BluePreferred Upgrade Options

Plan Comparison

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Benefits	Option 1		Option 2		Option 3	
	Base Plan	Upgrade	Base Plan	Upgrade	Base Plan	Upgrade
	Copayment 500 80/60	Copayment 100 90/70	Copayment 1000 80/50	Copayment 250 80/60	Copayment 1000 80/50	Copayment 500 80/60
Deductible	$500 single, $1000 family (cumulative PPO and Non-PPO)	$100 single, $200 family (cumulative PPO and Non-PPO)	$1000 single, $2000 family (cumulative PPO and Non-PPO)	$250 single, $500 family (cumulative PPO and Non-PPO)	$1000 single, $2000 family (cumulative PPO and Non-PPO)	$500 single, $1000 family (cumulative PPO and Non-PPO)
Coinsurance/ OOP Max PPO	80% up to member out-of-pocket max of $2500	90% up to member out-of-pocket max of $1000	80% up to member out-of-pocket max of $3000	80% up to member out-of-pocket max of $2000	80% up to member out-of-pocket max of $3000	80% up to member out-of-pocket max of $2500
Non-PPO	60% up to member out-of-pocket max of $5000	70% up to member out-of-pocket max of $2000	50% up to member out-of-pocket max of $6000	60% up to member out-of-pocket max of $4000	50% up to member out-of-pocket max of $6000	60% up to member out-of-pocket max of $5000
PCP Office Visit PPO	$15 copayment	$15 copayment	$25 copayment	$15 copayment	$25 copayment	$15 copayment
Non-PPO	60%	70%	50%	60%	50%	60%
Specialist Office Visit PPO	$25 copayment	$25 copayment	$35 copayment	$25 copayment	$35 copayment	$25 copayment
Non-PPO	60%	70%	50%	60%	50%	60%
Lab PPO	100%	100%	100%	100%	100%	100%
Non-PPO	60%	70%	50%	60%	50%	60%
Inpatient Hospital/ Outpatient Services PPO	80%	90%	80%	80%	80%	80%
Non-PPO	60%	70%	50%	60%	50%	60%
Emergency	$100 access fee, then 80%	$100 access fee, then 90%	$100 access fee, then 80%	$100 access fee, then 80%	$100 access fee, then 80%	$100 access fee, then 80%
Urgent Care PPO	$25 copayment	$25 copayment	$50 copayment	$25 copayment	$50 copayment	$25 copayment
Non-PPO	60%	70%	50%	60%	50%	60%
Prescription Drugs PPO / Non-PPO	$10/$25/$50/$80 Prescription drug copayment*	$10/$25/$50/$80 Prescription drug copayment*	$15/$35/$65/$120 Prescription drug copayment*	$10/$25/$50/$80 Prescription drug copayment*	$15/$35/$65/$120 Prescription drug copayment*	$10/$25/$50/$80 Prescription drug copayment*
Preventive Care PPO	$15 PCP $25 Specialist	$15 PCP $25 Specialist	$25 PCP $35 Specialist	$15 PCP $25 Specialist	$25 PCP $35 Specialist	$15 PCP $25 Specialist
Non-PPO	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Mammography PPO	80%, deductible waived	90%, deductible waived	80%, deductible waived	80%, deductible waived	80%, deductible waived	80%, deductible waived
Non-PPO	60%, deductible waived	70%, deductible waived	50%, deductible waived	60%, deductible waived	50%, deductible waived	60%, deductible waived
Physical, Occupational & Speech Therapy PPO	80%, deductible waived	90%, deductible waived	80%, deductible waived	80%, deductible waived	80%, deductible waived	80%, deductible waived
Non-PPO	60%, deductible waived	70%, deductible waived	50%, deductible waived	60%, deductible waived	50%, deductible waived	60%, deductible waived
	Any combination of Physical/Occupational Therapy: The first 80 combined modalities and/or therapeutic services per calendar year are subject to applicable coinsurance. Modalities and/or services exceeding this limit are subject to 50% coinsurance. The average number of modalities per visit is 4. Speech Therapy: The first 20 visits per calendar year are subject to applicable coinsurance. Visits exceeding this limit are subject to 50% coinsurance.					
In-Network Vision Avesis Providers only	$15 copayment, 1 exam per year Eyewear discounts available	$15 copayment, 1 exam per year Eyewear discounts available	$25 copayment, 1 exam per year Eyewear discounts available	$15 copayment, 1 exam per year Eyewear discounts available	$25 copayment, 1 exam per year Eyewear discounts available	$15 copayment, 1 exam per year Eyewear discounts available
Out-of-Network Vision Non-Avesis	Reimbursement for exam up to $25; no eyewear discounts	Reimbursement for exam up to $25; no eyewear discounts	Reimbursement for exam up to $25; no eyewear discounts	Reimbursement for exam up to $25; no eyewear discounts	Reimbursement for exam up to $25; no eyewear discounts	Reimbursement for exam up to $25; no eyewear discounts

*Member also responsible for difference between BCBSAZ allowed amount and pharmacy's billed charge.

Precertification is required for some services. If precertification is not obtained, services will be subject to an additional $300 deductible or denial of benefits.

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 in 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

Note: This is only a brief summary of benefits and exclusions. Please refer to the specific provisions found within the benefit plan booklet for complete information on benefits, limitations and exclusions. If the benefits on this summary differ from those stated in the benefit plan booklet, the terms of the benefit plan booklet apply.

When a service or supply is subject to coinsurance, the coinsurance amount is based on the BCBSAZ allowed amount.

For services to be covered under these benefit plans, they must be considered medically necessary by BCBSAZ, based on specific criteria that is available upon request. Where benefits are provided by a third-party administrator, such as Biodyne, the third-party administrator may determine medical necessity based on its own criteria – which is also available upon request.

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 BCBSAZ subscribers. This means that after payment of deductible, coinsurance or copayment amounts, these providers will not bill subscribers for the difference between the BCBSAZ allowed amount and the provider's billed charge for the service. However, when there is another source of payment, such as a liability insurer, government 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 the BCBSAZ allowed amount and their billed charge, pursuant to A.R.S. § 33-931.

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.

If the plan has a tiered pharmacy benefit and the price BCBSAZ pays a contracted pharmacy for a drug is less than the copayment, most pharmacies will charge the BCBSAZ price. However, some pharmacies will charge their usual and customary price (if also less than the copayment), rather than the BCBSAZ price. When using the BCBSAZ ID card, a member will never be required to pay more than the copayment for a level 1, 2, 3 or 4 drug at a contracted pharmacy.

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 a physician may prescribe a higher dose or greater number of units.

An 11-month waiting period for pre-existing conditions may apply to a group's benefit plan. 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, Bona Fide Association, Indian Health Service or the Federal Employee Health Benefits Plan.