered Physician: Not covered	Facility: 90% Physician: 90% Delivery charges 100% (Deductible waived) Pre-natal and post-natal visits	Facility: 50% Physician: 70% Delivery charges 100% (Deductible waived) Pre-natal and post-natal visits	Facility: 40% Physician: 40% Delivery charges 100% (Deductible waived) Pre-natal and post-natal visits

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Nondurable Supplies • Coverage is provided for up to a 31-day supply of: • Sterile surgical supplies used immediately after surgery. • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances. • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter.	90%	75%	Not covered	85%	75%	Not covered	90%	75%	40%
Oral, Craniofacial, and TMJ Services • Restoration of teeth after an injury and repair of accidental injuries to the alveolar process. • Treatment of Temporomandibular Joint (TMJ) dysfunction or syndrome includes the initial physician visits as well as laboratory work, X-rays, dental appliances and surgery to the jaw but does not cover surgical services for dental implants, crowns, orthodontia and other related dental work. • Oral and/or Craniofacial Surgery for removal of tumors, cysts or impacted teeth (including wisdom teeth) that are partially or totally covered by bone.	• See the exclusions related to Dental Services in the Exclusions chapter. • Treatment of Accidental Injury Teeth (as caused by trauma from an external force) must be provided by a Dentist or Physician and is limited to restoration of teeth to their pre-injury level of health and function as determined by the Plan Administrator or its designee. This does not include an injury to the teeth caused by an intrinsic force, such as the force of biting or chewing. • Surgical treatment of Temporomandibular Joint (TMJ) dysfunction/syndrome requires precertification. See the Utilization Management chapter for details. • No coverage for dental services including but not limited to dental implants, root canal, gingivectomy, or dental abscess treatment. No coverage for orthognathic surgery to treat malposition of the bones of the jaw, unless such surgery is medically necessary.	Refer to the Benefit Coverage section of the covered service. Benefits payable In-Network SLHN up to the Allowed Charge								

2015 SCHEDULE OF MEDICAL BENEFITS

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Out-of-Area Services	• Only for sick Office Visits, Urgent Care services and Emergency Services, if traveling. •Only if temporarily living outside the service area for purposes other than for receiving care.	Refer to the Benefit Coverage section of the covered service. Benefits payable equivalent to the In-Network BCBSAZ up to the Allowed Charge								
Outpatient (Ambulatory) Facility • Ambulatory (Outpatient) Surgical Facility (e.g., outpatient hospital, surgicenter, same day surgery). • Physician fees are covered under the Physician services section (see the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits). • Sterilization procedures (e.g. vasectomy and tubal ligation) are covered 100% (co-pay and deductible waived).	• Use of an outpatient surgical facility requires precertification. See the Utilization Management chapter for details. • Pre-Admission testing including laboratory tests, x-rays and other medically necessary tests performed on an outpatient basis prior to a scheduled outpatient surgery will be included with the facility charges. • Under certain circumstances the Plan will pay for the facility fees and anesthesia associated with medically necessary dental services covered by the Dental Plan if the utilization management firm determines that hospitalization or outpatient surgery facility care is medically necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or any assistant dental provider fees under this Plan.	$150 co-pay, then plan pays 100%	Not covered	Not covered	$200 co-pay, then plan pays 100%	$400 co-pay, then plan pays 50%	Not covered	90%	50%	Not covered
Pain Management (Professional Fees)	• Pain management services require precertification. No precertification required for a consultation visit. See the Utilization Management chapter for details. • See the Durable Medical Equipment (DME) row of this Schedule of Medical Benefits for implantable infusion pumps and pain medication delivery systems.	90%	70%	Not covered	85%	70%	Not covered	90%	70%	40%

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Radiology Services (Outpatient Facility) • Facility fees associated with radiology and nuclear medicine services such as MRI/MRA, CT Scan, PET Scan, discogram and myelogram. •X-rays •Ultrasounds	• Precertification is required for certain services. See the Utilization Management chapter of this document for details. • Covered only when ordered by a Physician or Healthcare Practitioner. • See the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits for information on how professional fees are covered. •One co-pay per test type (i.e. MRI of two different areas on same visit).	$100 co-pay, then 90% for MRI/MRA, CT Scan, Pet Scan $10 co-pay, then plan pays 100% for X-ray, Ultrasound	Not covered for MRI/MRA, CT Scan, Pet Scan 50% for X-ray, Ultrasound	Not covered	$150 co-pay, then plan pays 85% for MRI/MRA, CT Scan, Pet Scan $15 co-pay, then plan pays 100% for X-ray, Ultrasound	$200 co-pay, then plan pays 50% for MRI/MRA, CT Scan, Pet Scan 75% for X-ray, Ultrasound	Not covered	90%	50%	40%

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Reconstructive Services and Breast Reconstruction After Mastectomy • This Plan complies with the Women's Health and Cancer Rights Act that indicates that for any Covered Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage is provided in a manner determined in consultation with the attending physician and the patient, including: • reconstruction of the breast on which the mastectomy was performed; • reconstruction of the other breast to produce a symmetrical appearance; and • prostheses and physical complications for all stages of mastectomy, including lymphedemas (e.g., arm swelling). • Reconstructive Surgery only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital anomaly that causes a functional defect.	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) and Prophylactic Services/Surgery in the Exclusions chapter. Most Cosmetic services are excluded from coverage. • See also the Corrective Appliances row of this Schedule of Medical Benefits for information on coverage for wigs. • Removal and or replacement of a ruptured breast implant is not covered if the original purpose of the implant was for cosmetic purposes, not post-mastectomy purposes. •All potential cosmetic procedures require precertification. See the Utilization Management chapter for details.	For Facility fees, see the Hospital Services (Inpatient) row or Outpatient Surgery Facility row of this Schedule of Medical Benefits. For Professional fees, see the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits.								

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Rehabilitation Services (Cardiac and Pulmonary) • **Cardiac Rehabilitation** is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.). • **Pulmonary Rehabilitation** is available to those individuals with a chronic respiratory disorder, such as asthma or emphysema, who are able to actively participate in a Pulmonary Rehabilitation program that is likely to improve their respiratory condition, as determined by the Plan Administrator or its designee.	• 12-week maximum per person per calendar year. • Cardiac and/or Pulmonary Rehabilitation programs require precertification. See the Utilization Management chapter for details. • Cardiac and/or Pulmonary Rehabilitation programs must be ordered by a Physician. • See also the Definition of "Cardiac Rehabilitation" and "Pulmonary Rehabilitation" in the Definitions chapter.	90%	50%	Not covered	85%	50%	Not covered	90%	80%	40%

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Rehabilitation Therapy Services (Outpatient): (Physical, Occupational, Speech and Exercise Therapy) • Medically Necessary short term active, progressive Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • Outpatient Rehabilitation Therapy Services includes physical therapy (PT), occupational therapy (OT), speech therapy (ST), home physical therapy and exercise (aquatic/water) therapy, and physical therapy services from an in-network Chiropractor. • Habilitative Services are excluded from coverage.	• 60 visit maximum per person per calendar year for all combined outpatient therapy services. • Speech therapy requires pre-certification. • Rehabilitation services are covered only when ordered by a Physician. • Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagic or swallowing defects and disorders lost due to illness, injury or surgical procedure. • Speech therapy for functional purposes, (including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin) or childhood developmental speech delays and disorders are excluded from coverage. • Maintenance Rehabilitation. Passive Rehabilitation outside of a hospitalization (see the definition of "Rehabilitation Therapy" in the Definitions chapter) and coma stimulation services are not covered. See specific exclusions relating to Rehabilitation in the Exclusions chapter.	$5 co-pay, then plan pays 100% $15 co-pay, then plan pays 100% for speech therapy	50%	Not covered	$10 co-pay, then plan pays 100% $15 co-pay, then plan pays 100% for speech therapy	75%	Not covered	90%	50%	40%
Skilled Nursing Facility (SNF), Long Term Acute Care Facility (LTAC) or Sub acute Facility • To determine if a facility is a skilled nursing or sub acute facility, see those terms as defined in the Definitions chapter.	• Admission to a facility requires precertification. See the Utilization Management chapter for details. • Services must be ordered by a Physician. • Coverage is limited to 120 days per calendar year.	90%	75%	Not covered	85%	75%	Not covered	90%	75%	40%

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Sleep Study (Facility Fees) • Technical facility fees associated with diagnostic sleep studies. • For coverage of professional fees associated with a sleep study see the Physician and Other Healthcare practitioner Services of of this Schedule of Medical Benefits.	• Covered only when ordered by a Physician or Healthcare Practitioner.	90%	75%	Not covered	85%	70%	Not covered	90%	70%	40%
STAT Doctors • Online urgent care services available 24/7 via web portal. •See the Quick Reference Chart for contact information.	• Coverage for employees and their spouses/partners and dependent children ages 3 and older.	$25 co-pay	Not available	Not available	$25 co-pay	Not available	Not available	50%	Not available	Not available

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		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Transplants (Organ and Tissue) • Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue along with the facility and professional services, FDA approved drugs, and medically necessary equipment and supplies. • Organ or tissue testing, procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor. • Reasonable and necessary expenses incurred by a donor who is covered by this Plan and who donates to an individual whose transplant is covered under this Plan, are covered without any Deductibles and Coinsurance applicable to those expenses. These donor expenses apply toward the transplant recipient's annual maximum. • Reasonable and necessary expenses incurred by a donor who is not covered by this Plan, without any Deductibles and Coinsurance applicable to those expenses, but only to the extent the donor is not covered by the donor's own insurance or healthcare plan.	• Transplant services including pre-transplant workup tests require precertification. See the Utilization Management chapter for details. • See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions chapter. • No coverage for travel/lodging related transplant expenses.	For Facility fees, see the Hospital Services (Inpatient) row or Outpatient Surgery Facility row of this Schedule of Medical Benefits. For Professional fees, see the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits.								
Urgent Care Facility/Professional Fees • See the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits for covered professional fees.	• Coverage provided for Hospital-based or free standing facility only. • See also the Definition of "Urgent Care" in the Definitions chapter.	$25 co-pay, then plan pays 100%	$75 co-pay, then plan pays 100%	Not covered	$25 co-pay, then plan pays 100%	$75 co-pay, then plan pays 100%	Not covered	90%	80%	40%

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Weight Management Benefit • Coverage is limited to employees and their spouse/partner only. • The Plan's Weight Management Benefit includes surgical procedures for the treatment of obesity/morbid obesity along with physician office visits, hospital services, and lab tests. Surgical services must be pre-certified for medical necessity.	• Treatment of any skin reduction procedure is excluded from the health plan. •Treatment of post-operative complications, reversal procedures and any other medical complications as the result of surgical procedures regardless of the date the original surgery took place is excluded from the health plan, unless the original surgery took place at Scottsdale Healthcare Bariatric Center after January 1, 2011. • Services and procedures are limited to Scottsdale Healthcare Bariatric Center only.	For Facility fees, see the Hospital Services (Inpatient) row or Outpatient Surgery Facility row of this Schedule of Medical Benefits. For Professional fees, see the Physician and Other Healthcare Practitioner Services row of this Schedule of Medical Benefits.								

2015 SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits covered by the Plan up to the Allowed Charge. See also the Exclusions and Definitions chapters of this document for important information.
SLHN means Scottsdale Healthcare and John C. Lincoln hospitals, ancillary services and employed physician groups, the physician networks Scottsdale Health Partners and John C. Lincoln Physician Network and Joint Venture partnerships.
BCBSAZ means the Blue Cross Blue Shield of Arizona hospitals, physicians and ancillary services and OON means Out-Of-Network facilities/providers

Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Wellness & Preventive Healthcare Services: •Routine Preventive Physical Exam •BRCA1 or BRCA2 genetic test and counseling for routine breast cancer susceptibility gene. The following over-the-counter drugs are covered at 100% no deductible. See the schedule for outpatient prescription drugs for explanations and limitations: •Aspirin for men between the ages of 45-79. •Aspirin for women between the ages of 55-79. •Folic Acid for women. •Iron Supplements for children age 0-1 year. •Oral fluoride supplements (prescription products only).	• Coverage is provided for one annual preventive physical exam including screening lab test. • BRCA1 or BRAC2 is covered for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRAC2 genes. Must be prescribed by a physician. Services and procedures are limited to the Virginia G. Piper Cancer Center. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. • When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). • The Plan will use reasonable medical management techniques - such as age, location for service and test frequency - for consideration of payable preventive services.	100%	Not covered	Not covered	100%	100%	Not covered	100%	Not covered	Not covered

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Benefit Coverage	Explanations and Limitations	Coordinated Care Plan			Standard Plan			Health Savings Account Plan (HDHP)		
		SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON	SLHN	BCBSAZ	OON
Well-Woman Care • Deductibles and coinsurance do not apply to these benefits.	• Coverage is provided for one annual gynecological exam and cervical cancer screening Pap smear lab test and related diagnostic cultures and blood work. • Coverage is provided for a breast cancer screening mammogram and interpretation of it, according to the following schedule: • Up to age 39 – one baseline mammogram. • Age 40 and up – annually. • Additional mammograms that are medically necessary because of the patient's condition are covered subject to the Plan's deductibles, coinsurance or co-payments and all other Plan provisions. • Coverage is provided for one screening colonoscopy every 5 years for individuals age 50 and up.	100%	Not covered	Not covered	100%	100%	Not covered	100%	Not covered	Not covered
Well-Man Care • Deductibles and coinsurance do not apply to these benefits.	• Annual Prostatic Specific Antigen (PSA) prostate cancer screening blood test and exam. • Coverage is provided for one screening colonoscopy every 5 years for individuals age 50 and up.	100%	Not covered	Not covered	100%	100%	Not covered	100%	Not covered	Not covered
Well-Child Care • Deductibles and coinsurance do not apply to these benefits.	• Coverage is provided for newborn and well-child visits for health exams and related testing.	100%	Not covered	Not covered	100%	100%	Not covered	100%	Not covered	Not covered
Immunizations • Deductibles and coinsurance do not apply to these benefits.	• Immunizations per CDC recommendations are covered.	100%	Not covered	Not covered	100%	100%	Not covered	100%	Not covered	Not covered