

BluePreferred Basic PPO Plan Benefit Summary Grandfathered Plan



An Independent Licensee of the Blue Cross and Blue Shield Association

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

In-Network Providers (Contracted)

In-network providers are eligible providers who meet one of the following criteria: (1) are contracted with Blue Cross Blue Shield of Arizona; or (2) are located out-of-state and licensed in the United States, and contracted with an out-of-state Blue Cross and/or Blue Shield Plan ("Host Blue") as PPO providers. In-network providers will file members' claims with Blue Cross Blue Shield of Arizona or the Host Blue plan. In-network providers cannot charge more than the allowed amount for covered services.* Members have lower out-of-pocket costs for covered services when they use in-network providers.

Out-of-Network Providers (Contracted and Noncontracted)

Out-of-network providers are eligible providers who meet any of the following criteria: (1) are not contracted with Blue Cross Blue Shield of Arizona (BCBSAZ); (2) are contracted with a Host Blue as "Participating-only" Providers; or (3) are contracted with the BlueCard Worldwide program. Noncontracted providers are not obligated to file members' claims. Members have higher out-of-pocket costs for covered services when they use out-of-network providers.

Allowed Amount

All claims are processed using the BCBSAZ "Allowed Amount." BCBSAZ reimbursement, member cost share payments, and accumulations toward deductibles and out-of-pocket limits are calculated on the BCBSAZ Allowed Amount. The allowed amount is the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost share payment. It does not include any balance bill. The allowed amount is based on BCBSAZ or other fee schedules. It is not tied to and does not necessarily reflect a provider's regular billed charges.

Payment of Reimbursement

BCBSAZ or the Host Blue reimburses **contracted providers** the allowed amount, minus any portion allocated to member cost-share. When a member sees a **noncontracted provider**, BCBSAZ reimburses the **member** the allowed amount, minus any portion allocated to member cost-share.

Balance Bills

The balance bill is the difference between the BCBSAZ allowed amount and a noncontracted provider's billed charge. Any time you see a noncontracted provider, you are responsible for the balance bill.

FOR EMERGENCY SERVICES, YOU WILL PAY YOUR IN-NETWORK COST SHARE, EVEN IF SERVICES RECEIVED ARE FROM OUT-OF-NETWORK PROVIDERS. IF YOU RECEIVE EMERGENCY SERVICES FROM A NONCONTRACTED PROVIDER, YOU WILL ALSO BE RESPONSIBLE FOR THE BALANCE BILL, WHICH MAY BE SUBSTANTIAL.

BluePreferred Basic PPO Plan Benefit Summary

Grandfathered Plan

SUMMARY OF BENEFITS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER*																												
<p>Deductible (Calendar-year) Copays and access fees do not count toward the deductible. In-network deductibles are accumulated separately from out-of-network deductibles. All deductibles are based on allowed amount and must be met for all covered services unless otherwise stated.</p>	<table border="1"> <thead> <tr> <th>Per member</th> <th>Family</th> </tr> </thead> <tbody> <tr> <td>\$ 1,500</td> <td>\$ 3,000</td> </tr> <tr> <td>\$ 2,500</td> <td>\$ 5,000</td> </tr> <tr> <td>\$ 3,500</td> <td>\$ 7,000</td> </tr> <tr> <td>\$ 5,000</td> <td>\$10,000</td> </tr> <tr> <td>\$ 7,500</td> <td>\$15,000</td> </tr> <tr> <td>\$10,000</td> <td>\$20,000</td> </tr> </tbody> </table>	Per member	Family	\$ 1,500	\$ 3,000	\$ 2,500	\$ 5,000	\$ 3,500	\$ 7,000	\$ 5,000	\$10,000	\$ 7,500	\$15,000	\$10,000	\$20,000	<table border="1"> <thead> <tr> <th>Per member</th> <th>Family</th> </tr> </thead> <tbody> <tr> <td>\$ 3,000</td> <td>\$ 6,000</td> </tr> <tr> <td>\$ 5,000</td> <td>\$10,000</td> </tr> <tr> <td>\$ 7,000</td> <td>\$14,000</td> </tr> <tr> <td>\$10,000</td> <td>\$20,000</td> </tr> <tr> <td>\$15,000</td> <td>\$30,000</td> </tr> <tr> <td>\$20,000</td> <td>\$40,000</td> </tr> </tbody> </table>	Per member	Family	\$ 3,000	\$ 6,000	\$ 5,000	\$10,000	\$ 7,000	\$14,000	\$10,000	\$20,000	\$15,000	\$30,000	\$20,000	\$40,000
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<p>Coinsurance This is a percentage you must pay for covered services after meeting the calendar-year deductible. You will pay a higher coinsurance percentage when using an out-of-network provider. Coinsurance is based on the allowed amount and not on a provider's billed charges.</p>	BCBSAZ pays 80% , you pay 20% (80%/20%) of the allowed amount for most covered services, after meeting deductible, unless a copay or different coinsurance percentage is indicated.	BCBSAZ pays 50% , you pay 50% (50%/50%) of the allowed amount for most covered services, after meeting deductible, unless a copay or different coinsurance percentage is indicated.																												
<p>Coinsurance calculation and accumulation towards out-of-pocket coinsurance maximum</p>	BCBSAZ calculates member coinsurance payments and accruals toward deductibles and out-of-pocket coinsurance maximums based on the BCBSAZ allowed amount and based on a calendar year. We do not use a provider's billed charges. Only the member's coinsurance payment counts toward the out-of-pocket coinsurance maximums. Many cost share payments do not count toward these maximums, including: deductibles, copays, access fees, certain other charges listed in the benefit plan booklet, precertification charges, amounts paid for noncovered services, and noncontracted providers' balance bills. A member must continue to pay all of these cost share amounts (other than deductible) even after meeting the maximums.																													
<p>Out-of-Pocket Coinsurance Maximum (Calendar-year) The in-network out-of-pocket coinsurance maximum is accumulated separately from the out-of-network out-of-pocket coinsurance maximum.</p>	\$4,000 per member	\$8,000 per member																												
<p>Physician Services – Office Services Primary Care Physicians (PCP) include internal medicine, family practice, general practice and pediatrics. All other physicians are specialists.</p> <p>Deductible and coinsurance apply to services rendered by radiologists or pathologists.</p>	<p>Deductible option determines PCP copay.</p> <table border="1"> <thead> <tr> <th>Deductible</th> <th>PCP Copay</th> </tr> </thead> <tbody> <tr> <td>\$ 1,500</td> <td>\$25</td> </tr> <tr> <td>\$ 2,500, \$3,500</td> <td>\$30</td> </tr> <tr> <td>\$ 5,000, \$7,500</td> <td>\$35</td> </tr> <tr> <td>\$10,000</td> <td>\$40</td> </tr> </tbody> </table> <p>Office visit copay per member, per provider, per day for most covered services performed in a physician's office.</p> <p>Specialist: 80%/20% after meeting deductible.</p>	Deductible	PCP Copay	\$ 1,500	\$25	\$ 2,500, \$3,500	\$30	\$ 5,000, \$7,500	\$35	\$10,000	\$40	50%/50% after meeting deductible.																		
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<p>Urgent Care Copay applies per member, per provider, per day at facilities specifically contracted for urgent care.</p>	<p>Deductible option determines copay.</p> <table border="1"> <thead> <tr> <th>Deductible</th> <th>Copay</th> </tr> </thead> <tbody> <tr> <td>\$1,500</td> <td>\$45</td> </tr> <tr> <td>\$2,500, \$3,500</td> <td>\$50</td> </tr> <tr> <td>\$5,000</td> <td>\$55</td> </tr> <tr> <td>\$7,500, \$10,000</td> <td>\$60</td> </tr> </tbody> </table>	Deductible	Copay	\$1,500	\$45	\$2,500, \$3,500	\$50	\$5,000	\$55	\$7,500, \$10,000	\$60	50%/50% after meeting deductible.																		
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<p>Preventive Services</p> <ul style="list-style-type: none"> Certain Screening Services Immunizations Routine Physicals Mammography 	<p>Physician office visit copay or 80%/20% depending on whether services are received from a PCP or specialist.</p> <p>Services provided outside the physician's office are subject to coinsurance.</p> <p style="text-align: center;">The deductible does not apply to covered preventive services.</p> <p>Preventive services are those services performed for screening purposes when the member does not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition. The combination of the diagnosis and procedure codes submitted by the provider determines whether a service is preventive.</p>	50%/50% deductible waived for mammography; all other preventive services not covered.																												

SUMMARY OF BENEFITS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER*									
Laboratory Services Deductible and coinsurance apply to services rendered by pathologists.	In a PCP physician's office, applicable office visit copay is 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 and coinsurance waived. At all other facilities 80%/20% after meeting deductible.	50%/50% after meeting deductible.									
Other Professional Services	80%/20% after meeting deductible. Other professional services include diagnostic, surgical and anesthesia services rendered outside the physician's office.	50%/50% after meeting deductible.									
Prescription Medications at Retail and Mail Order Pharmacy¹ 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 the BCBSAZ Prescription Benefits Unit. These limitations include, but are not limited to, quantity, age, gender and refill limitations. BCBSAZ prescription medication limitations are subject to change at any time without prior notice.	Member pays the lesser of the allowed amount or the copay. <table border="0" style="margin-left: 40px;"> <tr> <td></td> <td style="text-align: center;"><u>Retail pharmacy</u></td> <td style="text-align: center;"><u>Mail order</u></td> </tr> <tr> <td>Generic medications:</td> <td style="text-align: center;">\$ 30 copay</td> <td style="text-align: center;">\$ 60 copay</td> </tr> <tr> <td>Brand name medications:</td> <td style="text-align: center;">\$125 copay</td> <td style="text-align: center;">\$250 copay</td> </tr> </table> <p>If a contracted pharmacy's regular price for a prescription medication is less than your copay, some pharmacies may charge you the lower price. You will never have to pay more than your copay at a contracted pharmacy. When you fill a prescription at a noncontracted retail pharmacy, in addition to the applicable prescription medication copay, you are also responsible for the balance bill.</p> <p>Mail order is available only through the in-network mail order provider. Mail order is not covered through a noncontracted provider.</p>		<u>Retail pharmacy</u>	<u>Mail order</u>	Generic medications:	\$ 30 copay	\$ 60 copay	Brand name medications:	\$125 copay	\$250 copay	
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Generic medications:	\$ 30 copay	\$ 60 copay									
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Inpatient Hospital²	80%/20% after meeting deductible.	50%/50% after meeting deductible.									
Outpatient Services	80%/20% after meeting deductible.	50%/50% after meeting deductible.									
Emergency	\$150 access fee per member, per facility, per day, 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. Routine maternity, including most C-sections, is not covered.	50%/50% after meeting deductible.									
Physical, Occupational and Speech Therapy	80%/20% after meeting deductible.	50%/50% after meeting deductible.									
Chiropractic	80%/20% after meeting deductible.	50%/50% after meeting deductible.									
Vision Exams (Routine)	\$15 copay for one routine eye exam per member, per calendar year.	Reimbursement up to \$25 for one routine eye exam per member, per calendar year.									
Ambulance Services	80%/20% deductible waived.										
Behavioral and Mental Health Services² Cost sharing for behavioral/mental health does not apply to any out-of-pocket coinsurance maximum. Both in-network and out-of-network admissions count toward the 2-admission, 30-day limit.	Outpatient: You may choose in-network or out-of-network providers or the behavioral services administrator (BSA). BSA: \$15 copay per visit for psychotherapy and counseling. (BSA services available only in Arizona.) In-network and out-of-network providers: BCBSAZ pays 50% , you pay 50% after meeting deductible, with a maximum of 20 psychological sessions per member, per calendar year. Inpatient: Two admissions per member, per calendar year, up to a combined total of 30 days. In-network facility: 80%/20% after meeting deductible.	Out-of-network facility: 50%/50% after meeting deductible. Inpatient professional services: 50%/50% after meeting deductible.									
Inpatient Rehabilitation Services² Both in-network and out-of-network admissions count toward the 120-day per member 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.	50%/50% 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.									
Home Health and Infusion¹ Limited to three two-hour visits per member per day.	80%/20% after meeting deductible. Certain injectable medications are also available through the specialty self-injectable medication benefit.	50%/50% after meeting deductible.									

SUMMARY OF BENEFITS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER*
Skilled Nursing Facility² Both in-network and out-of-network admissions count toward the 180-day per member calendar-year limit.	80%/20% after meeting deductible, for 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. Coverage is limited to 180 days per member, per calendar year.	50%/50% after meeting deductible, for 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.
Specialty Self-Injectable Medications through Specialty Pharmacy¹ For certain specified self-injectable prescription biologic medications. Specialty self-injectable medications are not covered under the retail and mail order medication benefit.	<u>Contracted Specialty Pharmacy</u> 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 self-injectable medications and contracted specialty pharmacies or call BCBSAZ. Specialty self-injectable medications may also be available under the home health benefit, subject to deductible and coinsurance.	Not covered (see Home Health).
Bariatric Surgery²	\$1,000 access fee per member, per surgery, plus applicable deductible and coinsurance.	

1 Precertification is required for certain medications including all specialty self-injectable medications. Lists 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.

2 Precertification is required. If precertification is not obtained, services will not be covered or you will be subject to a precertification charge.

* 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 balance bill. The obligation to pay the balance bill continues even after the member's out-of-pocket coinsurance maximum is met.

Explanatory Notes:

- This is only a brief summary of benefits and exclusions. Please refer to the specific provisions found within the benefit plan booklet for detailed information about benefits, limitations and exclusions. If the benefits listed in this summary differ from those stated in the benefit plan booklet, the terms of the benefit plan booklet apply. There is no guarantee of continued benefits outlined in this summary or the benefit plan booklet. The benefit plan may be amended, and benefits may be added, deleted or changed by BCBSAZ upon 31 days' notice to the policy holder.
- BCBSAZ believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve coverage that was already in effect when that law was enacted. Since this plan is a grandfathered plan, it will not be subject to certain mandatory benefit changes required by PPACA for non-grandfathered plans. However, PPACA does require grandfathered health plans to make certain benefit revisions. You may contact BCBSAZ with questions regarding which changes apply and which changes do not apply to a grandfathered health plan by calling the number located on the back of your BCBSAZ ID card. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.
- 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 benefits. 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.
- In-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.

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

Pre-existing condition waiting periods and waivers apply.

- 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
- Benefit-specific exclusions and limitations listed in the benefit plan booklet under particular benefits
- Body art, piercing and 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 shelters. 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
- 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, including reproductive and genetic services
- Flat feet
- Foot care, except as stated in the benefit plan
- Free services
- Genetic and chromosomal testing and screening
- Government services provided at no charge to the member through a governmental program or facility
- Growth hormone, except as specified in 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
- Maternity, except as stated in the benefit plan
- Medical equipment, supplies and medications sold on or through unregulated distribution channels as determined by BCBSAZ
- Medical marijuana and any costs or fees associated with obtaining medical marijuana
- 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 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 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/her are excluded from coverage.
- Services from ineligible providers
- Services paid for by other organizations
- Services provided prior to effective date
- 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 related to or associated with noncovered services
- Services without a prescription when a prescription is required
- Services for sexual dysfunction, regardless of the cause, and all medications for the treatment of sexual dysfunction
- 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
- 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, except as stated in the benefit plan
- Vitamins, except as stated in the benefit plan
- Waivered conditions
- 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 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 benefit plan effective date.



An Independent Licensee of the Blue Cross and Blue Shield Association