



BluePreferred[®]

Standard Group
Stand Alone Option 250 90/70
\$15/\$25 Copay

Summary of Benefits



An Independent Licensee of the Blue Cross and Blue Shield Association

www.bcbsaz.com

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See Provider Alternatives for more information on the impact of using in-network and out-of-network providers.

Summary of Benefits	Preferred Provider (PPO) In-Network	Non-Preferred Provider (Non-PPO) Out-of-Network
Deductible	Calendar-year deductible, per person – \$250 , family maximum deductible – \$500	
Coinsurance	BCBSAZ pays 90% , after meeting deductible, unless a different coinsurance percentage is indicated below.	BCBSAZ pays 70% , after meeting deductible, unless a different coinsurance percentage is indicated below.
Out-of-pocket Maximum	\$2,000 per person, per calendar year (excluding, e.g., deductible, copayments, access fees). After meeting the out-of-pocket maximum, BCBSAZ pays 100%	\$4,000 per person, per calendar year (excluding, e.g., deductible, copayments, access fees). After meeting the out-of-pocket maximum, BCBSAZ pays 100%
PCP Office Visit	\$15 copayment per visit (PCP – general practice, family practice, internal medicine, pediatrics)	BCBSAZ pays 70% , after meeting deductible
Specialist Office Visit	\$25 copayment per visit	
Laboratory Services	During an office visit, copay applies. At contracted, freestanding, independent clinical labs, BCBSAZ pays covered services at 100%.	BCBSAZ pays 70% , after meeting deductible
Other Professional Services	BCBSAZ pays 90% , after meeting deductible Diagnostic, surgical and anesthesia services rendered outside the doctor's office	BCBSAZ pays 70% , after meeting deductible
Inpatient - Hospital	BCBSAZ pays 90% , after meeting deductible	BCBSAZ pays 70% , after meeting deductible
Outpatient Services (Facility charges)	BCBSAZ pays 90% , after meeting deductible	BCBSAZ pays 70% , after meeting deductible
Emergency Room	\$100 access fee per visit; then BCBSAZ pays 90% , after meeting deductible; emergency room access fee is waived if member is admitted to the hospital	
Urgent Care	\$25 copayment, deductible waived	BCBSAZ pays 70% , after meeting deductible
Prescription Drugs A prescription drug mail order program is available for maintenance drugs.	\$10 Generic \$25 Preferred Brand \$50 Non-Preferred Brand A \$80 Non-Preferred Brand B	In addition to the applicable prescription drug copayment, member will be responsible for the difference between the out-of-network pharmacy's billed charge and BCBSAZ's allowed amount
Preventive Care • Well-child care • Well-woman care • Routine physicals	\$15/\$25 copayment per visit, depending on whether services are received from a PCP or specialist (OB/gyn physicians are specialists)	Not covered
Mammography	BCBSAZ pays 90% , deductible waived	BCBSAZ pays 70% , deductible waived
Maternity	Physician: Office visit copayment applies only to first prenatal visit. Calendar-year deductible and coinsurance are waived on physician's global delivery fee Hospital: BCBSAZ pays 90% , after meeting deductible	Physician and Hospital: BCBSAZ pays 70% , after meeting deductible
Skilled Nursing Facility	BCBSAZ pays 90% , after meeting deductible, for up to 90 days. After 90 days, BCBSAZ pays 50% , up to an additional 90 days, which will not count toward out-of-pocket maximum	BCBSAZ pays 70% , after meeting deductible, for up to 90 days. After 90 days, BCBSAZ pays 50% , up to an additional 90 days, which will not count toward out-of-pocket maximum
Inpatient Extended Active Rehabilitation	BCBSAZ pays 90% , after meeting deductible, for up to 60 days. After 60 days, BCBSAZ pays 50% , up to an additional 60 days, which will not count toward out-of-pocket maximum	BCBSAZ pays 70% , after meeting deductible, for up to 60 days. After 60 days, BCBSAZ pays 50% , up to an additional 60 days, which will not count toward out-of-pocket maximum
Physical, Occupational & Speech Therapy	Physical/Occupational Therapy - BCBSAZ pays 90% , deductible waived, for first 80 modalities or therapeutic services per calendar year Speech Therapy - BCBSAZ pays 90% , deductible waived, for first 20 visits per calendar year After the first 80 modalities or 20 visits, BCBSAZ pays 50%, deductible waived	Physical/Occupational Therapy - BCBSAZ pays 70% , deductible waived, for first 80 modalities or therapeutic services per calendar year Speech Therapy - BCBSAZ pays 70% , deductible waived, for first 20 visits per calendar year After the first 80 modalities or 20 visits, BCBSAZ pays 50%, deductible waived
Behavioral/Mental Health Biodyne services are available only in Arizona.	Inpatient: One admission per calendar year (for up to 30 days) PPO provider: BCBSAZ pays 90% , after meeting deductible Non-PPO provider: BCBSAZ pays 50% , after meeting deductible Outpatient: Member may choose PPO or non-PPO providers or the behavioral services administrator (Biodyne). PPO/Non-PPO providers: BCBSAZ pays 50% , after meeting deductible, for 20 psychological sessions per calendar year Biodyne: unlimited psychotherapy and counseling: \$10 per visit for the first 10 visits per year. \$100 calendar-year copayment maximum per person; \$200 calendar-year copayment maximum per family	
Routine Vision Services Avesis services are available only in Arizona.	\$15 copayment for one routine exam per year when received through the vision services administrator (Avesis); discounts on eyewear	Reimbursement up to \$25 , for one routine exam per year from a non-Avesis provider; no eyewear discounts
Contract Maximum	\$3,000,000 maximum benefit per person while the contract is in force. All payments by BCBSAZ (for both PPO and non-PPO providers) apply toward the contract maximum.	

Provider Alternatives – Out-of-pocket costs will differ depending on type of provider selected

BluePreferred Providers (PPO)	These providers have agreed to accept the BCBSAZ allowed amount for covered services and will file claims with BCBSAZ for members.
Participating Providers (Non-PPO)	Arizona health care providers who are not contracted for BCBSAZ's BluePreferred plans but are part of the BCBSAZ Participating provider network. These providers have agreed to accept the BCBSAZ allowed amount for covered services and will file claims with BCBSAZ for members.
Noncontracted Providers (Non-PPO)	Providers who have no agreement with BCBSAZ. Noncontracted providers may charge members for the difference between the allowed amount and their billed charges. Members will have more out-of-pocket expense, and noncontracted providers are not obligated to file claims for members.

Network providers are independent contractors exercising independent medical judgement and are not employees, agents or representatives of BCBSAZ. BCBSAZ has no control over any diagnosis, treatment or service rendered by any provider.

When there is another source of payment, such as a liability insurer, government or uninsured and/or uninsured motorist coverage, network providers may be entitled to collect from the other source or from proceeds received from the other source any difference between the BCBSAZ allowed amount and their billed charge.

Important Information:

- For services to be covered under 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, the third-party administrator may determine medical necessity based on its own criteria, which is also available upon request.
- The BCBSAZ allowed amount is calculated using the lesser of billed charges or the applicable BCBSAZ fee schedule, less any contractual discounts. Coinsurance is based on the BCBSAZ allowed amount for covered services.
- Certain services are excluded from the out-of-pocket maximum calculation. Coinsurance applicable to behavioral/mental health services does not count toward the out-of-pocket maximum. Benefits paid at 50% for the additional 60 days of inpatient rehabilitation or 90 days of skilled nursing services do not count toward the out-of-pocket maximum and will not be paid at 100% if the out-of-pocket maximum has been satisfied. Please refer to the benefit plan booklet for additional information on expenses that do not apply to the out-of-pocket maximum.
- Precertification is required for some services. If precertification is not obtained when required, benefits may be denied or you may have to pay an additional \$300 deductible. Please refer to your benefit plan booklet for detailed information on precertification requirements.
- When the price BCBSAZ pays a contracted pharmacy for a drug is less than your copayment, some pharmacies will charge you the BCBSAZ price. However, most pharmacies will charge you their usual and customary price (if also less than the copayment), rather than the BCBSAZ price. When using your BCBSAZ ID card at a contracted pharmacy, you will never be required to pay more than your copayment for a Level 1, 2, 3 or 4 drug at a contracted pharmacy.
- Certain injectable drugs are subject to precertification. Injectable drugs not covered at a retail pharmacy may be covered under medical benefits and are subject to BCBSAZ medical necessity guidelines.
- For certain prescription drugs indicated in the prescription medication guide, the quantity of medication covered per coinsurance/copayment may be limited by dose or by the number of units, even though your physician may prescribe a higher dose or greater number of units

AN 11-MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS MAY APPLY. 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 six (6) month period immediately preceding the subscriber's enrollment date. For purposes of determining a pre-existing condition waiting period, enrollment date means the subscriber's effective date of coverage under this benefit plan or the first day of the group's eligibility waiting period, whichever is earliest. **IMPORTANT:** Pregnancy is not considered a pre-existing condition. Credit will be given for periods of prior creditable coverage as long as there was no period of sixty-three (63) days or more (excluding group eligibility waiting periods) during which you were not covered under any creditable coverage. Creditable coverage is coverage provided under a group health plan (insured or self-insured), an individual insurance policy, Medicare, Medicaid, a public health plan (e.g., AHCCCS), a health risk benefits pool, CHAMPUS, Peace Corps, Bonafide Association, Indian Health Service or the Federal Employee Health Benefits Plan. You have the right to demonstrate to BCBSAZ that you have had prior creditable coverage by providing a Certificate of Creditable Health Coverage or other documentation of such coverage. BCBSAZ can calculate your creditable coverage prior to your effective date upon your request. Please call (602) 864-4456.

This is only a brief summary of this benefit plan. A complete listing of all benefits, limitations and exclusions is in the benefit plan booklet and is available prior to enrollment upon request. If the benefits on this summary differ from those stated in the benefit plan booklet, the terms of the benefit plan booklet apply.

Phoenix

(602) 864-4400

Statewide (800) 232-2345

Tucson

(520) 745-1883

Southern Arizona (800) 752-0193

Flagstaff

(928) 526-0232

Northern Arizona (800) 423-6484

Note: see Exclusions & Limitations on back page.

Exclusions & Limitations

Examples of Services and Supplies Not Covered

The following is a partial list of conditions and services that are limited or excluded. Expenses for services that exceed benefit limitations are not covered. A complete listing of all benefits, limitations and exclusions is in the benefit plan booklet and is available prior to enrollment upon request.

- Abortions (nonspontaneous, medically induced)
- Activity therapy
- Acupuncture
- Alternative medicine, including naturopathic and homeopathic medicine
- Biofeedback and/or hypnotherapy
- Cognitive and vocational therapy
- Complications of body piercing/tattooing
- Complications of noncovered benefits
- Cosmetic or aesthetic procedures, except for breast reconstruction following a medically necessary mastectomy in accordance with state and/or federal law
- Counseling or behavioral modification services
- Court-ordered services – testing, treatment or therapy, unless such services are otherwise covered under this benefit plan
- Custodial care, except for limited hospice benefits
- Dental/orthodontic services or supplies
- Dietary and nutritional supplements or special foods or diets, even if prescribed by a physician or other eligible provider, except for specific medical foods to treat inherited metabolic disorders in accordance with Arizona law, as described in the “Medical Foods” section of the benefit plan 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, except when medically appropriate for diabetics or neurological involvement or peripheral vascular disease of the foot or lower leg
- Genetic/chromosome testing and screening – genetic/chromosomal testing of an asymptomatic or unaffected individual or an individual not displaying signs or symptoms of a suspected or specific inherited disorder
- Government services – services available under a government health program
- Hearing services or devices – hearing aid services and supplies, and hearing exams, except for routine hearing screening that may be included in covered physical exams, including external, semi-implantable middle ear and implantable bone conduction hearing aids
- Investigational treatments, procedures, equipment, drugs, devices or supplies, as determined by BCBSAZ, except as required by Arizona law
- Lodging and meals, except for covered transplant travel benefits
- 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. This does not include eligible injectable drugs administered in the physician’s office
- 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, 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 this benefit plan
- Services or supplies delivered prior to the coverage effective date or after the coverage termination date
- Services or supplies related to or associated with a noncovered service or supply
- 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 a licensed professional
- Sexual dysfunction – evaluation and/or testing, diagnosis, treatment (surgical or non-surgical), or medication or devices for sexual dysfunction, regardless of the cause of the condition, including trauma
- Smoking cessation programs, medications or devices, except as otherwise stated in the benefit plan
- Telephonic or electronic consultations
- Therapy services, except as expressly provided in this benefit plan
- Training and education, except for certain diabetic 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 or radiation administered in conjunction with a noncovered transplant
- Transport 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/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, except as otherwise stated as a benefit in the benefit plan
- Vitamins – except for certain vitamins when a prescription is written by a physician
- Weight loss/gain therapy or treatment, including, but not limited to, Xenical® and Meridia® (except for certain surgical services)
- 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