

Summary of Benefits

BlueSolutions® PPO Plan 2500 Copay



An Independent Licensee of the Blue Cross and Blue Shield Association

azblue.com

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

BluePreferred PPO Providers (in-network providers)	<p>These providers have agreed to accept the BCBSAZ allowed amount for covered services and will file claims to BCBSAZ for members. Out-of-pocket costs are lower when Preferred providers are used.</p> <p>Preferred providers are also available outside Arizona through the BlueCard® program. To locate BlueCard PPO providers, call (800) 810-BLUE or check the BlueCard Doctor and Hospital Finder at bcbs.com.</p>
NonPreferred Providers (out-of-network providers) Participating Providers (NonPreferred)	<p>Members pay higher cost-sharing when they use nonPreferred providers. There are two types of nonPreferred providers.</p> <p>Arizona health care providers who are not contracted for BCBSAZ's BluePreferred plans, but are part of the BCBSAZ Participating provider network. Although members will pay higher cost-sharing, these providers have agreed to accept the BCBSAZ allowed amount for covered services and will file claims to BCBSAZ for members.</p> <p>Participating providers are also available outside Arizona through the BlueCard program and some Participating hospitals are available outside the U.S. To locate BlueCard providers, call (800) 810-BLUE or check the BlueCard Doctor & Hospital Finder at bcbs.com.</p>
Noncontracted Providers (NonPreferred)	<p>Providers who have no contract with BCBSAZ. In addition to any applicable coinsurance and deductible, noncontracted providers may charge members the difference between their billed charges and the BCBSAZ allowed amount. The obligation to pay the difference between the provider's billed charges and the BCBSAZ allowed amount continues even after the member's out-of-pocket coinsurance maximum is met. Members will have more out-of-pocket expense and noncontracted providers are not obligated to file claims for members.</p>

- Contracted providers are independent contractors exercising independent medical judgment and are not employees, agents or representatives of BCBSAZ. BCBSAZ has no control over any diagnosis, treatment or service rendered by any provider.
- BCBSAZ has negotiated various reimbursement methods with contracted providers. These providers have agreed to accept the BCBSAZ allowed amount for covered services provided to BCBSAZ members. This means that after payment of deductible, coinsurance or copay amounts, these providers will not bill you for the difference between the provider's billed charges and the BCBSAZ allowed amount for covered services. However, when there is another source of payment, such as a liability insurer or government payer, providers may be entitled to collect from the other source or from proceeds received from the other source any difference between the provider's billed charges and the BCBSAZ allowed amount.
- Reimbursement to both members and providers is based on the BCBSAZ allowed amount. For Arizona providers, the BCBSAZ allowed amount is generally calculated using the lesser of billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements. For out-of-state providers, the BCBSAZ allowed amount is generally calculated using the prevailing fee from the Blue Cross and/or Blue Shield plan in the state where services are received. **For emergency or accident services only:** When the provider is a noncontracted provider (either in Arizona or out-of-state), the BCBSAZ allowed amount is based on billed charges. All noncontracted providers may bill you up to their full billed charges.

Summary of Benefits

Summary of Benefits	Preferred Provider In-Network	NonPreferred Provider Out-of-Network
Deductible Deductible must be met for all covered services unless otherwise stated.	Calendar-year deductible, per person – \$2,500 , family maximum deductible – \$5,000 .	
Coinsurance This is a percentage members must pay for covered services after meeting the calendar-year deductible. Members will pay a higher coinsurance percentage when using a nonPreferred provider. Coinsurance is based on the BCBSAZ allowed amount.	BCBSAZ pays 70% , member pays 30% of the BCBSAZ allowed amount for most covered services, after meeting deductible, unless a different coinsurance percentage is indicated below.	BCBSAZ pays 50% , member pays 50% of the BCBSAZ allowed amount for most covered services, after meeting deductible, unless a different coinsurance percentage is indicated below.
Out-of-Pocket Coinsurance Maximum Deductible, copays and access fees do not count toward the out-of-pocket coinsurance maximum.	\$5,000 per person, \$10,000 family per calendar year	\$10,000 per person, \$20,000 family per calendar year Member is still responsible for a noncontracted provider's billed charges even after the out-of-pocket coinsurance maximum is met.

BlueSolutions PPO Plan 2500 Copay

Summary of Benefits

Summary of Benefits	Preferred Provider In-Network	NonPreferred Provider Out-of-Network
Physician Services – Primary Care Physician (PCP) Office Services Primary Care Physicians (PCP) include family practice, general practice, internal medicine, Pediatrics. All other physicians are specialists.	\$35 copay (per person, per provider, per day) for most covered services performed in a physician's office.	50%/50% after meeting deductible
Physician Services – Specialist Office Services	70%/30% after meeting deductible	50%/50% after meeting deductible
Urgent Care	70%/30% after meeting deductible	50%/50% after meeting deductible
Laboratory Services	70%/30% after meeting deductible	50%/50% after meeting deductible
Radiology Services CT, MRI, MRA and PET scans also subject to a \$100 hi-tech radiology access fee, per procedure type, per person, per provider, per day (maximum of 3 access fees per person, per calendar year) in addition to deductible and coinsurance. Hi-tech radiology access fee is waived for radiology services performed while an inpatient at an acute hospital and while in the emergency room.	70%/30% after meeting deductible	50%/50% after meeting deductible
Other Professional Services	70%/30% after meeting deductible Covered services include diagnostic, surgical and anesthesia services rendered outside a physician's office.	50%/50% after meeting deductible
Inpatient – Hospital[†]	\$150 access fee (maximum of 3 access fees per person, per calendar year) , then 70%/30% after meeting deductible	\$150 access fee (maximum of 3 access fees per person, per calendar year) , then 50%/50% after meeting deductible
Outpatient Services (Facility charges)	70%/30% after meeting deductible	50%/50% after meeting deductible
Outpatient Surgery (Facility charges)	70%/30% after meeting deductible	50%/50% after meeting deductible
Emergency Room	\$150 access fee (per person, per provider, per day); then 70%/30% after meeting deductible; emergency room access fee is waived if member is admitted to the hospital.	
Ambulance	70%/30% after meeting deductible	
Bariatric Surgery[†]	\$1,000 access fee, in addition to applicable deductible and coinsurance	
Prescription Medications at Retail and Mail Order Pharmacy Payment for mail order must be made with a debit or credit card and is only available through the Preferred mail order provider.	30 day retail supply Generic medications: Member pays the lesser of the BCBSAZ allowed amount or a \$30 copay. Brand name medications: Member pays the lesser of the BCBSAZ allowed amount or a \$125 copay. Mail order is only available through the Preferred mail order provider. Precertification is required for certain medications covered under the retail and mail order pharmacy benefit. A list of medications that require precertification and the process for obtaining precertification is available on the BCBSAZ Web site at azblue.com or by calling BCBSAZ at (602) 864-4273 or (800) 232-2345, ext. 4273. Otherwise covered eligible medications will not be covered if precertification is not obtained when required.	Members must pay for prescriptions in full and submit a claim to BCBSAZ. Members will be reimbursed for amounts above \$125 , up to the BCBSAZ allowed amount per prescription. Members are also responsible for the difference between a noncontracted pharmacy's price and the BCBSAZ allowed amount. Mail order is not covered through a nonPreferred provider.
Specialty Self-Injectable Medications Through Specialty Pharmacy[†] For certain specified self-injectable prescription biologic medication. Specialty injectable medications are not covered under the Home Health or retail and mail order pharmacy benefits.	\$ 30 Level A copay \$ 60 Level B copay \$ 90 Level C copay \$120 Level D copay Please refer to azblue.com or call BCBSAZ for a listing of specialty self-injectable medications and contracted specialty pharmacies.	Not covered at nonPreferred specialty pharmacies.

Summary of Benefits	Preferred Provider In-Network	NonPreferred Provider Out-of-Network
Home Health	70%/30% after meeting deductible Precertification is required for certain medications provided through the Home Health benefit. A list of medications requiring precertification is available on the BCBSAZ Web site at azblue.com or by calling BCBSAZ at 602-864-4320 or (800) 232-2345, ext. 4320. Otherwise covered eligible medications will not be covered if precertification is not obtained when required.	50%/50% after meeting deductible
Preventive Care • Well-child care • Well-woman care • Well-man care	PCP – \$35 copay (per person, per provider, per day) for most services provided in a physician's office. 70%/30% for covered services provided outside the physician's office Specialists – 70%/30% after meeting deductible	Not covered.
Mammography	70%/30% after meeting deductible	50%/50% after meeting deductible
Maternity	Physician: 70%/30% after meeting deductible Hospital: \$150 access fee , then 70%/30% after meeting deductible	Physician and Hospital: 50%/50% after meeting deductible
Skilled Nursing Facility † Both in- and out-of-network admissions count toward the 180-day per person, per calendar year limit.	70%/30% after meeting deductible, for up to 90 days. After 90 days, BCBSAZ pays 50% , member pays 50% up to an additional 90 days, which will not count toward out-of-pocket coinsurance maximum.	50%/50% after meeting deductible for up to 90 days. After 90 days, BCBSAZ pays 50% , member pays 50% up to an additional 90 days, which will not count toward out-of-pocket coinsurance maximum.
Inpatient Extended Active Rehabilitation † Both in- and out-of-network admissions count toward the 120-day per person, per calendar year limit.	70%/30% after meeting deductible, for up to 60 days. After 60 days, BCBSAZ pays 50% , member pays 50% up to an additional 60 days, which will not count toward out-of-pocket coinsurance maximum.	50%/50% after meeting deductible for up to 60 days. After 60 days, BCBSAZ pays 50% , member pays 50% up to an additional 60 days, which will not count toward out-of-pocket coinsurance maximum.
Physical, Occupational & Speech Therapy	50%/50% after meeting deductible Coinsurance will not count toward the out-of-pocket coinsurance maximum.	50%/50% after meeting deductible
Benefit Plan Maximum	\$3,000,000 maximum benefit while the benefit plan is in force. All payments by BCBSAZ (for both Preferred and nonPreferred providers) apply toward the benefit plan maximum.	

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

†† In addition to any applicable deductible and coinsurance, noncontracted providers may charge members for the difference between their billed charges and the BCBSAZ allowed amount. This obligation to pay the difference between the provider's billed charges and the BCBSAZ allowed amount continues even after the member's out-of-pocket coinsurance maximum is met. Deductibles, copays, access fees and amounts the member pays for noncovered services do not count toward the out-of-pocket coinsurance maximum.

Important Information:

- 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 specific criteria that is available upon request.
- Precertification is the process BCBSAZ uses to determine eligibility for certain requested procedures or services. For example: Except for an emergency, hospital services require precertification. Member is responsible for making sure his/her provider obtains appropriate precertification approval. If precertification is not obtained, the member's benefits may be subject to an additional \$300 deductible or denial of benefits. The member's provider must call for precertification at (602) 864-4320 or (800) 232-2345, ext. 4320. Please refer to the precertification requirements in the benefit plan booklet, which will be sent to the member upon enrollment or upon request prior to enrollment.
- When the price BCBSAZ pays a contracted pharmacy for a medication is less than the member's cost-sharing, some pharmacies will charge the member the BCBSAZ price. However, most pharmacies will charge the member the retail price (if also less than the cost-sharing) rather than the BCBSAZ price. The member will not be required to pay more than the applicable cost-sharing for covered medications at a contracted pharmacy.
- BCBSAZ applies limitations to certain prescription medications obtained through the retail and mail order pharmacy benefit. A list of these medications is available online at azblue.com or by calling BCBSAZ. These limitations include, but are not limited to, quantity, age and gender limitations. BCBSAZ prescription medication limitations are subject to change at any time without prior notice.

Exclusions & Limitations

The following is a partial list of conditions and services that are limited or excluded. Expenses for services that exceed benefit limitations are not covered. Detailed information about benefits, limitations and exclusions is in the benefit plan booklet and is available prior to enrollment upon request.

- Abortions, except as stated in the benefit plan
- Activity therapy
- Acupuncture
- Alternative medicine, nontraditional or alternative medical therapies, including but not limited to, naturopathic and homeopathic medicine, diet therapies, nutritional or lifestyle therapies, aromatherapy
- Behavioral/Mental Health services, including but not limited to, alcohol and substance abuse and any diagnostic tests or treatment
- Biofeedback and/or hypnotherapy
- Chiropractic Services – all services performed by a chiropractor or chiropractic assistant including without limitation, examinations, evaluations, chiropractic treatment, physical therapy, manual therapy and massage.
- Cognitive and vocational therapy
- Complications of body piercing/tattooing
- Complications of noncovered benefits
- Cosmetic or aesthetic surgery or services, except for breast reconstruction following a medically necessary mastectomy in accordance with state and/or federal law
- Costs paid by other organizations - costs/services customarily paid for by an employer, the government, biotechnical, pharmaceutical or medical device industry sources or other individuals or organizations, including but not limited to, worksite or ergonomic evaluations
- Counseling or behavioral modification services
- Court-ordered services – testing, treatment or therapy, except as stated in the benefit plan
- Custodial care, except for limited hospice benefits
- Dental/orthodontic services or supplies– except emergency dental services rendered in an emergency room
- Detoxification for alcohol or substance abuse
- Dietary/nutritional supplements – all dietary, caloric and nutritional supplements including for example, specialized formulas for infants, children or adults or other special foods or diets, even if prescribed by a physician or other eligible provider, except as stated in the benefit plan
- Environmental medicine
- Fees other than for medically appropriate in-person, direct patient treatment, tests, services, medications, supplies or equipment
- Fertility or infertility treatment, medications or procedures
- Foot care, except as stated in the benefit plan
- Genetic/chromosome testing and screening
- Government services – services available under a governmental health program
- Growth hormone(s) – growth hormone except as determined medically necessary by BCBSAZ to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat Idiopathic Short Stature (ISS) is expressly excluded.
- Hearing services or devices, including but not limited to, cochlear implants for any reason
- Investigational treatments, procedures, equipment, medications, devices or supplies, as determined by BCBSAZ, unless required by Arizona law
- Lodging and meals
- Manipulations under anesthesia. This does not include reductions of fractures and/or dislocations done under anesthesia.
- Massage therapy, except as stated in the benefit plan.
- Medical foods, except as stated in the benefit plan
- Medications dispensed in a physician's/provider's office – prescription medications and over-the-counter medications, including pharmaceutical manufacturer's samples, dispensed to the patient in a physician's/provider's office by any mode of administration
- Medications for off-label, unlabeled or orphan medications (orphan medications are used for diagnosis, treatment or prevention of a rare disease or condition) unless otherwise specified by BCBSAZ medical or prescription medication coverage guidelines. This does not include medications used for the treatment of cancer.
- Neuropsychological and cognitive testing
- Non-medically necessary services, as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered.
- Osteopathic manipulations
- Over-the-counter medications – any medication, device, equipment, supply (except for certain diabetic supplies and inhaler spacers as described in the retail and mail order pharmacy benefit), that is lawfully obtainable without a prescription
- Personal comfort items
- Routine physical exams
- Routine vision exams
- Screening tests, except as stated in the benefit plan
- Services from family member(s) – services that are provided by an eligible provider who is part of the member's immediate family or services for which the member has no legal obligation to pay
- Services without a prescription, when a prescription is required
- Services of ineligible providers
- Services not requiring a licensed professional
- Services or supplies delivered prior to the coverage effective date or after the coverage termination date
- Services or supplies related to or associated with a noncovered service or supply
- Sexual dysfunction – evaluation and/or testing, diagnosis, treatment (surgical or non-surgical) or medication or devices for sexual dysfunction regardless of the cause of the condition, including trauma
- Sleep disorder diagnostic testing
- Smoking cessation programs, medications, aids or devices
- Strength training, cardiovascular endurance training, fitness/strengthening programs and/or other services designed to improve or increase fitness
- Telephonic or electronic consultations
- Therapy services, except as stated in the benefit plan
- Temporomandibular Joint Syndrome (TMJ) , including but not limited to, treatment or procedures
- Training and education, except as stated in the benefit plan
- Transplants (organ, tissue, bone marrow/peripheral stem cell rescue procedures) not approved by BCBSAZ; nor high-dose chemotherapy, radiation administered in conjunction with a noncovered transplant, expenses related to donation of an organ to a recipient who is not covered by BCBSAZ
- Transport services or travel expenses
- Transsexual treatment or surgery and/or any related services
- Treatment for behavioral/mental health conditions at non-acute facilities, (e.g., residential, skilled nursing)
- Vision therapy, radial keratotomy, all types of refractive keratoplasties, eyeglasses and contact lenses and the vision examination for prescribing and fitting of the same
- Vitamins – except for certain vitamins when a prescription is written by a physician
- Weight loss/gain therapy or treatment, except as stated in the benefit plan
- When a provider is also the covered person, services rendered by that provider for him/herself are excluded from coverage.
- Workers' Compensation – services for an illness or injury covered by Workers' Compensation or similar benefits, unless the member is exempt from such coverage or has made a statutory opt-out election

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 during the six (6) month period immediately preceding the member's enrollment date. For purposes of determining a pre-existing condition waiting period, enrollment date means the member's effective date of coverage under this benefit plan or the first day of the group's eligibility waiting period, whichever is earliest. **IMPORTANT:** Pregnancy is not considered a pre-existing condition. Credit will be given for periods of prior creditable coverage as long as there was no period of sixty-three (63) days or more (excluding group eligibility waiting periods) during which members were not covered under any creditable coverage. Creditable coverage is coverage provided under a group health plan (insured or self-insured), an individual insurance policy, Medicare, Medicaid, a public health plan (i.e., AHCCCS), a health risk benefits pool, TRICARE, Peace Corps, bonafide association, Indian Health Service, the Federal Employee Health Benefits Plan or the State Childrens 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 602-864-4456.

Note: This is only a brief summary of this benefit plan. More detailed information regarding benefits, limitations and exclusions is in the benefit plan booklet and is available prior to enrollment upon request. If the benefits on this summary differ from those stated in the benefit plan booklet, the terms of the benefit plan booklet apply.