



BluePreferred[®]

For Individuals

Summary of Benefits



An Independent Licensee of the Blue Cross and Blue Shield Association

www.azblue.com

PPO Plan - Benefit Summary

BluePreferred® for Individuals																		
<p>Provider alternatives Your out-of-pocket costs will differ, depending on the type of provider you select.</p>	<p>Preferred (PPO) providers These providers have signed a “Preferred Agreement” to accept the BCBSAZ allowed amount as payment in full and will file claims for you. You have lower out-of-pocket costs (deductibles, coinsurance, and copays) when you use Preferred providers.</p> <p>Preferred providers are also available outside Arizona. To locate BlueCard® PPO providers, call (800) 810-BLUE or check the BlueCard Doctor & Hospital Finder at www.bcbs.com.</p>	<p>Non-Preferred providers You pay a separate – and higher – deductible and coinsurance when you use non-Preferred providers. In addition, preventive care benefits are not covered at non-Preferred providers. There are two types of non-Preferred providers:</p> <p>Participating providers — have signed a “Participating Agreement” to accept the BCBSAZ allowed amount as payment in full and will file claims for you.</p> <p>Participating providers are also available outside Arizona, and some participating hospitals are available outside the U.S. To locate BlueCard providers, call (800) 810-BLUE or check the BlueCard Doctor & Hospital Finder at www.bcbs.com.</p> <p>Noncontracted providers — have no agreement with us and may not accept the BCBSAZ allowed amount as payment in full nor file claims for you. With noncontracted providers, you are responsible for the difference between the provider’s billed charges and the allowed amount, in addition to your non-Preferred deductible and coinsurance. This difference may be substantial.</p>																
	If you use a Preferred provider	If you use a non-Preferred provider																
<p>Deductibles Non-Preferred deductibles are accumulated separately from Preferred deductibles.</p>	<p>Calendar-year deductible: \$250, \$500, \$1,000, \$2,500 and \$5,000 Family calendar-year deductible maximum: \$500, \$1,000, \$2,000, \$5,000 and \$10,000</p> <p>Note: Copays are not applied toward the deductible.</p>	<p>Calendar-year deductible: \$750, \$1,000, \$1,500, \$3,000 and \$5,500 Family calendar-year deductible maximum: \$1,500, \$2,000, \$3,000, \$6,000 and \$11,000</p>																
<p>Coinsurance The non-Preferred out-of-pocket maximum is accumulated separately from the Preferred out-of-pocket maximum.</p> <p>Coinsurance is based on the BCBSAZ allowed amount for covered services. The BCBSAZ allowed amount is generally calculated using the lesser of billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements.</p>	<p>After you pay your Preferred calendar-year deductible, we pay 80% of the allowed amount for covered services. You pay the remaining 20% of the allowed amount, up to an out-of-pocket maximum expense per person. After you reach the maximum expense per person, we pay 100% of the allowed amount for covered services for the remainder of the calendar year.</p> <table border="0" data-bbox="472 1562 954 1686"> <thead> <tr> <th style="text-align: center;"><u>Deductible</u></th> <th style="text-align: center;"><u>Out-of-pocket maximum per person</u></th> </tr> </thead> <tbody> <tr> <td>\$250, \$500, \$1,000</td> <td>\$2,500</td> </tr> <tr> <td>\$2,500</td> <td>\$3,000</td> </tr> <tr> <td>\$5,000</td> <td>\$4,000</td> </tr> </tbody> </table> <p>Note: Copays and deductibles are not applied toward the out-of-pocket maximum.</p>	<u>Deductible</u>	<u>Out-of-pocket maximum per person</u>	\$250, \$500, \$1,000	\$2,500	\$2,500	\$3,000	\$5,000	\$4,000	<p>After you pay your non-Preferred calendar-year deductible, we pay 60% of the BCBSAZ allowed amount for covered services. You pay the remaining 40% of the allowed amount, up to an out-of-pocket maximum expense per person. After you reach the maximum expense per person, we pay 100% of the allowed amount for covered services for the remainder of the calendar year. If a noncontracted provider is used, you will be responsible for the difference between the provider’s billed charges and the BCBSAZ allowed amount.</p> <table border="0" data-bbox="1002 1696 1500 1820"> <thead> <tr> <th style="text-align: center;"><u>Deductible</u></th> <th style="text-align: center;"><u>Out-of-pocket maximum per person</u></th> </tr> </thead> <tbody> <tr> <td>\$250, \$500, \$1,000</td> <td>\$5,500</td> </tr> <tr> <td>\$2,500</td> <td>\$6,000</td> </tr> <tr> <td>\$5,000</td> <td>\$8,000</td> </tr> </tbody> </table>	<u>Deductible</u>	<u>Out-of-pocket maximum per person</u>	\$250, \$500, \$1,000	\$5,500	\$2,500	\$6,000	\$5,000	\$8,000
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<p>Copayments Copays only apply to services from Preferred providers.</p>	<p>You only pay a fixed copay at Preferred providers for physician office visits, urgent care facility visits, most prescription drugs, routine vision exams and outpatient behavioral health services from the behavioral services administrator. The deductible and coinsurance do not apply to these services.</p>																	

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<p>Physician office visits</p> <p>Deductible option determines copay.</p> <p>A primary care physician (PCP) generally practices in the area of internal medicine, family practice, general practice or pediatrics.</p>	<p>You pay a copay per visit (deductible does not apply):</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Deductible</th> <th style="text-align: center; border-bottom: 1px solid black;">PCP copay</th> <th style="text-align: center; border-bottom: 1px solid black;">Specialist copay</th> </tr> </thead> <tbody> <tr> <td>\$250</td> <td style="text-align: center;">\$15</td> <td style="text-align: center;">\$30</td> </tr> <tr> <td>\$500</td> <td style="text-align: center;">\$20</td> <td style="text-align: center;">\$35</td> </tr> <tr> <td>\$1,000</td> <td style="text-align: center;">\$25</td> <td style="text-align: center;">\$40</td> </tr> <tr> <td>\$2,500</td> <td style="text-align: center;">\$30</td> <td style="text-align: center;">\$40</td> </tr> <tr> <td>\$5,000</td> <td style="text-align: center;">\$30</td> <td style="text-align: center;">\$40</td> </tr> </tbody> </table> <p>The copay covers doctor office visits, plus any diagnostic testing or surgeries that are conducted within the doctor's office.</p> <p>Plan pays 100% for covered lab services provided outside the doctor's office by contracted independent clinical labs.</p>	Deductible	PCP copay	Specialist copay	\$250	\$15	\$30	\$500	\$20	\$35	\$1,000	\$25	\$40	\$2,500	\$30	\$40	\$5,000	\$30	\$40	<p>Services are subject to the non-Preferred deductible and coinsurance.</p>
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<p>Other professional services</p>	<p>Services are subject to the Plan deductible and coinsurance, except the Plan pays 100% for covered lab services provided by contracted independent clinical labs. Diagnostic lab and X-ray services provided outside the doctor's office, surgeon and anesthesiologist services.</p>																			
<p>Preventive care</p>	<p>Services <i>provided in the physician's office</i> are subject to your office visit copay. For services <i>provided outside the physician's office</i>, the Plan pays 100% for covered lab services from contracted independent clinical labs and 80% for other services outside the physician's office, such as routine mammograms and colonoscopies.</p> <p>Preventive care services include annual physical exams and related tests and screenings, well-child care, routine immunizations, annual gynecologic exams, routine mammograms, routine sigmoidoscopy or colonoscopy.</p> <p>The deductible does not apply to preventive care services.</p>	<p>Preventive care is not covered at non-Preferred providers, except for routine mammograms.</p> <p>When mammograms are provided by non-Preferred providers, the deductible does not apply and the Plan pays 60% of the BCBSAZ allowed amount.</p>																		
<p>Maternity care</p>	<p>Services are subject to the Plan deductible and coinsurance. Only complications of pregnancy are covered; normal maternity care and delivery are not covered.</p>																			
<p>Prescription drugs</p> <p>For certain prescription drugs, the quantity of medication covered may be limited by BCBSAZ. FDA dosage limitations also apply.</p> <p>Most injectable drugs are only available from home health providers, are subject to the Plan deductible and coinsurance, and require precertification.</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center; border-bottom: 1px solid black;"><u>Participating pharmacy (30-day supply)</u></th> <th style="text-align: center; border-bottom: 1px solid black;"><u>Mail order (90-day supply)</u></th> </tr> </thead> <tbody> <tr> <td>Level 1:</td> <td style="text-align: center;">\$15 copay</td> <td style="text-align: center;">\$15 copay</td> </tr> <tr> <td>Level 2:*</td> <td style="text-align: center;">\$35 copay</td> <td style="text-align: center;">\$70 copay</td> </tr> <tr> <td>Level 3:</td> <td style="text-align: center;">\$65 copay</td> <td style="text-align: center;">\$195 copay</td> </tr> <tr> <td>Level 4:*</td> <td style="text-align: center;">\$120 copay</td> <td style="text-align: center;">\$360 copay</td> </tr> </tbody> </table> <p>*Please refer to the Prescription Medication Guide online at www.azblue.com for a list of Level 2 and Level 4 drugs.</p> <p>When the price BCBSAZ pays a contracted pharmacy for a drug is less than your copay, some participating pharmacies will charge you the BCBSAZ price. However, most pharmacies will charge you their usual and customary price (if it is also less than your copay), rather than the BCBSAZ price. You will never be charged more than your copay.</p> <p>Note: When you fill a prescription at a noncontracted pharmacy, you will be responsible for the difference between the pharmacy's retail price and BCBSAZ's reimbursement to noncontracted providers, in addition to your copay.</p>		<u>Participating pharmacy (30-day supply)</u>	<u>Mail order (90-day supply)</u>	Level 1:	\$15 copay	\$15 copay	Level 2:*	\$35 copay	\$70 copay	Level 3:	\$65 copay	\$195 copay	Level 4:*	\$120 copay	\$360 copay				
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Hospital services (Must be precertified except for emergencies.)	Services are subject to the Plan deductible and coinsurance. Covered services include room and board, special care units, operating and recovery room, diagnostic testing, blood transfusions, radiation therapy or chemotherapy, and anesthesia.													
Outpatient services (Must be precertified.)	Services are subject to the Plan deductible and coinsurance.													
Urgent care facility services Deductible option determines copay.	You pay a copay per visit (deductible does not apply): <table style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;"><u>Deductible</u></th> <th style="text-align: left; padding: 2px;"><u>Copay</u></th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">\$250</td> <td style="padding: 2px;">\$35</td> </tr> <tr> <td style="padding: 2px;">\$500</td> <td style="padding: 2px;">\$40</td> </tr> <tr> <td style="padding: 2px;">\$1,000</td> <td style="padding: 2px;">\$45</td> </tr> <tr> <td style="padding: 2px;">\$2,500</td> <td style="padding: 2px;">\$50</td> </tr> <tr> <td style="padding: 2px;">\$5,000</td> <td style="padding: 2px;">\$50</td> </tr> </tbody> </table>	<u>Deductible</u>	<u>Copay</u>	\$250	\$35	\$500	\$40	\$1,000	\$45	\$2,500	\$50	\$5,000	\$50	Services are subject to the non-Preferred deductible and coinsurance.
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Emergency room services	Services are subject to the Preferred deductible and coinsurance. There is also a \$100 access fee per visit, but it is waived if you are admitted. Follow-up care is paid as any other non-emergency service.													
Ambulance	Services are subject to the Preferred coinsurance; the Plan pays 80% . The deductible does not apply.													
Behavioral and mental health services (Inpatient care and outpatient services from the BSA must be precertified.)	<p>Outpatient psychotherapy and counseling services from the behavioral services administrator (BSA): \$10 copay per visit (deductible does not apply). Includes psychotherapy and counseling for substance abuse, personal and family problems, lifestyle education and stress management.</p> <p>Inpatient and outpatient services of professionals (e.g., psychiatrists and psychologists) who are contracted with BCBSAZ and outpatient facility charges: After you meet your applicable deductible (Preferred or non-Preferred), the Plan pays 50% of the BCBSAZ allowed amount. There is a maximum benefit of 20 outpatient visits per person per calendar year.</p> <p>Inpatient facility charges: Benefits are limited to 2 admissions, up to a combined total of 30 days per person per calendar year.</p> <p>PPO facility: Services are subject to Plan deductible and coinsurance.</p> <p>Non-PPO facility: Services are subject to Plan deductible and 50% coinsurance.</p> <p>Noncontracted facility: Services are subject to Plan deductible and 50% coinsurance plus the difference between the provider's billed charges and the BCBSAZ allowed amount.</p> <p>\$25,000 maximum benefit while the contract is in force.</p>													
Inpatient rehabilitation (Must be precertified.)	Services are subject to the Plan deductible and coinsurance for the first 60 days. After 60 days, we pay 50% of the BCBSAZ allowed amount up to an additional 60 days, which will not count toward any out-of-pocket maximum. Limited to 120 days per calendar year.													

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<p>Outpatient rehabilitation therapy</p> <p>“Modalities” are physical agents such as traction and ultrasound.</p> <p>“Therapeutic services” means the application of clinical skills/ services such as exercise and gait training.</p>	<p>Outpatient physical and/or occupational therapy: The first 80 modalities and/or therapeutic services per calendar year are subject to the Plan coinsurance (deductible does not apply). Modalities and/or services exceeding this limit are subject to 50% coinsurance up to the annual out-of-pocket maximum (deductible does not apply). The average number of modalities or services performed per visit is 4.</p> <p>Chiropractic services: Physical and/or occupational therapy services performed by a chiropractor count toward the limit described above. Visits to Preferred chiropractors are covered at your specialist office visit copay (deductible does not apply).</p> <p>Outpatient speech therapy: The first 20 visits per calendar year are subject to the Plan coinsurance (deductible does not apply). Visits exceeding this limit are subject to 50% coinsurance up to the annual out-of-pocket maximum (deductible does not apply).</p>	
<p>Home health (Must be precertified.)</p>	<p>Services subject to the Plan deductible and coinsurance. Up to 3 visits of 2 hours or less per day.</p>	
<p>Skilled nursing facility (Must be precertified.)</p>	<p>Services are subject to Plan deductible and coinsurance for first 90 days per calendar year. After 90 days, we pay 50% of the BCBSAZ allowed amount, up to an additional 90 days, which will not count toward any out-of-pocket maximum. Limited to 180 days per calendar year.</p>	
<p>Routine vision care</p>	<p>Eye exam at vision services administrator providers: You pay your PCP office visit copay (deductible does not apply).</p> <p>One refractive eye exam per calendar year for prescription glasses or contact lenses. If the initial order of contacts is not purchased through the examining provider, a professional services fee of up to \$50 may be charged.</p> <p>Discounts on frames and lenses, including contact lenses, at vision services administrator providers.</p>	<p>If a provider not contracted with the vision services administrator performs the routine eye exam, a reimbursement of up to \$25 per calendar year is allowed.</p>
<p>Contract benefit maximum</p>	<p>\$3,000,000 maximum benefit per person while the contract is in force.</p>	

Medical necessity

For services to be covered by this benefit plan, they must be considered medically necessary by BCBSAZ, based on specific criteria that is available to you upon request. Where benefits are provided by a third-party administrator, such as the behavioral services administrator, the third-party administrator may determine medical necessity based on its own criteria.

Precertification is required for some services

If precertification is not obtained, your benefits may be subject to an additional \$300 deductible or denial of benefits. Your provider must call for precertification at (602) 864-4320 or (800) 232-2345. Please refer to the precertification requirements in your contract booklet, which will be sent to you upon enrollment, or upon request prior to enrollment.

Exclusions and Limitations

The following is a partial list of conditions and services that are limited or excluded. A complete list of all benefits, limitations and exclusions can also be found in the contract booklet, which will be sent to you when you enroll, or upon request prior to enrollment. Expenses for services that exceed benefit limitations are not covered. In addition, no benefits will be paid for expenses associated with the following:

- Abortions
- Activity therapy
- Acupuncture
- Alternative medicine, non-traditional or alternative medical therapies, including but not limited to naturopathic and homeopathic medicine, diet therapies, nutritional or lifestyle therapies, aromatherapy
- Biofeedback and/or hypnotherapy
- Cognitive and vocational therapy
- Complications of body piercing/tattooing
- Complications of noncovered benefits
- Cosmetic or aesthetic surgery and services, except for breast reconstruction following a medically necessary mastectomy in accordance with state and/or federal law, or for congenital defects for newborns and adopted children
- Counseling or behavioral modification services (except as may be available through the behavioral services administrator, if applicable to your plan)
- Court-ordered services – testing, treatment or therapy, unless such services are otherwise covered under the contract
- Custodial care, except for limited hospice benefits
- Dental/orthodontic services or supplies
- Dietary/nutritional supplements – all dietary, caloric and nutritional supplements, including, for example, specialized formulas for infants, children or adults or other special foods or diets, even if prescribed by a physician or other eligible provider, except as otherwise specifically provided under the “Medical Foods” section of the contract booklet
- Environmental medicine
- Fees other than for medically appropriate in-person, direct patient treatment, tests, services, medications, supplies or equipment
- Fertility or infertility treatment, drugs or procedures
- Foot care
- Genetic/chromosome testing and screening
- Government services – services available under a governmental health program
- Growth hormone(s) – Growth hormone except as determined medically necessary by BCBSAZ to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat Idiopathic Short Statute (ISS) is expressly excluded
- Hearing services or devices
- Investigational treatments, procedures, equipment, drugs, devices or supplies, as determined by BCBSAZ and only as required by Arizona law
- Lodging and meals
- Medications dispensed in a physician’s/provider’s office – prescription medications and over-the-counter medications, including pharmaceutical manufacturer’s samples, dispensed to the patient in a physician’s/provider’s office by any mode of administration
- Nonmedically necessary services as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Over-the-counter drugs – any drug, medicine, device, equipment or supply (except for certain diabetic supplies and inhaler spacers, as described in the pharmacy benefit), that is lawfully obtainable without a prescription
- Personal comfort items
- Screening tests, except as specifically described in the contract booklet
- Services from family member(s) – services that are provided by an eligible provider who is a member of your immediate family, or services for which you have no legal obligation to pay
- Services without a prescription, when a prescription is required
- Services of ineligible providers
- Services not requiring licensed professional
- Services or supplies delivered prior to the coverage effective date or after coverage termination date
- Services or supplies related to or associated with a noncovered service or supply
- Sexual dysfunction – evaluation and/or testing, diagnosis, treatment (surgical or nonsurgical), or medication or devices for sexual dysfunction, regardless of the cause of the condition, including trauma
- Smoking cessation programs, medications, aids or devices, except as stated in the contract
- Telephonic or electronic consultations
- Therapy services, except as expressly provided in the contract
- Training and education, except for certain diabetes and asthma training or training related to BCBSAZ-established disease management program(s)
- Transplants (organ, tissue, bone marrow/peripheral stem cell rescue procedures) not approved by BCBSAZ; nor high-dose chemotherapy, radiation administered in conjunction with a noncovered transplant, expenses related to donation of an organ to a recipient who is not covered by BCBSAZ
- Transportation services or travel expenses, except for covered ambulance services and covered transplant travel benefits
- Transsexual treatment or surgery, and/or any related services
- Treatment for behavioral or mental health conditions at non-acute facilities (e.g., residential, skilled nursing)
- Vision therapy, radial keratotomy, all types of refractive keratoplasties, eyeglasses and contact lenses and the vision examination for prescribing and fitting of the same
- Vitamins – except for certain vitamins when a prescription is written by a physician
- Weight loss/gain therapy or treatment
- When a provider is also the covered person, services rendered by that provider for him/herself are excluded from coverage
- Workers’ Compensation – services for an illness or injury covered by Workers’ Compensation or similar benefits, unless you are exempt from such coverage or have made a statutory opt-out election

Additional exclusions for BluePreferred.

- Normal maternity services
- Waivered conditions
- AN 11-MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS APPLIES. A pre-existing condition is defined as a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months before your effective date. Services for pre-existing conditions are not covered until 11 months after the contract effective date.

Important note

This is only a general summary of benefits. A complete listing and description of all benefits, limitations and exclusions that govern determinations of coverage are found in the contract, which will be sent to you upon enrollment, or upon request prior to enrollment.

There is no guarantee of continued benefits as outlined in this summary or your contract booklet. The contract may be amended, and benefits may be added, deleted or changed by BCBSAZ upon 31 days' notice to the contract holder.

Network providers

All BluePreferred and participating network providers are independent contractors who have an agreement with BCBSAZ regarding reimbursement and administrative policies. Network providers exercise independent medical judgment and are not employees, agents or representatives of BCBSAZ. BCBSAZ has no control over any diagnosis, treatment or services rendered by any provider.

BCBSAZ has negotiated various reimbursement methods with contracted network providers. These providers have agreed to accept the BCBSAZ allowed amount for covered services provided to our customers. This means that after you pay any deductible, coinsurance or copay amounts, these providers will not bill you for any difference between their billed charge for the service and the BCBSAZ allowed amount. However, when there is another source of payment – such as a liability insurer, government payer or uninsured and/or underinsured motorist coverage – network providers may be entitled to collect from the other source or from proceeds received from the other source any difference between their billed charges and the BCBSAZ allowed amount.

The contracted networks of providers are subject to change at any time. Every specialty type may not be available in the networks.

Portability/Conversion Coverage

Notice to applicants who have lost group health coverage or who are transferring from a Blue Cross and/or Blue Shield plan in another state: If you terminated your group health plan (employer provided health coverage) or COBRA continuation coverage within the past 63 days, you may be eligible for **Individual Portability Coverage**. If you terminated BCBSAZ group coverage or any coverage from another Blue Cross and/or Blue Shield plan within the past 31 days, you may be eligible for **Conversion Coverage**.

Individual Portability Coverage and Conversion Coverage do not require medical underwriting. There is no waiting period for pre-existing conditions or normal maternity services on Individual Portability Coverage. However, the premiums are higher for these health plans. To request brochures and applications for Individual Portability Coverage or Conversion Coverage, visit www.azblue.com or give us a call.