

BluePreferred No Copay Plan Comparison



An Independent Licensee of the Blue Cross and Blue Shield Association

This document is designed to help you understand the similarities and variations between different options in the BluePreferred No Copay product line. For more information on the details of a specific plan, please refer to the benefit summary or the benefit booklet.

BENEFITS		BLUEPREFERRED PLAN 100 90/70	BLUEPREFERRED 2,000 100/50	BLUEPREFERRED 5,000 100/50
Deductible Deductible must be met for all covered services unless otherwise stated.		\$100 per member, \$200 family (cumulative PPO and NonPPO)	\$2,000 per member, \$4,000 family (cumulative PPO and NonPPO)	\$5,000 per member, \$10,000 family (cumulative PPO and NonPPO)
Coinsurance**	PPO	90%/10%	100%/0%	100%/0%
	NonPPO	70%/30%	50%/50%	50%/50%
OOP Coinsurance Maximum**	PPO	\$1,000 per member, \$2,000 family	\$0 per member, \$0 family	\$0 per member, \$0 family
	NonPPO	\$2,000 per member, \$4,000 family	\$20,000 per member, \$40,000 family	\$20,000 per member, \$40,000 family
PCP Office Services	PPO	90%/10%	100%/0%	100%/0%
	NonPPO	70%/30%	50%/50%	50%/50%
Specialist Office Services	PPO	90%/10%	100%/0%	100%/0%
	NonPPO	70%/30%	50%/50%	50%/50%
Laboratory Services	PPO	100%/0%*	100%/0%*	100%/0%*
	NonPPO	70%/30%	50%/50%	50%/50%
Inpatient Hospital/ Outpatient Services	PPO	90%/10%	100%/0%	100%/0%
	NonPPO	70%/30%	50%/50%	50%/50%
Emergency Room		\$150 access fee, then 90%/10%	\$200 access fee, then 100%/0%	\$200 access fee, then 100%/0%
Urgent Care	PPO	90%/10%	100%/0%	100%/0%
	NonPPO	70%/30%	50%/50%	50%/50%
Prescription Medications at Retail and Mail Order Pharmacy^{††}	PPO	\$10/\$25/\$50/\$80	\$15/\$35/\$65/\$120 Mail Order – 2x applicable copay	\$15/\$35/\$65/\$120
	NonPPO	Prescription medication copay plus difference between billed and allowed amount.		
Preventive Services	PPO	90%/10%, deductible waived	100%/0%, deductible waived	100%/0%, deductible waived
	NonPPO	Not covered	Not covered	Not covered
Routine Mammography	PPO	90%/10%, deductible waived	100%/0%, deductible waived	100%/0%, deductible waived
	NonPPO	70%/30%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived
Physical, Occupational & Speech Therapy	PPO	90%/10%	100%/0%	100%/0%
	NonPPO	70%/30%	50%/50%	50%/50%
Vision Exams (Routine)	PPO	\$15 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

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

†† Precertification is required for certain medications.

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

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

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BENEFITS	BLUEPREFERRED COPAY 100 90/70	BLUEPREFERRED COPAY 250 90/70	BLUEPREFERRED COPAY 250 80/60	BLUEPREFERRED COPAY 500 90/70	BLUEPREFERRED COPAY 500 80/60	BLUEPREFERRED COPAY 1000 80/50	BLUEPREFERRED COPAY 2000 80/50	BLUEPREFERRED COPAY 1500 100/50	BLUEPREFERRED COPAY 2500 100/50	BLUEPREFERRED COPAY 5000 100/50
Deductible - Deductible must be met for all covered services (cumulative PPO and NonPPO) unless otherwise stated.	\$100 per member, \$200 family (cumulative PPO and NonPPO)	\$250 per member, \$500 family (cumulative PPO and NonPPO)	\$250 per member, \$500 family (cumulative PPO and NonPPO)	\$500 per member, \$1,000 family (cumulative PPO and NonPPO)	\$500 per member, \$1,000 family (cumulative PPO and NonPPO)	\$1,000 per member, \$2,000 family (cumulative PPO and NonPPO)	\$2,000 per member, \$4,000 family (cumulative PPO and NonPPO)	\$1,500 per member, \$3,000 family (cumulative PPO and NonPPO)	\$2,500 per member, \$5,000 family (cumulative PPO and NonPPO)	\$5,000 per member, \$10,000 family (cumulative PPO and NonPPO)
Coinsurance** PPO	90%/10%	90%/10%	80%/20%	90%/10%	80%/20%	80%/20%	80%/20%	100%/0%	100%/0%	100%/0%
Non-PPO	70%/30%	70%/30%	60%/40%	70%/30%	60%/40%	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
OOP Coinsurance Maximum**	\$1,000 per member, \$2,000 family	\$2,000 per member, \$4,000 family	\$2,000 per member, \$4,000 family	\$2,500 per member, \$5,000 family	\$2,500 per member, \$5,000 family	\$3,000 per member, \$6,000 family	\$4,000 per member, \$8,000 family	\$0 per member, \$0 family	\$0 per member, \$0 family	\$0 per member, \$0 family
Non-PPO	\$4,000 per member, \$8,000 family	\$4,000 per member, \$8,000 family	\$4,000 per member, \$8,000 family	\$5,000 per member, \$10,000 family	\$5,000 per member, \$10,000 family	\$6,000 per member, \$12,000 family	\$8,000 per member, \$16,000 family	\$10,000 per member, \$20,000 family	\$10,000 per member, \$20,000 family	\$20,000 per member, \$40,000 family
PCP Office Services	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay
Non-PPO	70%/30%	70%/30%	60%/40%	70%/30%	60%/40%	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Specialist Office Services	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$35 copay	\$35 copay	\$40 copay	\$40 copay	\$40 copay
Non-PPO	70%/30%	70%/30%	60%/40%	70%/30%	60%/40%	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Laboratory Services	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%
Non-PPO	70%/30%	70%/30%	60%/40%	70%/30%	60%/40%	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Inpatient Hospital/Outpatient Services	90%/10%	90%/10%	80%/20%	90%/10%	80%/20%	80%/20%	80%/20%	100%/0%	100%/0%	100%/0%
Non-PPO	70%/30%	70%/30%	60%/40%	70%/30%	60%/40%	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Emergency Room	\$150 access fee, then 90%/10%	\$150 access fee, then 90%/10%	\$150 access fee, then 80%/20%	\$150 access fee, then 90%/10%	\$150 access fee, then 80%/20%	\$150 access fee, then 80%/20%	\$150 access fee, then 80%/20%	\$200 access fee, then 100%/0%	\$200 access fee, then 100%/0%	\$200 access fee, then 100%/0%
PPO	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$50 copay	\$50 copay	\$75 copay	\$75 copay	\$75 copay
Non-PPO	70%/30%	70%/30%	60%/40%	70%/30%	60%/40%	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Retail and Mail Order Prescription Medications††	Retail \$10/\$25/\$50/\$80	Retail \$10/\$25/\$50/\$80	Retail \$10/\$25/\$50/\$80	Retail \$10/\$25/\$50/\$80	Retail \$10/\$25/\$50/\$80	Retail \$15/\$35/\$65/\$120	Retail \$15/\$35/\$65/\$120	Retail \$15/\$35/\$65/\$120	Retail \$15/\$35/\$65/\$120	Retail \$15/\$35/\$65/\$120
Non-PPO	Prescription medication copay plus difference between billed and allowed amount.	Prescription medication copay plus difference between billed and allowed amount.	Prescription medication copay plus difference between billed and allowed amount.	Prescription medication copay plus difference between billed and allowed amount.	Prescription medication copay plus difference between billed and allowed amount.	Prescription medication copay plus difference between billed and allowed amount.	Prescription medication copay plus difference between billed and allowed amount.	Prescription medication copay plus difference between billed and allowed amount.	Prescription medication copay plus difference between billed and allowed amount.	Prescription medication copay plus difference between billed and allowed amount.
Preventive Services	\$15 PCP \$25 Specialist	\$15 PCP \$25 Specialist	\$15 PCP \$25 Specialist	\$15 PCP \$25 Specialist	\$15 PCP \$25 Specialist	\$25 PCP \$35 Specialist	\$25 PCP \$35 Specialist	\$25 PCP \$40 Specialist	\$25 PCP \$40 Specialist	\$25 PCP \$40 Specialist
Non-PPO	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Routine Mammography	90%/10%, deductible waived	90%/10%, deductible waived	80%/20%, deductible waived	90%/10%, deductible waived	80%/20%, deductible waived	80%/20%, deductible waived	80%/20%, deductible waived	100%/0%, deductible waived	100%/0%, deductible waived	100%/0%, deductible waived
Non-PPO	70%/30%, deductible waived	70%/30%, deductible waived	60%/40%, deductible waived	70%/30%, deductible waived	60%/40%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived
Physical, Occupational & Speech Therapy	90%/10%	90%/10%	80%/20%	90%/10%	80%/20%	80%/20%	80%/20%	100%/0%	100%/0%	100%/0%
Non-PPO	70%/30%	70%/30%	60%/40%	70%/30%	60%/40%	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Vision Exams (Routine)	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$15 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay
PPO	One exam per member, per calendar year.	One exam per member, per calendar year.	One exam per member, per calendar year.	One exam per member, per calendar year.	One exam per member, per calendar year.	One exam per member, per calendar year.	One exam per member, per calendar year.	One exam per member, per calendar year.	One exam per member, per calendar year.	One exam per member, per calendar year.
Non-PPO	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.	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.

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

†† Precertification is required for certain medications.

* 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.

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

Exclusions and Limitations

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

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

AN 11 MONTH WAITING PERIOD FOR PRE-EXISTING CONDITION 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 6 months before the effective date. Services for pre-existing conditions may not be covered until 11 consecutive months after the benefit plan effective date.

BluePreferred Basic Plan Comparison



An Independent Licensee of the Blue Cross and Blue Shield Association

This document is designed to help you understand the similarities and variations between different options in the BluePreferred Basic product line. For more information on the details of a specific plan, please refer to the benefit summary or the benefit booklet.

BENEFITS	BLUEPREFERRED BASIC 1,500 80/50	BLUEPREFERRED BASIC 2,500 80/50	BLUEPREFERRED BASIC 5,000 80/50	BLUEPREFERRED BASIC 10,000 80/50
Deductible Deductible must be met for all covered services unless otherwise stated.	\$1,500 per member, \$3,000 family (cumulative PPO and NonPPO)	\$2,500 per member, \$5,000 family (cumulative PPO and NonPPO)	\$5,000 per member, \$10,000 family (cumulative PPO and NonPPO)	\$10,000 per member, \$20,000 family (cumulative PPO and NonPPO)
Coinsurance**	PPO	80%/20%	80%/20%	80%/20%
	NonPPO	50%/50%	50%/50%	50%/50%
Out of Pocket Coinsurance Maximum**	PPO	\$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
PCP Office Services	PPO	\$25	\$30	\$35
	NonPPO	50%/50%	50%/50%	50%/50%
Specialist Office Services	PPO	80%/20%	80%/20%	80%/20%
	NonPPO	50%/50%	50%/50%	50%/50%
Laboratory Services	PPO	100%/0%*	100%/0%*	100%/0%*
	NonPPO	50%/50%	50%/50%	50%/50%
Radiology	PPO	80%/20%	80%/20%	80%/20%
	NonPPO	50%/50%	50%/50%	50%/50%
Inpatient Hospital†/ Outpatient Services	PPO	80%/20%	80%/20%	80%/20%
	NonPPO	50%/50%	50%/50%	50%/50%
Emergency Room	\$150 access fee, then 80%/20%	\$150 access fee, then 80%/20%	\$150 access fee, then 80%/20%	\$150 access fee, then 80%/20%
Urgent Care	PPO	\$45	\$50	\$55
	NonPPO	50%/50%	50%/50%	50%/50%
Retail and Mail Order Prescription Medications††	PPO	Generic medications: Member pays the lesser of the BCBSAZ allowed amount or a \$30 copay. Brand medications: Member pays the lesser of the BCBSAZ allowed amount or a \$125 copay.		
	NonPPO	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 BSBCAZ allowed amount.		
Preventive Services	PPO	\$25 PCP 80%/20% specialist, deductible waived	\$30 PCP 80%/20% specialist, deductible waived	\$35 PCP 80%/20% specialist, deductible waived
	NonPPO	Not covered	Not covered	Not covered
Routine Mammography	PPO	80%/20%, deductible waived	80%/20%, deductible waived	80%/20%, deductible waived
	NonPPO	50%/50%, deductible waived	50%/50%, deductible waived	50%/50%, deductible waived
Physical, Occupational & Speech Therapy	PPO	80%/20%	80%/20%	80%/20%
	NonPPO	50%/50%	50%/50%	50%/50%
Vision Exams (Routine)	PPO	\$15 copay One exam per member, per calendar year	\$15 copay One exam per member, per calendar year	\$15 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

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

†† Precertification is required for certain medications.

* At contracted, freestanding, independent clinical labs and in a PCP's office if the only services received are laboratory services. In a specialist physician's office, deductible and coinsurance applies as specified. At all other facilities, deductible and coinsurance apply.

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

Exclusions and Limitations

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

AN 11 MONTH WAITING PERIOD FOR PRE-EXISTING CONDITION 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 6 months before the effective date. Services for pre-existing conditions may not be covered until 11 consecutive months after the benefit plan effective date.

Available only to employer groups of 2-50 eligible employees. Employer groups are only eligible for BlueSolutions if they have been uninsured for a minimum of six (6) months prior to the effective date of BlueSolutions.

BENEFITS		PLAN 2500 COPAY	PLAN 5000 COPAY
Deductible (deductible applies unless otherwise specified)		\$2,500 per member, \$5,000 family (cumulative PPO and NonPPO)	\$5,000 per member, \$10,000 family (cumulative PPO and NonPPO)
Coinsurance**	PPO	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%
OOP Coinsurance Maximum**	PPO	\$5,000 per member, \$10,000 family	\$5,000 per member, \$10,000 family
	NonPPO	\$10,000 per member, \$20,000 family	\$10,000 per member, \$20,000 family
Physician Office Services (PCP)	PPO	\$35 copay	\$35 copay
	NonPPO	50%/50%	50%/50%
Specialist Office Services	PPO	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%
Urgent Care	PPO	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%
Laboratory*	PPO	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%
Radiology	PPO	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%
CT, MRI, MRA and PET scans also subject to a \$100 hi-tech radiology access fee per procedure type, per member, per provider, per day, (maximum of 3 access fees per member, 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.			
Inpatient Hospital†	PPO	\$150 access fee (maximum of 3 access fees per member, per calendar year) then 70%/30%	\$150 access fee (maximum of 3 access fees per member, per calendar year) then 70%/30%
	NonPPO	\$150 access fee (maximum of 3 access fees per member, per calendar year) then 50%/50%	\$150 access fee (maximum of 3 access fees per member, per calendar year) then 50%/50%
Outpatient Services	PPO	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%
Outpatient Surgery (facility)	PPO	70%/30%	70%/30%
	NonPPO	50%/50%	50%/50%
Emergency	\$150 access fee, then 70%/30%		
Ambulance	70%/30% of billed charges		
Retail and Mail Order Prescription Medications†† Payment for mail order must be made with a debit or credit card and is only available through the in-network mail order provider.	PPO	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.	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.
	NonPPO	In addition to the prescription medication copay, member is also responsible for the difference between an out-of-network pharmacy's price and the allowed amount.	In addition to the prescription medication copay, member is also responsible for the difference between an out-of-network pharmacy's price and the allowed amount.
Preventive Services • Certain Screening Services • Immunizations • Routine Physicals • Mammography	PPO	PCP - \$35 copay	
	NonPPO	Specialist – 70%/30% 50%/50%, deductible waived for mammography only; all other services not covered	
Physical, Occupational & Speech Therapy Coinsurance will not count toward the out-of-pocket coinsurance maximum.	PPO	50%/50%	50%/50%
	NonPPO	50%/50%	50%/50%

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

†† Precertification is required for certain medications.

* PCP office visit copay is waived for laboratory services provided in a PCP's office if the only services received are laboratory services.

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

Exclusions and Limitations

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

- Abortions, except as stated in the benefit plan
- Activity therapy
- Acupuncture
- Alternative medicine, non-traditional and alternative medical therapies; interventions; services and procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; nutritional and lifestyle therapies; aromatherapy
- Autism spectrum disorder (ASD) – services related to the treatment of ASD, except as stated in the benefit plan
- 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 plan booklet under particular benefits
- Biofeedback and hypnotherapy, except as stated in the benefit plan
- Body art, piercing, tattooing and any related complications
- Charges associated with the preparation, copying or production of health records
- 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 noncovered benefits
- Computer speech training and therapy programs and devices
- Cosmetic services and any related complications – surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy.
- Counseling and behavioral modification services, except as stated in the benefit plan
- Court-ordered services, except as stated in the benefit plan
- Custodial care
- Dental, except as stated in the benefit plan
- Dietary and nutritional supplements, except as stated in the benefit plan
- Expenses for services that exceed benefit limitations
- Experimental or investigational services
- Fees other than for medically appropriate in-person, direct member services, except as stated in the benefit plan
- Fertility and infertility services
- Flat feet
- Foot care, except as stated in the benefit plan
- Free services
- Genetic and chromosomal testing and screening
- Government services – services provided at no charge to the member through a governmental program or facility
- Growth Hormone – except as specified in the BCBSAZ Medical Coverage Guidelines, and growth hormone to treat Idiopathic Short Stature (ISS)
- Hearing services and devices, except as stated in the benefit plan
- Lodging and meals, except as stated in the benefit plan
- Maintenance Services – services rendered after a member has met functional goals; services rendered when no objectively measurable improvement is reasonably anticipated, services to prevent regression to a lower level of function, services to prevent future injury and services to improve or maintain posture
- Manipulations of the spine under anesthesia
- Massage therapy, except in limited circumstances as described in the BCBSAZ Medical Coverage Guidelines
- Medications dispensed in a provider's office – prescription medications and over-the-counter medications, including pharmaceutical manufacturer's samples, dispensed to the member in a provider's office
- Medications – Medications which are:
 - Not FDA approved
 - Not required by the FDA to be obtained with a prescription
 - Not used in accordance with the BCBSAZ Medical Coverage Guidelines
 - Used to treat a condition not covered by BCBSAZ
 - Off-label, unlabeled and orphan medications, except as stated in the benefit plan
- Neurofeedback
- Non-medically necessary services, as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Over-the-counter items, except as stated in the benefit plan
- Personal comfort items
- Reversal of sterilization
- 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
- 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
- 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
- Treatment for behavioral and mental health conditions in a non-acute facility, such as residential or skilled nursing facilities
- Vision therapy; all types of refractive keratoplasties; any other procedures, treatments and devices for refractive correction; eyeglasses and contact lenses; vision examinations for fitting of eyeglasses and contact lenses
- Vitamins, except as stated in the benefit plan
- Workers' Compensation – illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election

AN 11 MONTH WAITING PERIOD FOR PRE-EXISTING CONDITION 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 6 months before the effective date. Services for pre-existing conditions may not be covered until 11 consecutive months after the benefit plan effective date.

BlueSelect HMO Plan Comparison



An Independent Licensee of the Blue Cross and Blue Shield Association

Effective January 1, 2009

This document is designed to help you understand the similarities and variations between different options in the BlueSelect product line. For more information on the details of a specific plan, please refer to the benefit summary or the benefit booklet.

BENEFITS**	BLUESELECT HMO PLAN 10**	BLUESELECT HMO PLAN 20**
Physician Services – Primary Care Physician (PCP) Office Services	\$10 copay (per member, per provider, per day)	\$20 copay (per member, per provider, per day)
Physician Services – Specialist Office Services	\$20 copay (per member, per provider, per day)	\$30 copay (per member, per provider, per day)
Chiropractic Services†	\$20 copay (per member, per provider, per day)	\$30 copay (per member, per provider, per day)
Out-of-Pocket Coinsurance Maximum/Out-of-Pocket Maximum	\$500 per member, per calendar year. Only coinsurance for PT, OT and ST applies toward 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.	\$2,500 per member, 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 not apply to the out-of-pocket maximum. All other copays and coinsurance apply to satisfaction of the out-of-pocket maximum.
Laboratory Services	BCBSAZ pays 100% for covered services at contracted, free-standing labs.*	BCBSAZ pays 100% for covered services at contracted, free-standing labs.*
Hospital Services	Inpatient† BCBSAZ pays 100% for covered services. Outpatient BCBSAZ pays 100% for covered services.	Member pays \$250 copay per member, per day (maximum of 3 days), per admission, then BCBSAZ pays 100% for covered services. For outpatient surgery, member pays \$100 copay per member, per day, then BCBSAZ pays 100% for covered services.
Radiology (facility)	At network physician's office, copay applies. All other covered services, BCBSAZ pays 100% . MRI, MRA and PET scans require precertification.	Member pays \$100 copay per procedure type, per member, per provider, per day for CT, MRI, MRA and PET scans. All other covered services, BCBSAZ pays 100% . MRI, MRA and PET scans require precertification.
Emergency Room	\$150 copay (per member, per provider, per day)	\$150 copay (per member, per provider, per day)
Urgent Care	\$25 copay (per member, per provider, per day) at facilities that are specifically contracted as freestanding urgent care providers.	\$50 copay (per member, per provider, per day) at facilities that are specifically contracted as freestanding urgent care providers.
Prescription Benefit for Retail Pharmacy††	Level One \$10 copay Level Two \$25 copay Level Three \$50 copay Level Four \$80 copay	\$10 copay \$25 copay \$50 copay \$80 copay
Physical, Occupational & Speech Therapy	Physical/Occupational Therapy: BCBSAZ pays 100% for covered services, up to 80 modalities and/or therapeutic services per member, per calendar year. Speech Therapy: BCBSAZ pays 100% for covered services, up to 20 visits per member, per calendar year. Additional visits <u>exceeding these limits</u> are available, subject to 50% coinsurance until member reaches the \$500 out-of-pocket coinsurance maximum per calendar year. After the \$500 out-of-pocket coinsurance maximum is met, BCBSAZ will pay 100% for covered services.	Physical/Occupational Therapy: BCBSAZ pays 100% for covered services, up to 80 modalities and/or therapeutic services per member, per calendar year. Speech Therapy: BCBSAZ pays 100% for covered services, up to 20 visits per member, per calendar year. Additional visits <u>exceeding these limits</u> are available, subject to 50% coinsurance until member reaches the \$2,500 out-of-pocket maximum per calendar year. After the \$2,500 out-of-pocket maximum is met, BCBSAZ will pay 100% for covered services.
Preventive Care	\$10/\$20 copay (per member, per provider, per day) depending on whether services are received from a PCP or specialist.	\$20/\$30 copay (per member, per provider, per day) depending on whether services are received from a PCP or specialist.
Skilled Nursing Facility†	BCBSAZ pays 100% for up to 90 days per member, per calendar year. After the first 90 days, BCBSAZ pays 50% , member pays 50% up to an additional 90 days per member, per calendar year.	Member pays \$250 copay per member, per day (maximum of 3 days), per admission, then BCBSAZ pays 100% for covered services for up to 90 days per member, per calendar year.
Inpatient Extended Active Rehabilitation†	BCBSAZ pays 100% for up to 60 days per member, per calendar year. After the first 60 days, BCBSAZ pays 50% , member pays 50% up to an additional 60 days per member, per calendar year.	Member pays \$250 copay per member, per day (maximum of 3 days), per admission, then BCBSAZ pays 100% for covered services for up to 60 days per member, per calendar year.
Behavioral Health – BSA Exclusive†	Inpatient BCBSAZ pays 100% for covered services, up to 30 days per member, per calendar year. Outpatient \$15 copay per member, per visit	\$250 copay per member, per day (maximum of 3 days), per admission, then BCBSAZ pays 100% for covered services, up to 30 days per member, per calendar year. \$15 copay per member, per visit
Vision	\$10 copay, one routine vision exam per member, per calendar year.	\$30 copay, one routine vision exam per member, per calendar year.

† Precertification is required. If precertification is not obtained, services will not be covered

†† Precertification is required for certain medications.

* For lab services provided in a physician's office, the office visit copay is waived if the only services received are laboratory services.

** Except for emergency services, all services must be rendered by network providers or the service will not be covered.

Exclusions and Limitations

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

- Abortions, except as stated in the benefit plan
- Activity therapy
- Acupuncture
- Alternative medicine, non-traditional and alternative medical therapies; interventions; services and procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; nutritional and lifestyle therapies; aromatherapy
- Autism spectrum disorders (ASD) – services related to treatment of ASD, except as stated in the benefit plan
- Benefit-specific exclusions and limitations listed in the benefit plan booklet under particular benefits
- Biofeedback and hypnotherapy, except as stated in the benefit plan
- Body art, piercing, tattooing and any related complications
- Charges associated with the preparation, copying or production of health records
- Cognitive and vocational therapy
- Complications of noncovered benefits
- Computer speech training and therapy programs and devices
- Cosmetic services and any related complications – surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy.
- Counseling and behavioral modification services, except as stated in the benefit plan
- Court-ordered services, except as stated in the benefit plan
- Custodial care
- Dental, except as stated in the benefit plan
- Dietary and nutritional supplements, except as stated in the benefit plan
- Expenses for services that exceed benefit limitations
- Experimental or investigational services
- Fees other than for medically appropriate in-person, direct member services, except as stated in the benefit plan
- Fertility and infertility services
- Flat feet
- Foot care, except as stated in the benefit plan
- Free services
- Genetic and chromosomal testing and screening
- Government services – services provided at no charge to the member through a governmental program or facility
- Growth Hormone – except as specified in the BCBSAZ Medical Coverage Guidelines, and growth hormone to treat Idiopathic Short Stature (ISS)
- Hearing services and devices, except as stated in the benefit plan
- Lodging and meals, except as stated in the benefit plan
- Maintenance Services – services rendered after a member has met functional goals; services rendered when no objectively measurable improvement is reasonably anticipated, services to prevent regression to a lower level of function, services to prevent future injury and services to improve or maintain posture
- Manipulations of the spine under anesthesia
- Massage therapy, except in limited circumstances as described in the BCBSAZ Medical Coverage Guidelines
- Medications dispensed in a provider's office – prescription medications and over-the-counter medications, including pharmaceutical manufacturer's samples, dispensed to the member in a provider's office
- Medications – Medications which are:
 - Not FDA approved
 - Not required by the FDA to be obtained with a prescription
 - Not used in accordance with the BCBSAZ Medical Coverage Guidelines
 - Used to treat a condition not covered by BCBSAZ
 - Off-label, unlabeled and orphan medications, except as stated in the benefit plan
- Neurofeedback
- Non-medically necessary services, as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Over-the-counter items, except as stated in the benefit plan
- Personal comfort items
- Reversal of sterilization
- Screening tests, except as stated in the benefit plan
- Services for Idiopathic Environmental Intolerance
- Services for sexual dysfunction, regardless of the cause, and all medications for the treatment of sexual dysfunction
- Services for weight loss and gain, except as stated in the benefit plan
- Services from a family member – services that are provided by an eligible provider who is part of the member's immediate family. When a provider is also the covered person, services rendered by that provider for him/herself are excluded from coverage.
- Services from 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
- Therapy services, except as stated in the benefit plan
- Training and education, except as stated in the benefit plan
- Transplants and related services not precertified by BCBSAZ
- Transportation services and travel expenses, except as stated in the benefit plan
- Transsexual treatment, surgery, medications and related services
- Treatment for behavioral and mental health conditions in a non-acute facility, (such as residential or skilled nursing facilities)
- Vision therapy; all types of refractive keratoplasties; any other procedures, treatments and devices for refractive correction; eyeglasses and contact lenses; vision examinations for fitting of eyeglasses and contact lenses, 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

BluePreferred Saver Plan Comparison



An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFITS		BLUEPREFERRED SAVER PLAN 1500-80	BLUEPREFERRED SAVER PLAN 1500-100	BLUEPREFERRED SAVER PLAN 2600-80	BLUEPREFERRED SAVER PLAN 2600-100	BLUEPREFERRED SAVER PLAN 5000-100
Deductible Deductible must be met for all covered services unless otherwise stated.		\$1,500 self-only, \$3,000 family Except for preventive care, the self-only deductible must be met on per member policies and the family deductible must be met on family policies before this plan begins to pay for covered services.	\$1,500 self-only, \$3,000 family Except for preventive care, the self-only deductible must be met on per member policies and the family deductible must be met on family policies before this plan begins to pay for covered services.	\$2,600 per member, \$5,150 family Except for preventive care, the deductible must be met before this plan begins to pay for covered services.	\$2,600 per member, \$5,150 family Except for preventive care, the deductible must be met before this plan begins to pay for covered services.	\$5,000 per member, \$10,000 family Except for preventive care, the deductible must be met before this plan begins to pay for covered services.
Coinsurance**	PPO	80%/20%	100%/0%	80%/20%	100%/0%	100%/0%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Out-of-Pocket Maximum*	NonPPO	\$5,000 per member, \$10,000 family	\$5,000 per member, \$10,000 family	\$5,000 per member, \$10,000 family	\$5,000 per member, \$10,000 family	\$5,000 per member, \$10,000 family
	NonPPO	\$10,000 per member, \$20,000 family	\$10,000 per member, \$20,000 family	\$10,000 per member, \$20,000 family	\$10,000 per member, \$20,000 family	\$10,000 per member, \$20,000 family
Physician Office Services	PPO	80%/20%	100%/0%	80%/20%	100%/0%	100%/0%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Preventive Services	PPO	80%/20%, deductible waived	100%/0%, deductible waived	80%/20%, deductible waived	100%/0%, deductible waived	100%/0%, deductible waived
	NonPPO	Not covered	Not covered	Not covered	Not covered	Not covered
Routine Mammography	PPO	80%/20%, deductible waived	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	50%/50%, deductible waived
Urgent Care	PPO	80%/20%	100%/0%	80%/20%	100%/0%	100%/0%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Inpatient Hospital†	PPO	80%/20%	100%/0%	80%/20%	100%/0%	100%/0%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Outpatient Services	PPO	80%/20%	100%/0%	80%/20%	100%/0%	100%/0%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Emergency	PPO	\$150 access fee; then 80%/20%	\$150 access fee; then 100%/0%	\$150 access fee; then 80%/20%	\$150 access fee; then 100%/0%	\$150 access fee; then 100%/0%
Retail and Mail Order Prescription Medications††	PPO	80%/20%	100%/0%	80%/20%	100%/0%	100%/0%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Laboratory	PPO	80%/20%	100%/0%	80%/20%	100%/0%	100%/0%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Radiology	PPO	80%/20%	100%/0%	80%/20%	100%/0%	100%/0%
	NonPPO	50%/50%	50%/50%	50%/50%	50%/50%	50%/50%
Vision Exams (Routine)	PPO	80%/20%	100%/0%	80%/20%	100%/0%	100%/0%
	NonPPO	Reimbursement for one exam up to \$25 per member, per calendar year; deductible and coinsurance waived.	Reimbursement for one exam up to \$25 per member, per calendar year; deductible and coinsurance waived.	Reimbursement for one exam up to \$25 per member, per calendar year; deductible and coinsurance waived.	Reimbursement for one exam up to \$25 per member, per calendar year; deductible and coinsurance waived.	Reimbursement for one exam up to \$25 per member, per calendar year; deductible and coinsurance waived.

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

†† Precertification is required for certain medications.

* Precertification charges, amounts paid for noncovered services and out-of-network providers' balance bills do not count toward meeting the out-of-pocket maximum and you must continue to pay all these cost-share amounts even after meeting the maximum.

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

Exclusions and Limitations

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

AN 11 MONTH WAITING PERIOD FOR PRE-EXISTING CONDITION 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 6 months before the effective date. Services for pre-existing conditions may not be covered until 11 consecutive months after the benefit plan effective date.