BluePreferred 90/70 Benefit Summary
$7,500 Deductible

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

	COST SHARE
Calendar-Year Deductible	**$7,500** per member, **$15,000** per family Deductible must be met for all covered services unless otherwise stated. Copays, access fees, precertification charges and balance bills do not count toward the deductible.

	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER[1]
Coinsurance This is a percentage members must pay for certain covered services after meeting the calendar-year deductible.	BCBSAZ pays **90%,** member pays **10% (90%/10%)** of the allowed amount for most covered services, after meeting deductible, unless a copay or different coinsurance percentage is indicated.	BCBSAZ pays **70%,** member pays **30% (70%/30%)** of the allowed amount for most covered services, after meeting deductible, unless a copay or different coinsurance percentage is indicated.
Calendar-Year Out-of-Pocket Coinsurance Maximums	**$2,000** per member, **$4,000** family.	**$4,000** per member, **$8,000** family.
How we calculate coinsurance and accumulations toward deductible and out-of-pocket coinsurance maximums	BCBSAZ calculates member coinsurance payments and accruals toward deductible and the out-of-pocket coinsurance maximums, based on the BCBSAZ allowed amount. We do not use a provider's billed charges. Only the member's coinsurance payment counts towards the out-of-pocket coinsurance maximums. Many cost share payments do not count toward the out-of-pocket maximums, 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. A member must continue to pay all these cost share amounts (other than the deductible) even after meeting the maximums.	
Physician Office Services Primary Care Physicians (PCP) include Family Practice, General Practice, Internal Medicine and Pediatrics. All other physicians are specialists. Deductible and coinsurance always apply to services rendered by radiologists and pathologists and to physical, occupational and speech therapy services.	**Copay** **PCP:** **$25** **Specialist:** **$40** Copay applies per member, per provider, per day for most covered services provided in a physician's office. **90%/10%** for other covered services, after meeting deductible.	**70%/30%** after meeting deductible.
Preventive Services	BCBSAZ pays **100%** of allowed amount for covered preventive services. Copays, deductible and coinsurance are waived.	**70%/30%** after meeting deductible for mammography and foreign travel immunizations; all other preventive services not covered.
	Preventive services are those services performed for screening purposes when the member does not have active signs or symptoms of a condition, and 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.	
Urgent Care	**$60** copay per member, per provider, per day at facilities specifically contracted for urgent care.	**70%/30%** after meeting deductible.
Laboratory Services	In a physician's office, BCBSAZ pays **100%**; physician office visit copay waived, if the only services a member receives during the visit are laboratory services. For all other diagnostic laboratory services, including pathologists, **90%/10%** after meeting deductible.	**70%/30%** after meeting deductible.
Other Professional Services	**90%/10%** after meeting deductible.	**70%/30%** after meeting deductible.
	Other professional services include diagnostic, surgical and anesthesia services rendered outside the physician's office.	
Outpatient Facility Services	**90%/10%** after meeting deductible.	**70%/30%** after meeting deductible.
Radiology Facility Services	**90%/10%** after meeting deductible.	**70%/30%** after meeting deductible.
Inpatient – Hospital	**90%/10%** after meeting deductible.	**70%/30%** after meeting deductible.

[1] Any time you see a noncontracted provider, you are responsible for the balance bill. Please see "Important Information" section of this benefit summary.

	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER[2]
Emergency	**$250** copay per member, per facility, per day. Emergency room copay is waived if member is admitted to the hospital. Following admission, **90%/10%** after meeting deductible for hospital and professional services related to the emergency.	
Ambulance	**90%/10%** after meeting deductible.	
Prescription Medications at Retail and Mail Order Pharmacy	**Copay Levels / Retail Pharmacy / Mail Order** **Level One** **$ 15** **$ 30** **Level Two** **$ 35** **$ 70** **Level Three** **$ 65** **$130** **Level Four** **$120** **$240**	**Retail Pharmacy:** When a member fills a prescription at an out-of-network retail pharmacy, member pays applicable prescription medication copay plus the balance bill (difference between a pharmacy's price and the allowed amount). **Mail Order:** Not covered.
Maternity	**Physician:** Office visit copay or **90%/10%** after meeting deductible. Other than initial copay, cost-sharing is waived on physician's global delivery fee, but applies to all other covered services. **Hospital: 90%/10%** after meeting deductible.	**Physician and Hospital**: **70%/30%** after meeting deductible.
Chiropractic	**Physician: $40** office visit copay per member, per provider, per day for most covered services provided in a chiropractor's office. For other covered services: **90%/10%**, after meeting deductible.	**70%/30%** after meeting deductible.
Physical, Occupational & Speech Therapy	**90%/10%** after meeting deductible.	**70%/30%** after meeting deductible.
	Group physical and occupational therapy is not covered.	
Routine Vision Exams	**$25** copay for one routine vision exam per member, per calendar year. Cost share is waived for routine vision exams for members under age 5.	**70%/30%** after meeting deductible for one routine vision exam per member, per calendar year.
Behavioral/Mental Health Member may choose in-network or out-of-network providers or the behavioral services administrator (BSA). BSA services are available only in Arizona.	**Inpatient: 90%/10%** after meeting deductible. **Outpatient:** Depending on the type of provider**, physician office visit copay or 90%/10% after meeting deductible**. **BSA:** Unlimited psychotherapy and counseling; **$15** copay per member, per visit.	**70%/30%** after meeting deductible.
Inpatient Extended Active Rehabilitation	After meeting deductible, **90%/10%** for first **60** days, and **50%/50%** for next **60** days. **Coinsurance for days 61-120 does not count toward out-of-pocket coinsurance maximum.**	After meeting deductible, **70%/30%** for first **60** days, and **50%/50%** for next **60** days. **Coinsurance for days 61-120 does not count toward out-of-pocket coinsurance maximum.**
	Limited to **120** days per member, per calendar year, combined in and out of network.	
Skilled Nursing Facility	After meeting deductible, **90%/10%** for first **90** days, and **50%/50%** for next **90** days. **Coinsurance for days 91-180 does not count toward out-of-pocket coinsurance maximum.**	After meeting deductible, **70%/30%** for first **90** days, and **50%/50%** for next **90** days. **Coinsurance for days 91-180 does not count toward out-of-pocket coinsurance maximum.**
	Limited to **180** days per member, per calendar year, combined in and out of network.	
Home Health and Infusion Limited to three two-hour visits per member per day.	**90%/10%** after meeting deductible.	**70%/30%** after meeting deductible.
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.	**Contracted Specialty Pharmacy** Level A: **$50 copay** Level B: **$100 copay** Level C: **$150 copay** Level D: **$200 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.
Bariatric Surgery (Inpatient and Outpatient)	**$1,000** access fee, plus **90%/10%** after meeting deductible.	**$1,000** access fee, plus **70%/30%** after meeting deductible.

[2] Any time you see a noncontracted provider, you are responsible for the balance bill. Please see "Important Information" section of this benefit summary.

IMPORTANT INFORMATION

Allowed Amount: All claims are processed using the BCBSAZ "Allowed Amount." BCBSAZ reimbursement, member cost share payments, and accumulations toward deductible 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.

Balance Bill: This 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.

Providers, claims, and out of pocket costs: This plan allows members to go to in and out-of-network providers. 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. In-network providers will file members' claims and generally 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. Noncontracted providers can charge members full billed charges, which will include the difference between the BCBSAZ allowed amount and the provider's regular billed charges ("the balance bill"). Members are responsible for paying up to a noncontracted 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. Any amounts paid for balance bills do not count toward deductible, coinsurance or any out-of-pocket coinsurance maximum.

EMERGENCY SERVICES: 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.

Precertification: Some services and medications require precertification. Except for emergencies, urgent care, and maternity admissions, precertification is always required for inpatient admissions (acute care, behavioral health, long term acute care, extended active rehabilitation, and skilled nursing facilities) and specialty injectable medications. Precertification may be required for other covered services and medications. The member is responsible for making sure his or her physician obtains precertification approval if it is required. If precertification is not obtained, the member's benefits may be denied or the member may be subject to a precertification charge. Information on precertification requirements, including 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.

Medications and Prescriptions

- When the price BCBSAZ pays an in-network pharmacy for a medication is less than the member's cost-share, 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-share), rather than the BCBSAZ price. The member will not be required to pay more than the applicable cost-share 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, gender and refill limitations. BCBSAZ prescription medication limitations are subject to change at any time without prior notice.

Preexisting Conditions

AN 11 MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS MAY APPLY FOR MEMBERS AGE 19 AND OLDER. A pre-existing condition is defined as a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) month period immediately preceding the 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 or (800) 232-2345, Ext. 4456 for additional information.

IMPORTANT WARNING

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, ON REQUEST. IF THE TERMS OF THIS SUMMARY DIFFER FROM THE TERMS OF THE BENEFIT PLAN BOOKLET, THE TERMS OF THE BOOKLET CONTROL AND 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 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; aromatherapy
- For groups with 50 or less eligible employees: Autism spectrum disorders (ASD) – services related to treatment of ASD
- Benefit-specific exclusions and limitations listed in the benefit book under particular benefits
- Biofeedback and hypnotherapy, except as stated in the benefit plan
- 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 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 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, 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
- 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 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 as defined in the benefit plan. 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 except as stated in the benefit plan
- 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
- 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

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