BluePreferred Benefit Summary

$1,500 100/50 $25/$40 Copay

Effective April 1, 2009

Provider Information – Out-of-pocket costs will differ depending on which type of provider is selected.

In-Network Providers

In-network providers have a contract with BCBSAZ. Members pay lower out-of-pocket costs when they receive covered services from in-network providers. In-network providers will file members' claims with BCBSAZ. In-network providers are independent contractors exercising independent medical judgment and are not employees, agents or representatives of BCBSAZ. In-network providers are also available outside Arizona through the BlueCard® program. To locate BlueCard PPO providers, call (800) 810-BLUE or check the BlueCard Doctor and Hospital Finder at **bcbs.com**.

Out-of-Network Providers

Out-of-network providers have no contract with BCBSAZ. Members pay higher out-of-pocket costs when they receive covered services from out-of-network providers. Out-of-network providers are not obligated to file members' claims.

BCBSAZ has no control over any diagnosis, treatment or service rendered by any provider.

Allowed Amount

The allowed amount is the amount of reimbursement allocated to a covered service.

For most claims, BCBSAZ bases the allowed amount on the lesser of a provider's billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements BCBSAZ has negotiated with an in-network provider. For claims from out-of-state providers, BCBSAZ generally bases the allowed amount on the lesser of the provider's billed charges or the contractual price negotiated by the Blue plan in the state where services were rendered. For emergency services provided by an out-of-network provider, either in Arizona or out-of-state, BCBSAZ bases the allowed amount on billed charges. The allowed amount includes any BCBSAZ payment plus any member cost-sharing.

For in-network providers, BCBSAZ reimburses the provider the allowed amount, minus any portion allocated to member cost-share. For out-of-network providers, BCBSAZ reimburses the member the allowed amount, minus any portion allocated to member cost-share.

The allowed amount is the figure that BCBSAZ uses to calculate any deductible or coinsurance and to accumulate toward any out-of-pocket coinsurance maximum. The allowed amount does not include access fees, precertification charges and any balance bills from out-of-network providers.

Balance Bills

The balance bill refers to the amount members may be charged for the difference between an out-of-network provider's billed charges and the allowed amount. Balance bills can be substantial.

In-network providers have agreed to accept the allowed amount for covered services. They will not charge members for the balance bill. They will collect only the member's cost-share portion, such as deductible, coinsurance or copay amounts. However, when there is another source of payment, such as a liability insurer or government payer, in-network providers may be entitled to collect their balance bill from the other source or from proceeds received from the other source.

Out-of-network providers have no obligation to accept the allowed amount as payment in full. **All out-of-network providers may bill you up to their full billed charges**. Members are responsible for paying up to an out-of-network provider's billed charges for covered services, even though BCBSAZ will reimburse members' claims based on the allowed amount, less any deduction for the member's cost-share portion. Depending on what billing arrangements members make with an out-of-network provider, the provider may charge members for full billed charges at the time of service or seek to balance bill members for the difference between billed charges and the amount of BCBSAZ reimbursement. The balance bill may be substantial. Any amounts paid for balance bills do not count toward deductible, coinsurance or the out-of-pocket coinsurance maximum.

BluePreferred $1,500 100/50 $25/$40 Copay

SUMMARY OF BENEFITS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER*
Deductible Deductible must be met for all covered services unless otherwise stated. Copays and access fees do not count toward the deductible.	Calendar-year deductible, per member – **$1,500**, family deductible maximum – **$3,000**	
Coinsurance* This is a percentage members must pay for covered services after meeting the calendar-year deductible. Members will pay a higher coinsurance percentage when using an out-of-network provider. Coinsurance is based on the BCBSAZ allowed amount and not on a provider's billed charges.	BCBSAZ pays **100%**, member pays **0% (100%/0%)** of the BCBSAZ allowed amount for most covered services, after meeting deductible, unless a different coinsurance percentage is indicated below.	BCBSAZ pays **50%**, member pays **50% (50%/50%)** of the BCBSAZ allowed amount for most covered services, after meeting deductible, unless a different coinsurance percentage is indicated below.
Out-of-Pocket Coinsurance Maximum	**$0** per member, **$0** family, per calendar year. The out-of-pocket coinsurance maximum is a maximum liability for coinsurance only and is based on the allowed amount rather than a provider's billed charges. Many cost-share payments do not count toward the out-of-pocket coinsurance maximum. The cost-share obligations that do not count include deductibles, copays, access fees, certain other charges listed in the benefit book, precertification charges, amounts paid for noncovered services and out-of-network providers' balance bills. To determine whether a specific cost-share payment counts toward the maximum, refer to the benefit book. You must continue to pay all these cost-share amounts even after meeting the maximum.	**$10,000** per member, **$20,000** family, per calendar year.
Physician Services-Primary Care Physician (PCP) Office Services Primary Care Physicians (PCP) include Family Practice, General Practice, Internal Medicine and Pediatrics. All other physicians are specialists. Deductible and coinsurance apply to services rendered by radiologists or pathologists.	**$25** copay (per member, per provider, per day) for most covered services provided in a physician's office. **100%/0%** for other covered services, after meeting deductible.	**50%/50%** after meeting deductible.
Physician Services – Specialist Office Services	**$40** copay (per member, per provider, per day) for most covered services provided in a physician's office. **100%/0%** for other covered services, after meeting deductible.	**50%/50%** after meeting deductible.
Laboratory Services	In a physician's office, BCBSAZ pays **100%**, physician office visit copay waived, if the only services you receive during your visit are laboratory services. At contracted, freestanding, independent clinical labs, BCBSAZ pays **100%** for covered services, deductible waived. At all other facilities, **100%** after meeting deductible.	**50%/50%** after meeting deductible.
Radiology Services	In a physician's office, applicable office visit copay applies. At all other facilities, **100%** after meeting deductible	**50%/50%** after meeting deductible.
Other Professional Services Other professional services include diagnostic, surgical and anesthesia services rendered outside the physician's office.	**100%/0%** after meeting deductible.	**50%/50%** after meeting deductible.
Inpatient – Hospital†	**100%/0%** after meeting deductible.	**50%/50%** after meeting deductible.
Outpatient Services (Facility charges)	**100%/0%** after meeting deductible.	**50%/50%** after meeting deductible.

SUMMARY OF BENEFITS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER*
Emergency	**$200** access fee (per member, per provider, per day); then **100%/0%** after meeting deductible; emergency room access fee is waived if member is admitted to the hospital.	
Urgent Care	**$75** copay (per member, per provider, per day) at facilities specifically contracted for urgent care.	**50%/50%** after meeting deductible.
Ambulance	**80%/20%**, deductible waived.	
Bariatric Surgery† (Inpatient and Outpatient)	**$1,000** access fee, then **100%/0%** after meeting deductible.	**$1,000** access fee, then **50%/50%** after meeting deductible.
Prescription Medications at Retail and Mail Order Pharmacy Retail and mail order prescription medication cost-sharing does not apply toward any medical plan deductible or out-of-pocket coinsurance maximum.	**Retail Prescription Medications:** **$ 15** Level One copay **$ 35** Level Two copay **$ 65** Level Three copay **$120** Level Four copay Mail order is only available through the in-network mail order provider. **Mail Order Prescription Medications:** **$ 30** Level One copay **$ 70** Level Two copay **$130** Level Three copay **$240** Level Four copay	When a member fills a prescription at an out-of-network pharmacy, in addition to the applicable prescription medication copay, the member is also responsible for the difference between an out-of-network retail pharmacy's price and the allowed amount. Mail order is not covered through an out-of-network provider.
	Precertification is required for certain medications covered under the retail and mail order pharmacy benefit. A list of medications that require precertification and the process for obtaining precertification is available on the BCBSAZ Web site at azblue.com or by calling BCBSAZ at (602) 864-4273 or (800) 232-2345, ext. 4273. Otherwise covered eligible medications will not be covered if precertification is not obtained when required.	
Specialty Self-Injectable Medications Through Specialty Pharmacy† For certain specified self-injectable prescription biologic medications. Specialty self-injectable medications are not covered under the retail and mail order pharmacy benefit.	**$ 30** Level A copay **$ 60** Level B copay **$ 90** Level C copay **$120** Level D copay Please refer to azblue.com or call BCBSAZ for a listing of specialty self-injectable medications and contracted specialty pharmacies. Injectable medications are also available from home health providers subject to deductible and coinsurance. See Home Health. Precertification is required for all medications obtained under this benefit.	**Not covered** at out-of-network specialty pharmacies. Specialty self-injectable medications are only available from out-of-network providers through the home health benefit. See Home Health.
Home Health	**100%/0%** after meeting deductible. Certain injectable medications are also available through the specialty self-injectable medication benefit.	**50%/50%** after meeting deductible.
	Precertification is required for certain medications provided through the Home Health benefit. A list of medications that require 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.	
Preventive Services • Certain Screening Services • Immunizations • Routine Physicals • Mammography Preventive services are those services performed for screening purposes when the member does not have active signs or symptoms of a condition, but does not include diagnostic tests performed because the member has a condition or an active symptom of a condition. Whether something is preventive is determined by the diagnosis submitted by the provider.	**$25/$40** copay (per member, per provider, per day) for covered services provided in a physician's office, depending on whether services are received from a PCP or specialist. **100%/0%** for covered services provided outside the physician's office, deductible waived.	**50%/50%,** deductible waived for mammography; all other preventive services **not covered**.

SUMMARY OF BENEFITS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER*
Maternity **Physician:** **Hospital:**	Office visit copay applies only to first prenatal visit. Deductible waived on physician's global delivery fee, but applies to all other services. **100%/0%** after meeting deductible.	**Physician and Hospital:** **50%/50%** after meeting deductible.
Skilled Nursing Facility† Both in- and out-of-network admissions count toward the 180-day per member calendar year limit.	**100%/0%** after meeting deductible, for up to **180** days. Limited to **180** days per member, per calendar year.	**50%/50%** after meeting deductible, for up to **60** days. After **60** days, BCBSAZ pays **50%**, member pays **50%** up to an additional **60** days, which will not count toward out-of-pocket coinsurance maximum.
Inpatient Extended Active Rehabilitation† Both in- and out-of-network admissions count toward the 120-day per member calendar year limit.	**100%/0%** after meeting deductible, for up to **120** days. Limited to **120** days per member, per calendar year.	**50%/50%** after meeting deductible, for up to **60** days. After **60** days, BCBSAZ pays **50%**, member pays **50%** up to an additional **60** days, which will not count toward out-of-pocket coinsurance maximum.
Physical, Occupational & Speech Therapy	**100%/0%** after meeting deductible.	**50%/50%** after meeting deductible.
Chiropractic	**$40** copay (per member, per provider, per day) for most covered services provided in a chiropractor's office. **100%/0%** for other covered services, after meeting deductible.	**50%/50%** after meeting deductible.
Behavioral/Mental Health† Both in- and out-of-network admissions count toward the 2-admission, 30-day per member, per calendar year limit. Cost-sharing for behavioral/mental health does not apply to any out-of-pocket coinsurance maximum.	**Inpatient:** Two admissions per member, per calendar year (up to a combined total of 30 days). **In-network provider: 100%/0%** after meeting deductible. **Out-of-network provider:** BCBSAZ pays **50%**, member pays **50%**, after meeting deductible. **Outpatient:** Member may choose in-network or out-of-network providers or the behavioral services administrator (BSA). **In-network providers:** BCBSAZ pays **100%**, member pays **0%**, after meeting deductible, with a maximum of **20** combined in- and out-of-network psychological sessions per member, per calendar year. **Out-of-network providers:** BCBSAZ pays **50%**, member pays **50%**, after meeting deductible, with a maximum of **20** combined in- and out-of-network psychological sessions per member, per calendar year. **BSA:** Unlimited psychotherapy and counseling: **$15** copay per member, per visit. BSA services are available **only** in Arizona. **Emergency: $200** access fee, then BCBSAZ pays **50%**, member pays **50%**, after meeting deductible. If member is admitted to the hospital, the emergency room access fee is waived and inpatient benefits stated above apply.	
Vision Exams (Routine)	**$25** copay for one routine vision exam per member, per calendar year.	Reimbursement up to **$25** for one routine vision exam per member, per calendar year.
Benefit Plan Maximum	**$5,000,000** maximum benefit while the benefit plan is in force. All payments by BCBSAZ (for both in-network and out-of-network providers) apply toward the benefit plan maximum.	

† Precertification is required. If precertification is not obtained, services may not be covered or the member will be subject to a precertification charge.

* Out-of-network providers may charge members their full billed charges. After insurance reimbursement based on the allowed amount, less any deduction for the member's cost-share portion, members are responsible to pay the balance bill. The obligation to pay the balance bill continues even after the member's out-of-pocket coinsurance maximum is met.

Other Information:

- BCBSAZ Medical Coverage Guidelines are BCBSAZ medical, dental and administrative criteria that are developed from review of published peer-reviewed medical and dental literature and other relevant information and used to help BCBSAZ determine whether a service, procedure, medical device or medication is eligible for benefits under a member's benefit plan. For services to be eligible for coverage under this benefit plan, the services must, in addition to other specified requirements, be considered medically necessary by BCBSAZ based on the BCBSAZ Medical Coverage Guidelines that are available 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.
- Precertification is the process BCBSAZ uses to determine eligibility for certain requested procedures or services. For example: Except for an emergency or maternity, inpatient facility admissions require precertification. The member is responsible for making sure his or her physician obtains precertification approval. If precertification is not obtained the member's benefits may be denied or the member may be subject to a precertification charge. The member's provider must call for precertification at (602) 864-4320 or (800) 232-2345, ext. 4320. Please refer to the precertification requirements in the benefit plan booklet, which will be sent to the member upon enrollment or upon request prior to enrollment.
- When the price BCBSAZ pays an in-network pharmacy for a medication is less than the member's cost-sharing, some pharmacies will charge the member the BCBSAZ price. However, most pharmacies will charge the member the retail price (if also less than the cost-sharing), rather than the BCBSAZ price. The member will not be required to pay more than the applicable cost-sharing for covered medications at an in-network pharmacy.
- BCBSAZ applies limitations to certain prescription medications obtained through the retail and mail order pharmacy benefit. A list of these medications and limitations is available online at azblue.com or by calling BCBSAZ. These limitations include, but are not limited to, quantity, age and gender limitations. BCBSAZ prescription medication limitations are subject to change at any time without prior notice.
- Benefits for employees who reside in Massachusetts may change 1/1/09 due to Massachusetts state regulations.

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 or if the condition was documented in medical records during the six (6) month period immediately preceding the member's enrollment date. A condition exists when the member had signs or symptoms, whether or not a specific injury, illness or disease is diagnosed. For purposes of determining a pre-existing condition waiting period, enrollment date means the member'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 members 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 (i.e., AHCCCS), a health risk benefits pool, TRICARE, Peace Corps, bonafide association, Indian Health Service, the Federal Employee Health Benefits Plan or the State Children's Health Insurance Plan. Members have the right to demonstrate to BCBSAZ that they have had prior creditable coverage by providing a Certificate of Creditable Health Coverage or other documentation of such coverage. BCBSAZ can calculate creditable coverage prior to member's effective date upon request. Please call our Membership Services Department at (602) 864-4456 if you need additional information.

NOTE: THIS IS ONLY A BRIEF SUMMARY OF THIS BENEFIT PLAN. MORE DETAILED INFORMATION REGARDING 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.

Exclusions and Limitations

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. Detailed information about benefits, limitations and exclusions is in the benefit plan booklet and is available prior to enrollment, upon request.

- Abortions, except as stated in the benefit plan
- Activity therapy
- Acupuncture
- Alternative medicine, non-traditional and alternative medical therapies; interventions; services and procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; nutritional and lifestyle therapies; aromatherapy
- Autism spectrum disorders (ASD) – services related to treatment of ASD, except as stated in the benefit plan
- Benefit-specific exclusions and limitations listed in the benefit plan booklet under particular benefits
- Biofeedback and hypnotherapy, except as stated in the benefit plan
- Body art, piercing, tattooing and any related complications
- Charges associated with the preparation, copying or production of health records
- Cognitive and vocational therapy
- Complications of noncovered benefits
- Computer speech training and therapy programs and devices
- Cosmetic services and any related complications – surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy.
- Counseling and behavioral modification services, except as stated in the benefit plan
- Court-ordered services, except as stated in the benefit plan
- Custodial care
- Dental, except as stated in the benefit plan
- Dietary and nutritional supplements, except as stated in the benefit plan
- Expenses for services that exceed benefit limitations
- Experimental or investigational services
- Fees other than for medically appropriate in-person, direct member services, except as stated in the benefit plan
- Fertility and infertility services
- Flat feet
- Foot care, except as stated in the benefit plan
- Free services
- Genetic and chromosomal testing and screening
- Government services – services provided at no charge to the member through a governmental program or facility
- Growth Hormone – except as specified in the BCBSAZ Medical Coverage Guidelines, and growth hormone to treat Idiopathic Short Stature (ISS)
- Hearing services and devices, except as stated in the benefit plan
- Lodging and meals, except as stated in the benefit plan
- Maintenance Services – services rendered after a member has met functional goals; services rendered when no objectively measurable improvement is reasonably anticipated, services to prevent regression to a lower level of function, services to prevent future injury and services to improve or maintain posture
- Manipulations of the spine under anesthesia
- Massage therapy, except in limited circumstances as described in the BCBSAZ Medical Coverage Guidelines
- Medications dispensed in a provider's office – prescription medications and over-the-counter medications, including pharmaceutical manufacturer's samples, dispensed to the member in a provider's office
- Medications – Medications which are:
  - Not FDA approved
  - Not required by the FDA to be obtained with a prescription
  - Not used in accordance with the BCBSAZ Medical Coverage Guidelines
  - Used to treat a condition not covered by BCBSAZ
  - Off-label, unlabeled and orphan medications, except as stated in the benefit plan
- Neurofeedback
- Non-medically necessary services, as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Over-the-counter items, except as stated in the benefit plan
- Personal comfort items
- Reversal of sterilization
- Screening tests, except as stated in the benefit plan
- Services for idiopathic environmental intolerance
- Services for sexual dysfunction, regardless of the cause, and all medications for the treatment of sexual dysfunction
- Services for weight loss and gain, except as stated in the benefit plan
- Services from a family member – services that are provided by an eligible provider who is part of the member's immediate family. When a provider is also the covered person, services rendered by that provider for him/herself are excluded from coverage.
- Services from ineligible providers
- Services paid for by other organizations
- Services provided after the member's coverage termination date, except as stated in the benefit plan
- Services provided by a proficient substitute for a professional caregiver
- Services provided prior to effective date
- Services related to or associated with noncovered services
- Services without a prescription, when a prescription is required
- Smoking cessation programs, medications, aids and devices
- Spinal decompression or vertebral axial decompression therapy
- Strength training, except as stated in the benefit plan
- Telephonic and electronic consultations, except as stated in the benefit plan
- Therapy services, except as stated in the benefit plan
- Training and education, except as stated in the benefit plan
- Transplants and related services not precertified by BCBSAZ
- Transportation services and travel expenses, except as stated in the benefit plan
- Transsexual treatment, surgery, medications and related services
- Treatment for behavioral and mental health conditions in a non-acute facility, such as residential or skilled nursing facilities
- Vision therapy; all types of refractive keratoplasties; any other procedures, treatments and devices for refractive correction; eyeglasses and contact lenses; vision examinations for fitting of eyeglasses and contact lenses
- Vitamins, except as stated in the benefit plan
- Workers' Compensation – illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election

An Independent Licensee of the Blue Cross and Blue Shield Association

09-0238

D15615 01/09

16198 0409