PPO Plan

BluePreferred®

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

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

PREFERRED PROVIDERS

These providers have agreed to accept the BCBSAZ allowed amount for covered services and will file claims to BCBSAZ for you. Out-of-pocket costs (e.g., deductibles, coinsurance and copays) are lower when Preferred providers are used.

Preferred providers are also available outside Arizona through the BlueCard® program. To locate BlueCard PPO providers, call (800) 810-BLUE or check the BlueCard Doctor & Hospital Finder at bcbs.com.

NONPREFERRED PROVIDERS

You pay a separate – and higher – deductible and coinsurance when you use nonPreferred providers. In addition, preventive care benefits are not covered at nonPreferred providers (except mammography services). There are two types of nonPreferred providers.

Participating providers — Arizona health care providers who are not contracted for BCBSAZ's BluePreferred plans, but are part of the BCBSAZ Participating provider network. Although you will pay a higher out-of-network deductible and coinsurance, these providers have agreed to accept the BCBSAZ allowed amount for covered services and will file claims to BCBSAZ for you. Participating providers are also available outside Arizona through the BlueCard program, 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 bcbs.com.

Noncontracted providers — Providers who have no contract with BCBSAZ**. In addition to deductible and any applicable coinsurance, noncontracted providers may charge you the difference between their billed charges and the BCBSAZ allowed amount. The obligation to pay the difference between the provider's billed charges and the BCBSAZ allowed amount continues even after your out-of-pocket coinsurance maximum is met.** You will have more out-of-pocket expense and noncontracted providers are not obligated to file claims for you.

- Contracted providers are independent contractors exercising independent medical judgment and are not employees, agents or representatives of BCBSAZ. BCBSAZ has no control over any diagnosis, treatment or service rendered by any provider.
- BCBSAZ has negotiated various reimbursement methods with contracted providers. These providers have agreed to accept the BCBSAZ allowed amount for covered services provided to BCBSAZ members. This means that after payment of deductible, coinsurance or copay amounts, these providers will not bill you for the difference between the provider's billed charges and the BCBSAZ allowed amount for covered services. However, when there is another source of payment, such as a liability insurer or government payer, providers may be entitled to collect from the other source or from proceeds received from the other source any difference between the provider's billed charges and the BCBSAZ allowed amount.
- Reimbursement is based on the BCBSAZ allowed amount. The BCBSAZ allowed amount is generally calculated using the lesser of billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements.

Below is an example of how out-of-pocket coinsurance expenses can differ depending on the provider chosen. This example is for services that do not have a copay and assumes the deductible has been met. The example also assumes your coinsurance is 20 percent of the BCBSAZ allowed amount at Preferred providers and 40 percent of the BCBSAZ allowed amount at nonPreferred providers.

Financial Responsibility Example

			Preferred Providers	**NonPreferred Providers**	
Billed Charges	BCBSAZ Allowed Amount	Financial Responsibility	PPO Contracted Providers	Contracted Participating Providers	Noncontracted Providers
$1,000	$400	BCBSAZ pays:	$320	$240	$240
		You pay:	**$80** coinsurance amount	**$160** coinsurance amount	**$160** coinsurance **+600** balance bill **$760**

The above figures are for demonstration only. Your savings may vary, depending on your benefit plan and the providers from whom you receive services.

Billed charges: what the provider bills BCBSAZ.
BCBSAZ allowed amount: the amount contracted providers agree to accept as the basis of payment.
You pay: what you must pay after BCBSAZ has paid its share of the BCBSAZ allowed amount.
Balance bill: noncontracted providers may bill you the difference between billed charges and the BCBSAZ allowed amount.

BluePreferred® | PPO PLAN Benefit Summary

	PREFERRED PROVIDER (PPO) IN-NETWORK	NONPREFERRED PROVIDER (NonPPO) OUT-OF-NETWORK
Deductible (Calendar-year) Copays are not applied toward the deductible. Preferred deductibles are accumulated separately from nonPreferred deductibles.	Per person: **$250, $500, $1,000, $2,500** and **$5,000** Family maximum: **$500, $1,000, $2,000, $5,000** and **$10,000**	Per person: **$750, $1,000, $1,500, $3,000** and **$5,500** Family maximum: **$1,500, $2,000, $3,000, $6,000 and $11,000**
Coinsurance [1, 2]	BCBSAZ pays **80%**; you pay **20%** after meeting deductible, unless a different coinsurance percentage is indicated.	BCBSAZ pays **60%**; you pay **40%** after meeting deductible, unless a different coinsurance percentage is indicated.
Out-of-Pocket Coinsurance Maximum [2] (Calendar-year) The Preferred out-of-pocket coinsurance maximum is accumulated separately from the nonPreferred out-of-pocket coinsurance maximum.	Deductible options / Per person **$250, $500, $1,000** / **$2,500** **$2,500** / **$3,000** **$5,000** / **$4,000**	Deductible options / Per person **$250, $500, $1,000** / **$5,500** **$2,500** / **$6,000** **$5,000** / **$8,000**
Physician Services – Office Visits [3] Deductible option determines copay. Primary care physician (PCP) - internal medicine, family practice, general practice or pediatrics. (OB/GYN physicians are specialists.)	Deductible / PCP Copay / Specialist Copay **$250** / **$15** / **$30** **$500** / **$20** / **$40** **$1,000** / **$25** / **$50** **$2,500** / **$30** / **$60** **$5,000** / **$35** / **$70**	**60%/40%** after meeting deductible.
Preventive Care, Mammography, Routine Physical Exams	Services provided in the physician's office are subject to your office visit copay. Services provided outside the physician's office are subject to coinsurance.	Not covered except for routine mammograms. Routine mammography: **60%/40%.**
	The deductible does not apply to covered preventive care services.	
Laboratory Services	During an office visit, copay applies as specified. At contracted, freestanding independent clinical labs, BCBSAZ pays **100%** for covered services, deductible waived. At all other facilities, **80%/20%** after meeting deductible.	**60%/40%** after meeting deductible.
Other Professional Services	**80%/20%** after meeting deductible.	**60%/40%** after meeting deductible.
	Covered services include diagnostic, surgical and anesthesia services rendered outside the doctor's office.	
Retail and Mail Order Pharmacy[4] Mail order is only available through the Preferred mail order provider.	Contracted pharmacy 30-day retail supply / Mail order 90-day retail supply Level 1: **$ 15 copay** / **$ 15 copay** Level 2: **$ 35 copay** / **$ 70 copay** Level 3: **$ 65 copay** / **$195 copay** Level 4: **$120 copay** / **$360 copay**	
	When you fill a prescription at a noncontracted pharmacy, in addition to the applicable prescription medication copay, you are also responsible for the difference between a noncontracted pharmacy's price and BCBSAZ's allowed amount.	
Inpatient Hospital [5]	**80%/20%** after meeting deductible.	**60%/40%** after meeting deductible.
Outpatient Services (Facility charges)	**80%/20%** after meeting deductible.	**60%/40%** after meeting deductible.
Urgent Care Deductible option determines copay.	Deductible / Copay **$250** / **$35** **$500** / **$40** **$1,000** / **$50** **$2,500** / **$60** **$5,000** / **$70**	**60%/40%** after meeting deductible.

BluePreferred® | PPO PLAN Benefit Summary

	PREFERRED PROVIDER (PPO) IN-NETWORK	NONPREFERRED PROVIDER (NonPPO) OUT-OF-NETWORK
Emergency or Accident	**$150** access fee per visit, then BCBSAZ pays **80%**, you pay **20%** after meeting deductible; emergency room access fee is waived if you are admitted to the hospital.	
Maternity – Complications of Pregnancy Only	**80%/20%** after meeting deductible.	**60%/40%** after meeting deductible.
Physical, Occupational and Speech Therapy	**80%/20%** after meeting deductible.	**60%/40%** after meeting deductible.
Chiropractic Services	**Office visits:** specialist office visit copay required. **Other services, such as physical and/or occupational therapy: 80%/20%** after meeting deductible.	**60%/40%** after meeting deductible.
Vision Exams (Routine) and Eyewear Discounts	PCP office visit copay for one routine eye exam per year when received through the vision services administrator [6] (VSA); discounts on eyewear.	Reimbursement up to **$25** for one routine eye exam per year from a nonVSA provider. No eyewear discounts.
Ambulance Services	Services are subject to the Preferred coinsurance; BCBSAZ pays **80%** of the BCBSAZ allowed amount. The deductible does not apply.	
Behavioral and Mental Health Services [5] Cost sharing for behavioral/mental health does not apply to any out-of-pocket coinsurance maximum. Both Preferred and nonPreferred admissions count toward the 2-admission, 30-day limit.	**Outpatient:** You may choose Preferred or nonPreferred providers or the behavioral services administrator [6] (BSA). **BSA: $15 copay** per visit. **Preferred and nonPreferred Providers:** BCBSAZ pays **50%** and you pay **50%** after meeting deductible, for **20** psychological visits per calendar year. **Inpatient:** Two admissions per calendar year, up to a combined total of **30** days. **Preferred facility: 80%/20%** after meeting deductible. | **NonPreferred facility: 50%/50%** after meeting deductible. **Preferred and NonPreferred inpatient professional services: 50%/50%** after meeting deductible. **$25,000 per person maximum** benefit while the contract is in force.	
Inpatient Rehabilitation Services [5] Both Preferred and nonPreferred admissions count toward the 120-day calendar-year limit.	**80%/20%** after meeting deductible, for up to **60** days. After 60 days, BCBSAZ pays **50%**, you pay **50%** up to an additional **60** days which will not count toward any out-of-pocket coinsurance maximum.	**60%/40%** after meeting deductible, up to **60** days. After 60 days, BCBSAZ pays **50%**, you pay **50%**, up to an additional **60** days which will not count toward any out-of-pocket coinsurance maximum.
	Limited to **120** days per calendar year.	
Home Health Services and Home Infusion – Medication Administration Therapy [7] Including specialty self-injectable medications	**80%/20%** after meeting deductible.	**60%/40%** after meeting deductible.
Skilled Nursing Facility [5] Both Preferred and nonPreferred admissions count toward the 180 day calendar-year limit.	**80%/20%** after meeting deductible, up to **90** days. After 90 days, BCBSAZ pays **50%**; you pay **50%** up to an additional **90** days which will not count toward any out-of-pocket coinsurance maximum.	**60%/40%** after meeting deductible, up to **90** days. After 90 days, BCBSAZ pays **50%**; you pay **50%** up to an additional **90** days which will not count toward any out-of-pocket coinsurance maximum.
	Limited to **180** days per calendar year.	

BluePreferred® | PPO PLAN Benefit Summary

	PREFERRED PROVIDER (PPO) IN-NETWORK	NONPREFERRED PROVIDER (NonPPO) OUT-OF-NETWORK
Specialty Self-Injectable Medications [5] For certain specified self-injectable prescription biologic medications. Specialty injectable medications are not covered under the retail or mail order medication benefit. *(Also see Home Health.)*	Contracted specialty Pharmacy (30-day supply) Level A: **$30 copay** Level B: **$60 copay** Level C: **$90 copay** Level D: **$120 copay** Please refer to azblue.com for a listing of specialty injectable medications and contracted specialty pharmacies or call BCBSAZ. Injectable medications are also available from home health providers subject to deductible and coinsurance.	**Not covered** (see Home Health).
Contract Maximum	**$3,000,000** maximum benefit per person while the contract is in force. All payments by BCBSAZ (for both Preferred and nonPreferred providers) apply toward the contract maximum.	

1 Coinsurance is a percentage you must pay for covered services after you have met the calendar-year deductible. You will pay a higher coinsurance percentage when using a nonPreferred provider. Coinsurance is based on the BCBSAZ allowed amount.

2 In addition to any applicable deductible and coinsurance, noncontracted providers may charge you for the difference between their billed charges and the BCBSAZ allowed amount. This obligation to pay the difference between the provider's billed charges and the BCBSAZ allowed amount continues even after the member's out-of-pocket coinsurance maximum is met. Copays, access fees and deductibles are not applied toward the out-of-pocket coinsurance maximum.

3 Office visit copays are required for covered services in a physician's office. Immunizations and allergy injections received in the physician's office will be paid at 100 percent of the BCBSAZ allowed amount and do not require a copay unless other services are received during the same visit. Only one copay per person, per provider, per day will be collected.

4 Precertification is required for certain medications covered under the retail and mail order pharmacy benefit. A list of medications that require precertification and the process for obtaining precertification is available on the BCBSAZ Web site at azblue.com or by calling BCBSAZ at (602) 864-4273 or (800) 232-2345, ext. 4273. Otherwise covered eligible medications will not be covered if precertification is not obtained when required.

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

6 Services are available only in Arizona.

7 Precertification is required for certain medications provided through the Home Health and Home Infusion - Medication Administration Therapy benefit. A list of medications requiring precertification is available on the BCBSAZ Web site at azblue.com or by calling BCBSAZ at (602) 864-4320 or (800) 232-2345, ext. 4320. Otherwise covered eligible medications will not be covered if precertification is not obtained when required.

Exclusions and 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 list of all benefits, limitations and exclusions is in the contract booklet and is available prior to enrollment upon request. **Pre-existing condition waiting periods apply to BluePreferred plans.**

- Abortions except as stated in the contract
- 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
- Costs paid by other organizations - costs/services customarily paid for by an employer, the government, biotechnical, pharmaceutical or medical device industry sources or other individuals or organizations including, but not limited to worksite or ergonomic evaluations
- Counseling or behavioral medication services except as stated in the contract.
- Court-ordered services – testing, treatment or therapy except as stated in 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 stated in the contract
- Environmental medicine
- Fees other than for medically appropriate in-person, direct patient treatment, tests, services, medications, supplies or equipment
- Fertility or infertility treatment, medications 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 Stature (ISS) is expressly excluded
- Hearing services or devices
- Investigational treatments, procedures, equipment, medications, devices or supplies, as determined by BCBSAZ and only as required by Arizona law
- Lodging and meals
- Manipulations of the spine under anesthesia
- Massage therapy except as stated in the contract
- 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
- Medications for off-label, unlabeled or orphan medications (orphan medications are used for diagnosis, treatment or prevention of a rare disease or condition) unless otherwise specified by BCBSAZ medical or prescription medication coverage guidelines. This does not include medications used for the treatment of cancer.
- Nonmedically necessary services as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Normal maternity services
- Over-the-counter medications – any medication, 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
- 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
- Strength training, cardiovascular endurance training, fitness/strengthening programs and/or other services primarily designed to improve or increase fitness
- Telephonic or electronic consultations
- Therapy services except as stated 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 or other related services administered in conjunction with a noncovered transplant
- Transport services or travel expenses, except as stated in the contract
- 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, as determined by BCBSAZ, when a prescription is written by a physician
- Waivered conditions
- Weight loss/gain therapy or treatment except as stated in the contract
- 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

- **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 consecutive months after the contract effective date.

Important Note

This is only a brief summary of benefits and exclusions. Please refer to the specific provisions found within the contract booklet for complete information on benefits, limitations and exclusions. If the benefits on this summary differ from those stated in the contract booklet, the terms of the contract booklet apply. There is no guarantee of continued benefits 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.

06-0986-90