BlueValue PPO Plan Benefit Summary

This plan is available for issuance effective October 1, 2008

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

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

In-Network Providers

In-network providers have a contract with Blue Cross Blue Shield of Arizona. Members pay lower out-of-pocket costs when they receive covered services from in-network providers. In-network providers will file members' claims with Blue Cross Blue Shield of Arizona. In-network providers are independent contractors exercising independent medical judgment and are not employees, agents or representatives of Blue Cross Blue Shield of Arizona (BCBSAZ). In-network 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.**

Out-Of-Network Providers

Out-of-network providers have no contract with BCBSAZ. Members pay higher out-of-network costs when they receive covered services from out-of-network providers. Out-of-network providers are not obligated to file members' claims.

BCBSAZ has no control over any diagnosis, treatment or service rendered by any provider.

Allowed Amount

The allowed amount is the amount of reimbursement allocated to a covered service.

For most claims, BCBSAZ bases the allowed amount on the lesser of a provider's billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements BCBSAZ has negotiated with an in-network provider. For claims from out-of-state providers, BCBSAZ generally bases the allowed amount on the lesser of the provider's billed charges or the contractual price negotiated by the Blue plan in the state where services were rendered. For emergency services provided by an out-of-network provider, either in Arizona or out-of-state, BCBSAZ bases the allowed amount on billed charges. The allowed amount includes any BCBSAZ payment plus any member cost-sharing.

For in-network providers, BCBSAZ reimburses the provider the allowed amount, minus any portion allocated to member cost-share. For out-of-network providers, BCBSAZ reimburses the member the allowed amount, minus any portion allocated to member cost-share.

The allowed amount is the figure that BCBSAZ uses to calculate any deductible or coinsurance and to accumulate toward any out-of-pocket coinsurance maximum. The allowed amount does not include access fees, precertification charges and any balance bills from out-of-network providers.

Balance Bills

The balance bill refers to the amount members may be charged for the difference between an out-of-network provider's billed charges and the allowed amount ("balance bill"). Balance bills can be substantial.

In-network providers have agreed to accept the allowed amount for covered services. They will not charge members for the balance bill. They will collect only the member's cost-share portion, such as deductible, coinsurance or copay amounts. However, when there is another source of payment, such as a liability insurer or government payer, in-network providers may be entitled to collect their balance bill from the other source or from proceeds received from the other source.

Out-of-network providers have no obligation to accept the allowed amount as payment in full. **All out-of-network providers may bill you up to their full billed charges.** Members are responsible for paying up to an out-of-network 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. Depending on what billing arrangements members make with an out-of-network provider, the provider may charge members for full billed charges at the time of service or seek to balance bill members for the difference between billed charges and the amount of BCBSAZ reimbursement. The balance bill may be substantial. Any amounts paid for balance bills do not count toward deductible, coinsurance or the out-of-pocket coinsurance maximum.

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	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER*
Deductible (Calendar-year) Copays and access fees do not count toward the deductible. In-network deductibles are accumulated separately from out-of-network deductibles. Deductibles must be met for all covered services unless otherwise stated.	Per member **$250, $500, $1,000, $2,000, $3,000, $5,000** and **$10,000** Family **$750, $1,500, $3,000, $6,000, $9,000, $15,000** and **$30,000**	Per member **$750, $1,000, $1,500, $2,500, $3,500, $5,500** and **$10,500** Family **$2,250, $3,000, $4,500, $7,500, $10,500, $16,500** and **$31,500**
Coinsurance This is a percentage you must pay for covered services after meeting the calendar-year deductible. You will pay a higher coinsurance percentage when using an out-of-network provider. Coinsurance is based on the allowed amount and not on a provider's billed charges.	BCBSAZ pays **70%**, you pay **30% (70%/30%)** of the allowed amount for most covered services, after meeting deductible, unless a different coinsurance percentage is indicated.	BCBSAZ pays **50%**, you pay **50% (50%/50%)** of the allowed amount for most covered services, after meeting deductible, unless a different coinsurance percentage is indicated.
Out-of-Pocket Coinsurance Maximum (Calendar-year) The in-network out-of-pocket coinsurance maximum is accumulated separately from the out-of-network out-of-pocket coinsurance maximum.	**$3,000** per member	**$6,000** per member
	The out-of-pocket coinsurance maximum is a maximum liability for coinsurance only and is based on the allowed amount rather than a provider's billed charges. Many cost share payments do not count toward the out-of-pocket maximum. The cost share obligations that do not count include deductibles, copays, access fees, certain other charges listed in the benefit plan booklet, precertification charges, amounts paid for noncovered services, and out-of-network providers' balance bills. To determine whether a specific cost share payment counts toward the maximum, refer to the benefit plan booklet. You must continue to pay all these cost share amounts even after meeting the maximum.	
Physician Services – Office Services[1] Primary care physicians (PCP) include internal medicine, family practice, general practice or pediatrics. All other physicians are specialists. Deductible and coinsurance apply to services rendered by radiologists or pathologists and to physical, occupational and speech therapy services.	**PCP: $25** copay applies to PCP office visits up to the **$160** annual copay dollar limit[1] per member for services received in a PCP's office. After the PCP **$160** annual copay dollar limit per member has been reached, deductible and **70%/30%** coinsurance apply to covered services received in a PCP's office for the remainder of the calendar year. **Specialist: 70%/30%** after meeting deductible.	**50%/50%** after meeting deductible.
Urgent Care	**$60** copay per member, per provider, per day at facilities specifically contracted as urgent care providers.	**50%/50%** after meeting deductible.
Preventive Services • Certain Screening Services • Immunizations • Routine Physicals • Mammography	PCP office visit copay or **70%/30%** depending on whether services are received from a PCP or specialist and whether the member has reached the PCP **$160** annual copay dollar limit[1].	**50%/50%** deductible waived for mammography; all other preventive services not covered.
	The deductible does not apply to covered preventive services. Preventive services are those services performed for screening purposes when the member does not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition. This is determined by the diagnosis submitted by the provider.	
Laboratory Services Deductible and coinsurance apply to services rendered by pathologists.	In a physician's office, PCP office visit copay is waived if the only services you receive during your visit are laboratory services. At contracted, freestanding, independent clinical labs, BCBSAZ pays **100%** for covered services, deductible and coinsurance waived. At all other facilities and at a PCP's office once the annual copay dollar limit[1] is reached, **70%/30%** after meeting deductible.	**50%/50%** after meeting deductible.

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Other Professional Services	**70%/30%** after meeting deductible. Other professional services include diagnostic, surgical and anesthesia services rendered outside the physician's office.	**50%/50%** after meeting deductible.
Prescription Medications at Retail and Mail Order Pharmacy[2] BCBSAZ applies limitations to certain prescription medications obtained through the retail and mail order pharmacy benefit. A list of these medications and limitations is available online at azblue.com or by calling the BCBSAZ Prescription Benefits Unit. These limitations include, but are not limited to, quantity, age and gender limitations. BCBSAZ prescription medication limitations are subject to change at any time without prior notice.	There is a **$500** prescription deductible per member, per calendar year, for Level 2, 3, and 4 prescription medications. The deductible does not apply to Level 1 medications. Amounts applied to the prescription deductible do not count toward any other plan deductible. Retail pharmacy / Mail order Level 1: **$ 15** copay / **$ 15** copay Level 2: **$ 35** copay / **$ 70** copay Level 3: **$ 65** copay / **$195** copay Level 4: **$120** copay / **$360** copay If a contracted pharmacy's regular price for a prescription medication is less than your copay, some pharmacies may charge you the lower price. You will never have to pay more than your copay at a contracted pharmacy. When you fill a prescription at a noncontracted retail pharmacy, in addition to the applicable prescription medication copay, you are also responsible for the balance bill. Mail order is only available through the in-network mail order provider. Mail order is not covered through a noncontracted provider.	
Inpatient Hospital[3]	**70%/30%** after meeting deductible.	**50%/50%** after meeting deductible.
Outpatient Services	**70%/30%** after meeting deductible.	**50%/50%** after meeting deductible.
Emergency	**$150** access fee per member, per provider, per day, then BCBSAZ pays **70%**, you pay **30%** after meeting deductible; emergency room access fee is waived if you are admitted to the hospital.	
Maternity – Complications of Pregnancy Only	**70%/30%** after meeting deductible.	**50%/50%** after meeting deductible.
Physical, Occupational and Speech Therapy	**70%/30%** after meeting deductible.	**50%/50%** after meeting deductible.
Chiropractic	**70%/30%** after meeting deductible.	**50%/50%** after meeting deductible.
Vision Exams (Routine)	**$25** copay for one routine eye exam per member, per calendar year.	Reimbursement up to **$25** for one routine eye exam per member, per calendar year.
Ambulance Services	**70%/30%** deductible waived.	
Behavioral and Mental Health Services[3] Cost sharing for behavioral/mental health does not apply to any out-of-pocket coinsurance maximum. Both In-network and out-of-network admissions count toward the 2-admission, 30-day limit.	**Outpatient:** You may choose in-network or out-of-network providers or the behavioral services administrator[4] (BSA). **BSA: $15** copay per visit for psychotherapy and counseling. **In-network and out-of-network providers:** BCBSAZ pays **50%**, you pay **50%** after meeting deductible, with a maximum of **20** psychological sessions per member, per calendar year. **Inpatient:** Two admissions per member, per calendar year, up to a combined total of **30** days. **In-network facility: 70%/30%** after meeting deductible.	**Out-of-network facility: 50%/50%** after meeting deductible. **Inpatient professional services: 50%/50%** after meeting deductible. **$25,000 per person benefit maximum** for all services (except from BSA) while the contract is in force.
Inpatient Rehabilitation Services[3] Both in-network and out-of-network admissions count toward the 120-day per member calendar-year limit.	**70%/30%** after meeting deductible, for up to **60** days. After **60** days, BCBSAZ pays **50%**, you pay **50%** up to an additional **60** days which will not count toward any out-of-pocket coinsurance maximum.	**50%/50%** after meeting deductible, for up to **60** days. After **60** days, BCBSAZ pays **50%**, you pay **50%** up to an additional **60** days which will not count toward any out-of-pocket coinsurance maximum. Coverage is limited to **120** days per member per calendar year.

	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER*
Home Health[2]	**70%/30%** after meeting deductible. Certain injectable medications are also available through the specialty self-injectable medication benefit.	**50%/50%** after meeting deductible.
Skilled Nursing Facility[3] Both in-network and out-of-network admissions count toward the 180-day per member calendar-year limit.	**70%/30%** after meeting deductible, for up to **90** days. After **90** days, BCBSAZ pays **50%**, you pay **50%** up to an additional **90** days which will not count toward any out-of-pocket coinsurance maximum.	**50%/50%** after meeting deductible, for up to **90** days. After **90** days, BCBSAZ pays **50%**, you pay **50%** up to an additional **90** days which will not count toward any out-of-pocket coinsurance maximum.
	Coverage is limited to **180** days per member, per calendar year.	
Specialty Self-Injectable Medications through Specialty Pharmacy[2] For certain specified self-injectable prescription biologic medications. Specialty self-injectable medications are not covered under the retail and mail order medication benefit.	Contracted Specialty Pharmacy Level A: **$30** copay Level B: **$60** copay Level C: **$90** copay Level D: **$120** copay Please refer to azblue.com for a listing of specialty self-injectable medications and contracted specialty pharmacies or call BCBSAZ. Injectable medications are also available from home health providers subject to deductible and coinsurance. See Home Health.	Not covered (see Home Health).
Bariatric Surgery[3]	**$1,000** access fee per member, per surgery, in addition to applicable deductible and coinsurance.	
Benefit Plan Maximum	**$5,000,000** maximum benefit per member while the benefit plan is in force. All payments by BCBSAZ (for both in-network and out-of-network providers) apply toward the benefit plan maximum.	

1 Services you receive from an in-network primary care physician (PCP) are subject to an annual copay dollar limit. After you have received PCP services and paid copays totaling the copay dollar limit, PCP services are subject to deductible and coinsurance. If you reach your annual PCP copay dollar limit in the middle of a claim, your in-network deductible and coinsurance will apply at the point you reach the limit, resulting in cost-share with a partial copay, as well as deductible and coinsurance. BCBSAZ applies claims toward the limit in the order that claims are received, which may be different from the date order in which you receive services.

2 Precertification is required for certain medications including all specialty self-injectable medications. Lists of medications that require precertification and the process for obtaining precertification is available on the BCBSAZ Web site at azblue.com or by calling BCBSAZ at (602) 864-4273 or (800) 232-2345, ext. 4273. Otherwise covered eligible medications will not be covered if precertification is not obtained when required.

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

4 Services are available only in Arizona.

* 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.

Explanatory Notes:

- BCBSAZ Medical Coverage Guidelines are BCBSAZ medical, dental and administrative criteria that are developed from review of published, peer-reviewed medical and dental literature and other relevant information and used to help BCBSAZ determine whether a service, procedure, medical device or medication is eligible for benefits under a member's benefit plan. For services to be eligible for coverage under this benefit plan, the services must, in addition to other specified requirements, be considered medically necessary by BCBSAZ based on the BCBSAZ Medical Coverage Guidelines that are available upon request. Where benefits are provided by a third-party administrator, the third-party administrator may determine medical necessity based on its own criteria, which is also available upon request.
- Precertification is the process BCBSAZ uses to determine eligibility for certain benefits. The member is responsible for making sure his or her physician obtains precertification approval. If precertification is not obtained, the member's benefits may be denied, or the member may be subject to a precertification charge. The member's provider must call for precertification at (602) 864-4320 or (800) 232-2345, ext. 4320. Please refer to the precertification requirements in the benefit plan booklet, which will be sent to the member upon enrollment or upon request prior to enrollment.
- This is only a brief summary of benefits and exclusions. Please refer to the specific provisions found within the benefit plan booklet for detailed information about benefits, limitations and exclusions. If the benefits listed in this summary differ from those stated in the benefit plan booklet, the terms of the benefit plan booklet apply. There is no guarantee of continued benefits outlined in this summary or the benefit plan booklet. The benefit plan may be amended, and benefits may be added, deleted or changed by BCBSAZ upon 31 days' notice to the policy holder.

Exclusions and Limitations – Examples of Services and Supplies Not Covered

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

- Abortions, except as stated in the benefit plan
- Activity therapy
- Acupuncture
- Alternative medicine – Non-traditional and alternative medical therapies; interventions; services and procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; nutritional and lifestyle therapies; aromatherapy
- Autism spectrum disorders (ASD) – services related to treatment of ASD
- Benefit-specific exclusions and limitations listed in the benefit plan booklet under particular benefits
- Biofeedback and hypnotherapy, except as stated in the benefit plan
- Body art, piercing and 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 provided at no charge to the member through a governmental program or facility
- Growth hormone, except as specified in BCBSAZ Medical Coverage Guidelines, and growth hormone to treat Idiopathic Short Stature (ISS)
- Hearing services and devices, except as stated in the benefit plan
- Lodging and meals, except as stated in the benefit plan
- Maintenance services – services rendered after a member has met functional goals; services rendered when no objectively measurable improvement is reasonably anticipated, services to prevent regression to a lower level of function, services to prevent future injury and services to improve or maintain posture
- Manipulation of the spine under anesthesia
- Massage therapy, except in limited circumstances as described in the BCBSAZ Medical Coverage Guidelines
- Maternity, except as stated in the benefit plan
- Medications dispensed in a provider's office – prescription medications and over-the-counter medications, including pharmaceutical manufacturers' samples, dispensed to the member in a provider's office
- Medications which are:
  - Not FDA approved
  - Not required by the FDA to be obtained with a prescription
  - Not used in accordance with BCBSAZ Medical Coverage Guidelines
  - Used to treat a condition not covered by BCBSAZ
  - Off-label, unlabeled and orphan medications, except as stated in the benefit plan
- Neurofeedback
- Non-medically necessary services as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Over-the-counter items, except as stated in the benefit plan
- Personal comfort items
- Reversal of sterilization
- Screening tests, except as stated in the benefit plan
- Services for Idiopathic Environmental Intolerance
- Services for weight loss and gain, except as stated in the benefit plan
- Services from a family member – services that are provided by an eligible provider who is part of the member's immediate family. When a provider is also the covered person, services rendered by that provider for him/her are excluded from coverage.
- Services from ineligible providers
- Services paid for by other organizations
- Services provided prior to effective date
- Services provided after the member's coverage termination date, except as stated in the benefit plan
- Services provided by a proficient substitute for a professional caregiver
- Services related to or associated with noncovered services
- Services without a prescription when a prescription is required
- Services for sexual dysfunction, regardless of the cause, and all medications for the treatment of sexual dysfunction
- Smoking cessation programs, medications, aids and devices
- Spinal decompression or vertebral axial decompression therapy
- Strength training, except as stated in the benefit plan
- Telephonic and electronic consultations, except as stated in the benefit plan
- Therapy services, except as stated in the benefit plan
- Training and education, except as stated in the benefit plan
- Transplants and related services not precertified by BCBSAZ
- Transportation services and travel expenses, except as stated in the benefit plan
- Transsexual treatment, surgery, medications and related services
- 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
- Waivered Conditions
- Workers' Compensation – illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election
- **AN 11-MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS APPLIES.** A pre-existing condition is defined as a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months before your effective date. Services for pre-existing conditions are not covered until 11 consecutive months after the benefit plan effective date.