

# BluePreferred No Copay Plan Comparison

The grid below is to help you understand the similarities and variations between different options in the BCBSAZ BluePreferred product line. For more information on the details of a specific plan, please refer to the benefit summary or the benefit book. This is not a complete listing of benefits. Please see the exclusions and limitations located at the end.

Benefits PPO & NonPPO <sup>1</sup>		BluePreferred 100 90/70	BluePreferred 2,000 100/50	BluePreferred 5,000 100/50
<b>Deductible</b> (cumulative PPO and NonPPO) Deductible is based on the allowed amount and must be met for all covered services unless otherwise stated.		<b>\$100</b> per member, <b>\$200</b> family	<b>\$2,000</b> per member, <b>\$4,000</b> family	<b>\$5,000</b> per member, <b>10,000</b> family
Copays, access fees, precertification charges and balance bills do not count toward the deductible.				
<b>Coinsurance</b> Coinsurance is based on the allowed amount.	PPO	<b>90%/10%</b>	<b>100%/0%</b>	<b>100%/0%</b>
	NonPPO	<b>70%/30%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Out-of-Pocket Coinsurance Maximum<sup>2</sup></b>	PPO	<b>\$1,000</b> per member, <b>\$2,000</b> family	<b>\$0</b> per member, <b>\$0</b> family	<b>\$0</b> per member, <b>\$0</b> family
	NonPPO	<b>\$2,000</b> per member, <b>\$4,000</b> family	<b>\$20,000</b> per member, <b>\$40,000</b> family	<b>\$20,000</b> per member, <b>\$40,000</b> family
<b>PCP Office Services</b>	PPO	<b>90%/10%</b>	<b>100%/0%</b>	<b>100%/0%</b>
	NonPPO	<b>70%/30%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Specialist Office Services</b>	PPO	<b>90%/10%</b>	<b>100%/0%</b>	<b>100%/0%</b>
	NonPPO	<b>70%/30%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Preventive Services</b>	PPO	<b>90%/10%</b> , deductible waived	<b>100%/0%</b> , deductible waived	<b>100%/0%</b> , deductible waived
	NonPPO	Not covered except for foreign travel immunizations.	Not covered except for foreign travel immunizations.	Not covered except for foreign travel immunizations.
<b>Routine Mammography</b>	PPO	<b>90%/10%</b> , deductible waived	<b>100%/0%</b> , deductible waived	<b>100%/0%</b> , deductible waived
	NonPPO	<b>70%/30%</b> , deductible waived	<b>50%/50%</b> , deductible waived	<b>50%/50%</b> , deductible waived
<b>Urgent Care</b>	PPO	<b>90%/10%</b>	<b>100%/0%</b>	<b>100%/0%</b>
	NonPPO	<b>70%/30%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Laboratory Services</b>	PPO	<b>100%/0%</b> <sup>3</sup>	<b>100%/0%</b> <sup>3</sup>	<b>100%/0%</b> <sup>3</sup>
	NonPPO	<b>70%/30%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Radiology Services</b>	PPO	<b>90%/10%</b>	<b>100%/0%</b>	<b>100%/0%</b>
	NonPPO	<b>70%/30%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Inpatient Hospital<sup>4</sup>/ Outpatient Services</b>	PPO	<b>90%/10%</b>	<b>100%/0%</b>	<b>100%/0%</b>
	NonPPO	<b>70%/30%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Emergency</b>		<b>\$150</b> access fee, then <b>90%/10%</b>	<b>\$200</b> access fee, then <b>100%/0%</b>	<b>\$200</b> access fee, then <b>100%/0%</b>
<b>Prescription Medications at Retail and Mail Order Pharmacy<sup>5</sup></b>	PPO	<b>\$10/\$25/\$50/\$80</b>	<b>\$15/\$35/\$65/\$120</b>	<b>\$15/\$35/\$65/\$120</b>
	NonPPO	Mail Order – 2x applicable copay Prescription medication copay plus difference between billed and allowed amount.		
<b>Physical, Occupational &amp; Speech Therapy</b>	PPO	<b>90%/10%</b>	<b>100%/0%</b>	<b>100%/0%</b>
	NonPPO	<b>70%/30%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Vision Exams (Routine)</b>	PPO	<b>\$15</b> copay. One exam per member, per calendar year.	<b>\$25</b> copay. One exam per member, per calendar year.	<b>\$25</b> copay. One exam per member, per calendar year.
	NonPPO	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year.	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year.	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year.

1 Noncontracted 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 provider's billed charge.

2 Many cost-share payments do not count toward the out-of-pocket coinsurance maximum including deductibles, copays, access fees, certain other charges listed in the benefit book, precertification charges, amounts paid for noncovered services and noncontracted providers' balance bills.

3 Deductible and coinsurance waived at contracted, freestanding, independent clinical labs. At all other facilities, deductible and coinsurance apply.

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

5 Precertification is required for certain medications.

# BluePreferred Copay Plan Comparison

The grid below is to help you understand the similarities and variations between different options in the BCBSAZ BluePreferred copay product line. For more information on the details of a specific plan, please refer to the benefit summary or the benefit book. This is not a complete listing of benefits. Please see the exclusions and limitations located at the end.

Benefits PPO & NonPPO <sup>1</sup>		BluePreferred Copay 100 90/70	BluePreferred Copay 250 90/70	BluePreferred Copay 250 80/60
<b>Deductible</b> (cumulative PPO and NonPPO) Deductible is based on the allowed amount and must be met for all covered services unless otherwise stated.		<b>\$100</b> per member, <b>\$200</b> family	<b>\$250</b> per member, <b>\$500</b> family	<b>\$250</b> per member, <b>\$500</b> family
Copays, access fees, precertification charges and balance bills do not count toward the deductible.				
<b>Coinsurance</b> Coinsurance is based on the allowed amount.	PPO	<b>90%/10%</b>	<b>90%/10%</b>	<b>80%/20%</b>
	NonPPO	<b>70%/30%</b>	<b>70%/30%</b>	<b>60%/40%</b>
<b>Out-of-Pocket Coinsurance Maximum<sup>2</sup></b>	PPO	<b>\$1,000</b> per member, <b>\$2,000</b> family	<b>\$2,000</b> per member, <b>\$4,000</b> family	<b>\$2,000</b> per member, <b>\$4,000</b> family
	NonPPO	<b>\$2,000</b> per member, <b>\$4,000</b> family	<b>\$4,000</b> per member, <b>\$8,000</b> family	<b>\$4,000</b> per member, <b>\$8,000</b> family
<b>PCP Office Services</b>	PPO	<b>\$15</b> copay	<b>\$15</b> copay	<b>\$15</b> copay
	NonPPO	<b>70%/30%</b>	<b>70%/30%</b>	<b>60%/40%</b>
<b>Specialist Office Services</b>	PPO	<b>\$25</b> copay	<b>\$25</b> copay	<b>\$25</b> copay
	NonPPO	<b>70%/30%</b>	<b>70%/30%</b>	<b>60%/40%</b>
<b>Preventive Services</b>	PPO	<b>\$15 PCP/\$25 Specialist</b>	<b>\$15 PCP/\$25 Specialist</b>	<b>\$15 PCP/\$25 Specialist</b>
	NonPPO	<b>Not covered</b> except for foreign travel immunizations.	<b>Not covered</b> except for foreign travel immunizations.	<b>Not covered</b> except for foreign travel immunizations.
<b>Routine Mammography</b>	PPO	<b>90%/10%</b> , deductible waived	<b>90%/10%</b> , deductible waived	<b>80%/20%</b> , deductible waived
	NonPPO	<b>70%/30%</b> , deductible waived	<b>70%/30%</b> , deductible waived	<b>60%/40%</b> , deductible waived
<b>Urgent Care</b>	PPO	<b>\$25</b> copay	<b>\$25</b> copay	<b>\$25</b> copay
	NonPPO	<b>70%/30%</b>	<b>70%/30%</b>	<b>60%/40%</b>
<b>Laboratory Services</b>	PPO	<b>100%/0%</b> <sup>3</sup>	<b>100%/0%</b>	<b>100%/0%</b>
	NonPPO	<b>70%/30%</b>	<b>70%/30%</b>	<b>60%/40%</b>
<b>Radiology Services</b> (Facility charges)	PPO	<b>90%/10%</b>	<b>90%/10%</b>	<b>80%/20%</b>
	NonPPO	<b>70%/30%</b>	<b>70%/30%</b>	<b>60%/40%</b>
<b>Inpatient Hospital<sup>4</sup>/ Outpatient Services</b>	PPO	<b>90%/10%</b>	<b>90%/10%</b>	<b>80%/20%</b>
	NonPPO	<b>70%/30%</b>	<b>70%/30%</b>	<b>60%/40%</b>
<b>Emergency</b>		<b>\$150</b> access fee, then <b>90%/10%</b>	<b>\$150</b> access fee, then <b>90%/10%</b>	<b>\$150</b> access fee, then <b>80%/20%</b>
<b>Prescription Medications at Retail and Mail Order Pharmacy<sup>5</sup></b>	PPO	Retail – <b>\$10/\$25/\$50/\$80</b>	Retail – <b>\$10/\$25/\$50/\$80</b> Mail Order – 2x applicable copay	Retail – <b>\$10/\$25/\$50/\$80</b>
	NonPPO	Prescription medication copay plus difference between billed and allowed amount.		
<b>Physical, Occupational &amp; Speech Therapy</b>	PPO	<b>90%/10%</b>	<b>90%/10%</b>	<b>80%/20%</b>
	NonPPO	<b>70%/30%</b>	<b>70%/30%</b>	<b>60%/40%</b>
<b>Vision Exams</b> (Routine)	PPO	<b>\$15</b> copay. One exam per member, per calendar year	<b>\$15</b> copay. One exam per member, per calendar year	<b>\$15</b> copay. One exam per member, per calendar year
	NonPPO	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year

1 Noncontracted 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 provider's billed charge. The obligation to pay the balance bill continues even after the member's out-of-pocket coinsurance maximum is met.

2 Many cost-share payments do not count toward the out-of-pocket coinsurance maximum including deductibles, copays, access fees, certain other charges listed in the benefit book, precertification charges, amounts paid for noncovered services and noncontracted providers' balance bills.

3 At contracted freestanding, independent clinical labs and in a physician's office, if the only services received are laboratory services. At all other facilities, deductible and coinsurance apply.

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

5 Precertification is required for certain medications.

# BluePreferred Copay Plan Comparison, *continued*

Benefits PPO & NonPPO <sup>1</sup>		BluePreferred Copay 500 90/70	BluePreferred Copay 500 80/60	BluePreferred Copay 1,000 80/50
<b>Deductible</b> (cumulative PPO and NonPPO) Deductible is based on the allowed amount and must be met for all covered services unless otherwise stated.		<b>\$500</b> per member, <b>\$1,000</b> family	<b>\$500</b> per member, <b>\$1,000</b> family	<b>\$1,000</b> per member, <b>\$2,000</b> family
Copays, access fees, precertification charges and balance bills do not count toward the deductible.				
<b>Coinsurance</b> Coinsurance is based on the allowed amount.	PPO	<b>90%/10%</b>	<b>80%/20%</b>	<b>80%/20%</b>
	NonPPO	<b>70%/30%</b>	<b>60%/40%</b>	<b>50%/50%</b>
<b>Out-of-Pocket Coinsurance Maximum<sup>2</sup></b>	PPO	<b>\$2,500</b> per member, <b>\$5,000</b> family	<b>\$2,500</b> per member, <b>\$5,000</b> family	<b>\$3,000</b> per member, <b>\$6,000</b> family
	NonPPO	<b>\$5,000</b> per member, <b>\$10,000</b> family	<b>\$5,000</b> per member, <b>\$10,000</b> family	<b>\$6,000</b> per member, <b>\$12,000</b> family
<b>PCP Office Services</b>	PPO	<b>\$15</b> copay	<b>\$15</b> copay	<b>\$25</b> copay
	NonPPO	<b>70%/30%</b>	<b>60%/40%</b>	<b>50%/50%</b>
<b>Specialist Office Services</b>	PPO	<b>\$25</b> copay	<b>\$25</b> copay	<b>\$35</b> copay
	NonPPO	<b>70%/30%</b>	<b>60%/40%</b>	<b>50%/50%</b>
<b>Preventive Services</b>	PPO	<b>\$15 PCP/\$25</b> Specialist	<b>\$15 PCP/\$25</b> Specialist	<b>\$25 PCP/\$35</b> Specialist
	NonPPO	<b>Not covered</b> except for foreign travel immunizations.	<b>Not covered</b> except for foreign travel immunizations.	<b>Not covered</b> except for foreign travel immunizations.
<b>Routine Mammography</b>	PPO	<b>90%/10%</b> , deductible waived	<b>80%/20%</b> , deductible waived	<b>80%/20%</b> , deductible waived
	NonPPO	<b>70%/30%</b> , deductible waived	<b>60%/40%</b> , deductible waived	<b>50%/50%</b> , deductible waived
<b>Urgent Care</b>	PPO	<b>\$25</b> copay	<b>\$25</b> copay	<b>\$50</b> copay
	NonPPO	<b>70%/30%</b>	<b>60%/40%</b>	<b>50%/50%</b>
<b>Laboratory Services</b>	PPO	<b>100%/0%</b>	<b>100%/0%</b>	<b>100%/0%</b> <sup>3</sup>
	NonPPO	<b>70%/30%</b>	<b>60%/40%</b>	<b>50%/50%</b>
<b>Radiology Services</b> (Facility charges)	PPO	<b>90%/10%</b>	<b>80%/20%</b>	<b>80%/20%</b>
	NonPPO	<b>70%/30%</b>	<b>60%/40%</b>	<b>50%/50%</b>
<b>Inpatient Hospital<sup>4</sup>/ Outpatient Services</b>	PPO	<b>90%/10%</b>	<b>80%/20%</b>	<b>80%/20%</b>
	NonPPO	<b>70%/30%</b>	<b>60%/40%</b>	<b>50%/50%</b>
<b>Emergency</b>		<b>\$150</b> access fee, then <b>90%/10%</b>	<b>\$150</b> access fee, then <b>80%/20%</b>	<b>\$150</b> access fee, then <b>80%/20%</b>
<b>Prescription Medications at Retail and Mail Order Pharmacy<sup>5</sup></b>	PPO	Retail – <b>\$10/\$25/\$50/\$80</b>	Retail – <b>\$10/\$25/\$50/\$80</b> Mail Order – 2x applicable copay	Retail – <b>\$15/\$35/\$65/\$120</b>
	NonPPO	Prescription medication copay plus difference between billed and allowed amount.		
<b>Physical, Occupational &amp; Speech Therapy</b>	PPO	<b>90%/10%</b>	<b>80%/20%</b>	<b>80%/20%</b>
	NonPPO	<b>70%/30%</b>	<b>60%/40%</b>	<b>50%/50%</b>
<b>Vision Exams</b> (Routine)	PPO	<b>\$15</b> copay. One exam per member, per calendar year	<b>\$15</b> copay. One exam per member, per calendar year	<b>\$25</b> copay. One exam per member, per calendar year
	NonPPO	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year

1 Noncontracted 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 provider's billed charge. The obligation to pay the balance bill continues even after the member's out-of-pocket coinsurance maximum is met.

2 Many cost-share payments do not count toward the out-of-pocket coinsurance maximum including deductibles, copays, access fees, certain other charges listed in the benefit book, precertification charges, amounts paid for noncovered services and noncontracted providers' balance bills.

3 At contracted freestanding, independent clinical labs and in a physician's office, if the only services received are laboratory services. At all other facilities, deductible and coinsurance apply.

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

5 Precertification is required for certain medications.

...BluePreferred Copay Plan Comparison *continued*

# BluePreferred Copay Plan Comparison, continued

Benefits PPO & NonPPO <sup>1</sup>	BluePreferred Copay 1,500 100/50	BluePreferred Copay 2,000 80/50	BluePreferred Copay 2,500 100/50	BluePreferred Copay 5,000 100/50
<b>Deductible</b> (cumulative PPO and NonPPO) Deductible is based on the allowed amount and must be met for all covered services unless otherwise stated.	\$1,500 per member, \$3,000 family	\$2,000 per member, \$4,000 family	\$2,500 per member, \$5,000 family	\$5,000 per member, \$10,000 family
Copays, access fees, precertification charges and balance bills do not count toward the deductible.				
<b>Coinsurance</b> PPO Coinsurance is based on the allowed amount.	100%/0%	80%/20%	100%/0%	100%/0%
NonPPO	50%/50%	50%/50%	50%/50%	50%/50%
<b>Out-of-Pocket Coinsurance Maximum<sup>2</sup></b> PPO	\$0 per member, \$0 family	\$4,000 per member, \$8,000 family	\$0 per member, \$0 family	\$0 per member, \$0 family
NonPPO	\$10,000 per member, \$20,000 family	\$8,000 per member, \$16,000 family	\$20,000 per member, \$40,000 family	\$20,000 per member, \$40,000 family
<b>PCP Office Services</b> PPO	\$25 copay	\$25 copay	\$25 copay	\$25 copay
NonPPO	50%/50%	50%/50%	50%/50%	50%/50%
<b>Specialist Office Services</b> PPO	\$40 copay	\$35 copay	\$40 copay	\$40 copay
NonPPO	50%/50%	50%/50%	50%/50%	50%/50%
<b>Preventive Services</b> PPO	\$25 PCP/\$40 Specialist	\$25 PCP/\$35 Specialist	\$25 PCP/\$40 Specialist	\$25 PCP/\$40 Specialist
NonPPO	<b>Not covered</b> except for foreign travel immunizations.	<b>Not covered</b> except for foreign travel immunizations.	<b>Not covered</b> except for foreign travel immunizations.	<b>Not covered</b> except for foreign travel immunizations.
<b>Routine Mammography</b> PPO	100%/0%, deductible waived	80%/20%, deductible waived	100%/0%, deductible waived	100%/0%, deductible waived
NonPPO	50%/50%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived
<b>Urgent Care</b> PPO	\$75 copay	\$50 copay	\$75 copay	\$75 copay
NonPPO	50%/50%	50%/50%	50%/50%	50%/50%
<b>Laboratory Services</b> PPO	100%/0% <sup>3</sup>	100%/0% <sup>3</sup>	100%/0% <sup>3</sup>	100%/0% <sup>3</sup>
NonPPO	50%/50%	50%/50%	50%/50%	50%/50%
<b>Radiology Services</b> (Facility charges) PPO	100%/0%	80%/20%	100%/0%	100%/0%
NonPPO	50%/50%	50%/50%	50%/50%	50%/50%
<b>Inpatient Hospital<sup>4</sup>/ Outpatient Services</b> PPO	100%/0%	80%/20%	100%/0%	100%/0%
NonPPO	50%/50%	50%/50%	50%/50%	50%/50%
<b>Emergency</b>	\$200 access fee, then 100%/0%	\$150 access fee, then 80%/20%	\$200 access fee, then 100%/0%	\$200 access fee, then 100%/0%
<b>Prescription Medications at Retail and Mail Order Pharmacy<sup>5</sup></b> PPO	Retail – \$15/\$35/\$65/\$120	Retail – \$15/\$35/\$65/\$120	Retail – \$15/\$35/\$65/\$120	Retail – \$15/\$35/\$65/\$120
NonPPO	Mail Order – 2x applicable copay Prescription medication copay plus difference between billed and allowed amount.			
<b>Physical, Occupational &amp; Speech Therapy</b> PPO	100%/0%	80%/20%	100%/0%	100%/0%
NonPPO	50%/50%	50%/50%	50%/50%	50%/50%
<b>Vision Exams</b> (Routine) PPO	\$25 copay. One exam per member, per calendar year	\$25 copay. One exam per member, per calendar year	\$25 copay. One exam per member, per calendar year	\$25 copay. One exam per member, per calendar year
NonPPO	Reimbursement for one exam up to \$25 per member, per calendar year	Reimbursement for one exam up to \$25 per member, per calendar year	Reimbursement for one exam up to \$25 per member, per calendar year	Reimbursement for one exam up to \$25 per member, per calendar year

1 Noncontracted 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 provider's billed charge. The obligation to pay the balance bill continues even after the member's out-of-pocket coinsurance maximum is met.

2 Many cost-share payments do not count toward the out-of-pocket coinsurance maximum including deductibles, copays, access fees, certain other charges listed in the benefit book, precertification charges, amounts paid for noncovered services and noncontracted providers' balance bills.

3 At contracted freestanding, independent clinical labs and in a physician's office, if the only services received are laboratory services. At all other facilities, deductible and coinsurance apply.

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

5 Precertification is required for certain medications.

# BluePreferred Basic Plan Comparison

The grid below is to help you understand the similarities and variations between different options in the BCBSAZ BluePreferred Basic product line. For more information on the details of a specific plan, please refer to the benefit summary or the benefit book. This is not a complete listing of benefits. Please see the exclusions and limitations located at the end.

Benefits PPO & NonPPO <sup>1</sup>	BluePreferred Basic 1,500 80/50	BluePreferred Basic 2,500 80/50	BluePreferred Basic 5,000 80/50	BluePreferred Basic 10,000 80/50
<b>Deductible</b> (cumulative PPO and NonPPO) Deductible is based on the allowed amount and must be met for all covered services unless otherwise stated.	<b>\$1,500</b> per member, <b>\$3,000</b> family	<b>\$2,500</b> per member, <b>\$5,000</b> family	<b>\$5,000</b> per member, <b>\$10,000</b> family	<b>\$10,000</b> per member, <b>\$20,000</b> family
Copays, access fees, precertification charges and balance bills do not count toward the deductible.				
<b>Coinsurance</b> PPO Coinsurance is based on the allowed amount.	<b>80%/20%</b>	<b>80%/20%</b>	<b>80%/20%</b>	<b>80%/20%</b>
NonPPO	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Out-of-Pocket</b> PPO	<b>\$4,000</b> per member	<b>\$4,000</b> per member	<b>\$4,000</b> per member	<b>\$4,000</b> per member
<b>Coinsurance</b> NonPPO	<b>\$8,000</b> per member	<b>\$8,000</b> per member	<b>\$8,000</b> per member	<b>\$8,000</b> per member
<b>Maximum<sup>2</sup></b>				
<b>PCP Office Services</b> PPO	<b>\$25</b> copay	<b>\$30</b> copay	<b>\$35</b> copay	<b>\$40</b> copay
NonPPO	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Specialist Office Services</b> PPO	<b>80%/20%</b>	<b>80%/20%</b>	<b>80%/20%</b>	<b>80%/20%</b>
NonPPO	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Preventive Services</b> PPO	PCP: <b>\$25</b> copay Specialist: <b>80%/20%</b> deductible waived.	PCP: <b>\$30</b> copay Specialist: <b>80%/20%</b> deductible waived.	PCP: <b>\$35</b> copay Specialist: <b>80%/20%</b> deductible waived.	PCP: <b>\$40</b> copay Specialist: <b>80%/20%</b> deductible waived.
NonPPO	<b>Not covered</b> except for foreign travel immunizations.	<b>Not covered</b> except for foreign travel immunizations.	<b>Not covered</b> except for foreign travel immunizations.	<b>Not covered</b> except for foreign travel immunizations.
<b>Routine Mammography</b> PPO	<b>80%/20%</b> , deductible waived	<b>80%/20%</b> , deductible waived	<b>80%/20%</b> , deductible waived	<b>80%/20%</b> , deductible waived
NonPPO	<b>50%/50%</b> , deductible waived	<b>50%/50%</b> , deductible waived	<b>50%/50%</b> , deductible waived	<b>50%/50%</b> , deductible waived
<b>Urgent Care</b> PPO	<b>\$45</b> copay	<b>\$50</b> copay	<b>\$55</b> copay	<b>\$60</b> copay
NonPPO	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Laboratory Services</b> PPO	<b>100%/0%</b> <sup>3</sup>	<b>100%/0%</b> <sup>3</sup>	<b>100%/0%</b> <sup>3</sup>	<b>100%/0%</b> <sup>3</sup>
NonPPO	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Radiology Services</b> PPO (Facility charges)	<b>80%/20%</b>	<b>80%/20%</b>	<b>80%/20%</b>	<b>80%/20%</b>
NonPPO	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Inpatient Hospital<sup>4</sup>/ Outpatient Services</b> PPO	<b>80%/20%</b>	<b>80%/20%</b>	<b>80%/20%</b>	<b>80%/20%</b>
NonPPO	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Emergency</b>	<b>\$150</b> access fee, then <b>80%/20%</b>	<b>\$150</b> access fee, then <b>80%/20%</b>	<b>\$150</b> access fee, then <b>80%/20%</b>	<b>\$150</b> access fee, then <b>80%/20%</b>
<b>Retail and Mail Order Prescription Medications<sup>5</sup></b> PPO	Member pays the lesser of the BCBSAZ allowed amount or the copay. <b>Generic medications: \$30 copay. Brand medications: \$125 copay.</b>			
NonPPO	Members will be reimbursed for amounts above <b>\$125</b> , up to the BCBSAZ allowed amount per prescription. Members are also responsible for the difference between billed and allowed amount.			
<b>Physical, Occupational &amp; Speech Therapy</b> PPO	<b>80%/20%</b>	<b>80%/20%</b>	<b>80%/20%</b>	<b>80%/20%</b>
NonPPO	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>	<b>50%/50%</b>
<b>Vision Exams</b> PPO (Routine)	<b>\$15</b> copay. One exam per member, per calendar year	<b>\$15</b> copay. One exam per member, per calendar year	<b>\$15</b> copay. One exam per member, per calendar year	<b>\$15</b> copay. One exam per member, per calendar year
NonPPO	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year	Reimbursement for one exam up to <b>\$25</b> per member, per calendar year

1 Noncontracted 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 provider's billed charge.

2 Many cost-share payments do not count toward the out-of-pocket coinsurance maximum including deductibles, copays, access fees, certain other charges listed in the benefit book, precertification charges, amounts paid for noncovered services and noncontracted providers' balance bills.

3 At contracted freestanding, independent clinical labs and in a physician's office, if the only services received are laboratory services. At all other facilities, deductible and coinsurance apply.

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

5 Precertification is required for certain medications.

# BluePreferred Saver Plan Comparison

The grid below is to help you understand the similarities and variations between different options in the BCBSAZ BluePreferred Saver product line. For more information on the details of a specific plan, please refer to the benefit summary or the benefit book. This is not a complete listing of benefits. Please see the exclusions and limitations located at the end.

Benefits PPO & NonPPO <sup>1</sup>		BluePreferred Saver 1,500 80/50	BluePreferred Saver 1,500 100/50	BluePreferred Saver 2,600 80/50	BluePreferred Saver 2,600 100/50	BluePreferred Saver 5,000 100/50
<b>Deductible</b> (cumulative PPO and NonPPO) Deductible is based on the allowed amount. Except for preventive care, the deductible must be met for all covered services unless otherwise stated.		<b>\$1,500</b> self-only, <b>\$3,000</b> family  The self-only deductible must be met on self-only policies and the family deductible must be met on family policies before BCBSAZ will begin to pay for covered services.	<b>\$1,500</b> per member, <b>\$3,000</b> family  The self-only deductible must be met on self-only policies and the family deductible must be met on family policies before BCBSAZ will begin to pay for covered services.	<b>\$2,600</b> per member, <b>\$5,150</b> family	<b>\$2,600</b> per member, <b>\$5,150</b> family	<b>\$5,000</b> per member, <b>\$10,000</b> family
Access fees, precertification charges and balance bills do not count toward the deductible.						
<b>Coinsurance</b> Coinsurance is based on the allowed amount.	PPO NonPPO	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>
<b>Out-of-Pocket Maximum<sup>2</sup></b>	PPO NonPPO	<b>\$5,000</b> per member, <b>\$10,000</b> family  <b>\$10,000</b> per member, <b>\$20,000</b> family	<b>\$5,000</b> per member, <b>\$10,000</b> family  <b>\$10,000</b> per member, <b>\$20,000</b> family	<b>\$5,000</b> per member, <b>\$10,000</b> family  <b>\$10,000</b> per member, <b>\$20,000</b> family	<b>\$5,000</b> per member, <b>\$10,000</b> family  <b>\$10,000</b> per member, <b>\$20,000</b> family	<b>\$5,000</b> per member, <b>\$10,000</b> family  <b>\$10,000</b> per member, <b>\$20,000</b> family
<b>Physician Office Services</b>	PPO NonPPO	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>
<b>Preventive Services</b>	PPO NonPPO	<b>80%/20%</b> , deductible waived.  <b>Not covered</b> except for foreign travel immunizations.	<b>100%/0%</b> , deductible waived.  <b>Not covered</b> except for foreign travel immunizations.	<b>80%/20%</b> , deductible waived.  <b>Not covered</b> except for foreign travel immunizations.	<b>100%/0%</b> , deductible waived.  <b>Not covered</b> except for foreign travel immunizations.	<b>100%/0%</b> , deductible waived.  <b>Not covered</b> except for foreign travel immunizations.
<b>Routine Mammography</b>	PPO NonPPO	<b>80%/20%</b> , deductible waived  <b>50%/50%</b> , deductible waived	<b>100%/0%</b> , deductible waived  <b>50%/50%</b> , deductible waived	<b>80%/20%</b> , deductible waived  <b>50%/50%</b> , deductible waived	<b>100%/0%</b> , deductible waived  <b>50%/50%</b> , deductible waived	<b>100%/0%</b> , deductible waived  <b>50%/50%</b> , deductible waived
<b>Urgent Care</b>	PPO NonPPO	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>
<b>Laboratory</b>	PPO NonPPO	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>
<b>Radiology Services</b>	PPO NonPPO	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>
<b>Outpatient Services</b>	PPO NonPPO	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>
<b>Inpatient Hospital<sup>3</sup></b>	PPO NonPPO	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>
<b>Emergency</b>		<b>\$150</b> access fee, then <b>80%/20%</b>	<b>\$150</b> access fee, then <b>100%/0%</b>	<b>\$150</b> access fee, then <b>80%/20%</b>	<b>\$150</b> access fee, then <b>100%/0%</b>	<b>\$150</b> access fee, then <b>100%/0%</b>
<b>Retail and Mail Order Prescription Medications<sup>4</sup></b>	PPO NonPPO	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>80%/20%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>	<b>100%/0%</b> <b>50%/50%</b>
<b>Vision Exams (Routine)</b>	PPO NonPPO	<b>80%/20%</b>  Reimbursement for one exam up to <b>\$25</b> per member, per calendar year deductible and coinsurance waived.	<b>100%</b>  Reimbursement for one exam up to <b>\$25</b> per member, per calendar year deductible and coinsurance waived.	<b>80%/20%</b>  Reimbursement for one exam up to <b>\$25</b> per member, per calendar year deductible and coinsurance waived.	<b>100%</b>  Reimbursement for one exam up to <b>\$25</b> per member, per calendar year deductible and coinsurance waived.	<b>100%</b>  Reimbursement for one exam up to <b>\$25</b> per member, per calendar year deductible and coinsurance waived.

1 Noncontracted 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 provider's billed charge.

2 Precertification charges, amounts paid for noncovered services and noncontracted providers' balance bills do not count toward meeting the out-of-pocket maximum.

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

4 Precertification is required for certain medications.

# BlueEssential Plan Comparison

The grid below is to help you understand the similarities and variations between different options in the BCBSAZ BlueEssential product line. For more information on the details of a specific plan, please refer to the benefit summary or the benefit book. This is not a complete listing of benefits. Please see the exclusions and limitations located at the end.

Benefits PPO & NonPPO <sup>1</sup>		BlueEssential 1,000 70/50	BlueEssential 2,000 70/50	BlueEssential 3,000 70/50	BlueEssential 5,000 70/50	BlueEssential 10,000 70/50
<b>Deductible</b> (cumulative PPO and NonPPO) Deductible is based on the allowed amount and must be met for all covered services unless otherwise stated.		\$1,000 per member, \$3,000 family	\$2,000 per member, \$6,000 family	\$3,000 per member, \$9,000 family	\$5,000 per member, \$15,000 family	\$10,000 per member, \$30,000 family
Copays, access fees, precertification charges and balance bills do not count toward the deductible.						
<b>Coinsurance</b> Coinsurance is based on the allowed amount.	PPO	70%/30%	70%/30%	70%/30%	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
<b>OOP Coinsurance Maximum<sup>2</sup></b>	PPO	\$4,000 per member	\$4,000 per member	\$4,000 per member	\$4,000 per member	\$4,000 per member
	NonPPO	\$8,000 per member	\$8,000 per member	\$8,000 per member	\$8,000 per member	\$8,000 per member
<b>PCP/Specialist Office Services</b>	PPO	\$25/\$50 copay or 70%/30%	\$25/\$50 copay or 70%/30%	\$25/\$50 copay or 70%/30%	\$25/\$50 copay or 70%/30%	\$25/\$50 copay or 70%/30%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Office visit copay is limited to 3 visits per member, per calendar-year; PCP and specialist combined. After the copay limit has been reached, 70%/30% after meeting deductible for the remainder of the calendar year.						
<b>Preventive Services</b>	PPO	Physician office visit copay or 70%/30%, deductible waived.	Physician office visit copay or 70%/30%, deductible waived.	Physician office visit copay or 70%/30%, deductible waived.	Physician office visit copay or 70%/30%, deductible waived.	Physician office visit copay or 70%/30%, deductible waived.
	NonPPO	Not covered except for foreign travel immunizations.	Not covered except for foreign travel immunizations.	Not covered except for foreign travel immunizations.	Not covered except for foreign travel immunizations.	Not covered except for foreign travel immunizations.
<b>Routine Mammography</b>	PPO	70%/30%, deductible waived	70%/30%, deductible waived	70%/30%, deductible waived	70%/30%, deductible waived	70%/30%, deductible waived
	NonPPO	50%/50%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived
<b>Urgent Care</b>	PPO	\$60 copay	\$60 copay	\$60 copay	\$60 copay	\$60 copay
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
<b>Laboratory Services</b>	PPO	100%/0% <sup>3</sup>	100%/0% <sup>3</sup>	100%/0% <sup>3</sup>	100%/0% <sup>3</sup>	100%/0% <sup>3</sup>
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
<b>Radiology Services</b> (Facility charges)	PPO	70%/30%	70%/30%	70%/30%	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
<b>Inpatient Hospital<sup>4</sup>/ Outpatient Services</b>	PPO	70%/30%	70%/30%	70%/30%	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
<b>Emergency</b>		\$150 access fee, then 70%/30%	\$150 access fee, then 70%/30%	\$150 access fee, then 70%/30%	\$150 access fee, then 70%/30%	\$150 access fee, then 70%/30%
<b>Retail and Mail Order Prescription Medications<sup>5</sup></b>	PPO	Member pays the lesser of the BCBSAZ allowed amount or the copay. <b>Generic medications: \$15 copay. Brand medications: \$125 copay.</b>				
	NonPPO	In addition to the applicable prescription medication copay, the member is also responsible for the balance bill.				
<b>Physical, Occupational &amp; Speech Therapy</b>	PPO	70%/30%	70%/30%	70%/30%	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
<b>Vision Exams</b> (Routine)	PPO	\$25 copay. One exam per member, per calendar year	\$25 copay. One exam per member, per calendar year	\$25 copay. One exam per member, per calendar year	\$25 copay. One exam per member, per calendar year	\$25 copay. One exam per member, per calendar year
	NonPPO	Reimbursement for one exam up to \$25 per member, per calendar year	Reimbursement for one exam up to \$25 per member, per calendar year	Reimbursement for one exam up to \$25 per member, per calendar year	Reimbursement for one exam up to \$25 per member, per calendar year	Reimbursement for one exam up to \$25 per member, per calendar year

1 Noncontracted 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 provider's billed charge.

2 Many cost-share payments do not count toward the out-of-pocket coinsurance maximum including deductibles, copays, access fees, certain other charges listed in the benefit book, precertification charges, amounts paid for noncovered services and noncontracted providers' balance bills.

3 At contracted freestanding, independent clinical labs and in a physician's office, if the only services received are laboratory services. At all other facilities, deductible and coinsurance apply.

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

5 Precertification is required for certain medications.

# BlueSolutions Plan Comparison

Available only to employer groups of 2-50 eligible employees. Employer groups are eligible for BlueSolutions only if they have been uninsured for a minimum of ninety (90) days prior to the effective date of BlueSolutions. The grid below is to help you understand the similarities and variations between different options in the BCBSAZ BlueSolutions product line. For more information on the details of a specific plan, please refer to the benefit summary or the benefit book. This is not a complete listing of benefits. Please see the exclusions and limitations located at the end.

Benefits PPO & NonPPO <sup>1</sup>		Plan 2,500	Plan 5,000
<b>Deductible</b> (cumulative PPO and NonPPO) Deductible is based on the allowed amount and must be met for all covered services unless otherwise stated.		<b>\$2,500</b> per member, <b>\$5,000</b> family	<b>\$5,000</b> per member, <b>\$10,000</b> family
Copays, access fees, precertification charges and balance bills do not count toward the deductible.			
<b>Coinsurance</b> Coinsurance is based on the allowed amount.	PPO	<b>70%/30%</b>	<b>70%/30%</b>
	NonPPO	<b>50%/50%</b>	<b>50%/50%</b>
<b>OOP Coinsurance Maximum<sup>2</sup></b>	PPO	<b>\$5,000</b> per member, <b>\$10,000</b> family	<b>\$5,000</b> per member, <b>\$10,000</b> family
	NonPPO	<b>\$10,000</b> per member, <b>\$20,000</b> family	<b>\$10,000</b> per member, <b>\$20,000</b> family
<b>PCP Office Services</b>	PPO	<b>\$35</b> copay	<b>\$35</b> copay
	NonPPO	<b>50%/50%</b>	<b>50%/50%</b>
<b>Specialist Office Services</b>	PPO	<b>70%/30%</b>	<b>70%/30%</b>
	NonPPO	<b>50%/50%</b>	<b>50%/50%</b>
<b>Preventive Services</b>	PPO	PCP: <b>\$35</b> copay. Specialist: <b>70%/30%</b> , deductible waived.	
	NonPPO	Not covered except for foreign travel immunizations.	
<b>Routine Mammography</b>	PPO	<b>70%/30%</b> , deductible waived	<b>70%/30%</b> , deductible waived
	NonPPO	<b>50%/50%</b> , deductible waived	<b>50%/50%</b> , deductible waived
<b>Urgent Care</b>	PPO	<b>70%/30%</b>	<b>70%/30%</b>
	NonPPO	<b>50%/50%</b>	<b>50%/50%</b>
<b>Laboratory</b>	PPO	<b>70%/30%</b> <sup>3</sup>	<b>70%/30%</b> <sup>3</sup>
	NonPPO	<b>50%/50%</b>	<b>50%/50%</b>
<b>Radiology Services</b>	PPO	<b>70%/30%</b>	<b>70%/30%</b>
	NonPPO	<b>50%/50%</b>	<b>50%/50%</b>
CT, MRI, MRA and PET scans also subject to a <b>\$100 high-tech radiology access fee</b> , (maximum of 3 access fees per member, per calendar year) in addition to deductible and coinsurance.			
<b>Outpatient Services</b>	PPO	<b>70%/30%</b>	<b>70%/30%</b>
	NonPPO	<b>50%/50%</b>	<b>50%/50%</b>
<b>Inpatient Hospital<sup>4</sup></b>	PPO	<b>\$150</b> access fee (maximum of 3 access fees per member, per calendar year) then <b>70%/30%</b>	<b>\$150</b> access fee (maximum of 3 access fees per member, per calendar year) then <b>70%/30%</b>
	NonPPO	<b>\$150</b> access fee (maximum of 3 access fees per member, per calendar year) then <b>50%/50%</b>	<b>\$150</b> access fee (maximum of 3 access fees per member, per calendar year) then <b>50%/50%</b>
<b>Emergency</b>		<b>\$150</b> access fee, then <b>70%/30%</b>	
<b>Retail and Mail Order Prescription Medications<sup>5</sup></b>	PPO	Member pays the lesser of the BCBSAZ allowed amount or the copay. <b>Generic medications: \$30</b> copay. <b>Brand medications: \$125</b> copay.	
	NonPPO	In addition to the applicable prescription medication copay, the member is also responsible for the balance bill.	
<b>Physical, Occupational &amp; Speech Therapy</b>	PPO	<b>50%/50%</b>	<b>50%/50%</b>
	NonPPO	<b>50%/50%</b>	<b>50%/50%</b>
Coinsurance will not count toward the out-of-pocket coinsurance maximum.			

1 Noncontracted 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 provider's billed charge.  
2 Many cost-share payments do not count toward the out-of-pocket coinsurance maximum including deductibles, copays, access fees, certain other charges listed in the benefit book, precertification charges, amounts paid for noncovered services and noncontracted providers' balance bills.  
3 PCP office visit copay is waived for laboratory services provided in a PCP's office if the only services received are laboratory services.  
4 Precertification is required. If precertification is not obtained, services may not be covered or the member will be subject to a precertification charge.  
5 Precertification is required for certain medications.

# BlueSelect HMO Plan Comparison

The grid below is to help you understand the similarities and variations between different options in the BCBSAZ BlueSelect product line. For more information on the details of a specific plan, please refer to the benefit summary or the benefit book. This is not a complete listing of benefits. Please see the exclusions and limitations located at the end.

Benefits <sup>1</sup>	BlueSelect Plan 10	BlueSelect Plan 20
<b>Out-of-Pocket Coinsurance Maximum/Out-of-Pocket Maximum</b>	<b>\$500</b> per person, per calendar year. Only coinsurance for PT, OT and ST applies to satisfaction of the maximum; copays and coinsurance for services other than PT, OT and ST do not apply toward satisfaction of the out-of-pocket coinsurance maximum.	<b>\$2,500</b> per person, per calendar year. Physician office visit copays, behavioral health inpatient and outpatient copays, retail and mail order prescription medication copays, specialty self-injectable medication copays, chiropractic services copays and routine vision exam copays do <b>not</b> apply to the out-of-pocket maximum. All other copays and coinsurance apply to satisfaction of the out-of-pocket maximum.
PCP Office Services	<b>\$10</b> copay	<b>\$20</b> copay
Specialist Office Services	<b>\$20</b> copay	<b>\$30</b> copay
Chiropractic Services <sup>2</sup>	<b>\$20</b> copay	<b>\$30</b> copay
Preventive Care	Physician office visit copay.	Physician office visit copay.
Urgent Care	<b>\$25</b> copay	<b>\$50</b> copay
Laboratory Services	BCBSAZ pays <b>100%</b> for covered services at contracted, free-standing labs <sup>3</sup> .	
Radiology Services (Facility charges)	<b>\$100</b> copay for CT, MRI, MRA and PET scans. All other covered services, BCBSAZ pays <b>100%</b> .	<b>\$100</b> copay for CT, MRI, MRA and PET scans. All other covered services, BCBSAZ pays <b>100%</b> .
Hospital Services		
Inpatient <sup>2</sup>	BCBSAZ pays <b>100%</b> for covered services.	<b>\$250</b> copay per person, per day (maximum of 3 days), per admission, then BCBSAZ pays <b>100%</b> for covered services.
Outpatient	BCBSAZ pays <b>100%</b> for covered services.	<b>\$100</b> copay per person, per surgery, then BCBSAZ pays <b>100%</b> for covered services.
Emergency	<b>\$150</b> copay	<b>\$150</b> copay
Prescription Medications at Retail and Mail Order Pharmacy <sup>4</sup>	Retail – <b>\$10/\$25/\$50/\$80</b>	Retail – <b>\$10/\$25/\$50/\$80</b>
	Mail Order – 2x applicable copay	
Physical, Occupational & Speech Therapy	<p><b>Physical/Occupational Therapy:</b> BCBSAZ pays <b>100%</b> for covered services, up to <b>80</b> modalities and/or therapeutic services per person, per calendar year.</p> <p><b>Speech Therapy:</b> BCBSAZ pays <b>100%</b> for covered services, up to <b>20</b> visits per person, per calendar year.</p> <p>Additional visits <u>exceeding these limits</u> are available, subject to <b>50%</b> coinsurance until member reaches the <b>\$500</b> out-of-pocket coinsurance maximum per calendar year. After the <b>\$500</b> out-of-pocket coinsurance maximum is met, BCBSAZ will pay <b>100%</b> for covered services.</p>	<p><b>Physical/Occupational Therapy:</b> BCBSAZ pays <b>100%</b> for covered services, up to <b>80</b> modalities and/or therapeutic services per person, per calendar year.</p> <p><b>Speech Therapy:</b> BCBSAZ pays <b>100%</b> for covered services, up to <b>20</b> visits per person, per calendar year.</p> <p>Additional visits <u>exceeding these limits</u> are available, subject to <b>50%</b> coinsurance until member reaches the <b>\$2,500</b> out-of-pocket maximum per calendar year. After the <b>\$2,500</b> out-of-pocket maximum is met, BCBSAZ will pay <b>100%</b> for covered services.</p>
Vision Exams (Routine)	<b>\$10</b> copay, one routine vision exam per person, per calendar year; eyewear discounts available	<b>\$30</b> copay, one routine vision exam per person, per calendar year; eyewear discounts available

<sup>1</sup> Except for emergency services, all services must be rendered by network providers or the service will not be covered.

<sup>2</sup> Precertification is required. If precertification is not obtained, services will not be covered.

<sup>3</sup> Physician office visit copay is waived for laboratory services provided in the physician's office if the only services received are laboratory services.

<sup>4</sup> Precertification is required for certain medications.

## 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 book 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
- **(BlueSolutions only)** Behavioral/Mental health services, including, but not limited to, alcohol and substance abuse and any diagnostic tests or treatment
- Benefit-specific exclusions and limitations listed in the benefit book under particular benefits
- Body art, piercing, tattooing and any related complications
- Certain types of inpatient and outpatient facility charges by: group homes, wilderness programs, boarding schools, halfway houses, assisted living centers or shelter. Inpatient and outpatient facility charges for residential treatment facilities except for certain, very limited situations based upon BCBSAZ medical necessity criteria.
- Charges associated with the preparation, copying or production of health records
- **(BlueSolutions only)** Chiropractic Services – all services performed by a Chiropractor or Chiropractor assistant including without limitation, examination, evaluations, chiropractic treatment, physical therapy, manual therapy and massage
- 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
- Lifestyle education and management services, biofeedback and hypnotherapy, 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
- Manipulation of the spine under anesthesia
- Massage therapy, except in limited circumstances as described in the BCBSAZ Medical Coverage Guidelines
- Medical equipment, supplies and medications sold on or through unregulated distribution channels as determined by BCBSAZ
- Medications dispensed in certain settings – prescription medications given to the member by any person or entity that is not a licensed pharmacy, home health agency, specialty pharmacy or hospital emergency room
- 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
- **(BlueSolutions only)** Routine vision exams
- 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
- **(BlueSelect only)** Services from noncontracted providers, except for emergencies
- 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
- **(BlueSolutions only)** Temporomandibular Joint Syndrome (TMJ), including but not limited to, treatment or procedures
- 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
- 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

*This provides a general summary of benefits only. A complete description of all benefits, limitations and exclusions is found in and governed by each plan's benefit book, which is also subject to the provisions of the employer's group master contract with BCBSAZ.*

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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 subscriber had signs or symptoms, whether or not a specific injury, illness or disease is diagnosed. For purposes of determining a pre-existing condition and pre-existing condition waiting periods, 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 the employer group's eligibility waiting period) during which a member was not covered under any creditable coverage. Creditable coverage includes the following: coverage provided under a group health plan (insured or self-insured), an individual insurance policy, Medicare, Medicaid, a federal or state public health plan, a health risk benefits pool, TRICARE, the Peace Corps, a Bonafide Association, Indian Health Services, 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 for additional information.

Network 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.



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