Traditional Indemnity - Benefit Summary

BlueClassic®

Provider alternatives Your out-of-pocket costs will differ, depending on the type of provider you select.	**Participating providers** — have signed a "Participating Agreement" to accept the BCBSAZ allowed amount as payment in full and will file claims for you. Participating providers are also available outside Arizona, 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 www.bcbs.com. **Noncontracted providers** — have no agreement with us and may not accept the BCBSAZ allowed amount as payment in full nor file claims for you. With noncontracted providers, you are responsible for the difference between the provider's billed charges and the allowed amount, in addition to your deductible and coinsurance. This difference may be substantial.
Deductibles	Calendar-year deductible: **$250, $500, $750, $1,250, $2,500 and $5,000** Family deductible maximum: **$500, $1,000, $1,500, $2,500, $5,000 and $10,000**
Coinsurance	After you pay your calendar-year deductible, we pay **80%** of the allowed amount for covered services. You pay the remaining **20%** of the allowed amount up to an out-of-pocket maximum expense of **$2,000 per person.** After you reach the $2,000 maximum expense, we pay 100% of the allowed amount for covered services for the remainder of the calendar year. If a noncontracted provider is used, you will be responsible for the difference between the provider's billed charges and the allowed amount.
Copayments Copays are not applied toward the deductible and coinsurance maximum.	You pay a fixed copayment (copay) for most prescription drugs, routine vision exams and outpatient behavioral health services from the behavioral services administrator. The deductible and coinsurance do not apply to these services. You also pay a copay for emergency room services, but it is charged in addition to the deductible and coinsurance.
Professional services	Doctor's office visits and inpatient consultations, surgeon and anesthesiologist services, diagnostic lab and X-ray services. Services are subject to the Plan deductible and coinsurance, except the Plan pays 100% for covered lab services provided by contracted independent clinical labs.

Prescription drugs

Deductible option determines copay.

For certain prescription drugs, the quantity of medication covered may be limited by BCBSAZ. FDA dosage limitations also apply.

$250, $500 and $750 deductible options:

	Participating pharmacy (30-day supply)	Mail order (90-day supply)
Generic:	**$7 copay**	**$7 copay**
Preferred brand:*	**$20 copay**	**$40 copay**
Non-preferred brand "A":	**$40 copay**	**$120 copay**
Non-preferred brand "B":*	**$80 copay**	**$240 copay**

$1,250, $2,500 and $5,000 deductible options:

	Participating pharmacy (30-day supply)	Mail order (90-day supply)
Generic:	**$10 copay**	**$10 copay**
Preferred brand:*	**$30 copay**	**$60 copay**
Non-preferred brand "A":	**$60 copay**	**$180 copay**
Non-preferred brand "B":*	**$120 copay**	**$360 copay**

*Please refer to the Prescription Medication Guide for a list of Preferred brand drugs and Non-preferred brand "B" drugs.

$2,500 and $5,000 deductible options: The copays listed above apply only after you meet a prescription drug deductible each calendar year.

$2,500 deductible option: **$250 prescription drug deductible**
$5,000 deductible option: **$500 prescription drug deductible**

Most injectable drugs are only available from home health providers and are subject to Plan deductible and coinsurance and require precertification.

When the price BCBSAZ pays a contracted pharmacy for a drug is less than your copay, some participating pharmacies will charge you the BCBSAZ price. However, most pharmacies will charge you their usual and customary price (if it is also less than your copay), rather than the BCBSAZ price. You will never be charged more than your copay.

Note: When you fill a prescription at an out-of-network pharmacy, you will be responsible for the difference between the pharmacy's usual and customary price and the BCBSAZ price, in addition to any deductibles and copays.

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Preventive care	Annual physical exams and related tests and screenings, well-child care, routine immunizations, annual gynecologic exams, routine mammograms, routine sigmoidoscopy or colonoscopy. Services are subject to the Plan deductible and coinsurance, except the Plan pays 100% for covered lab services provided by contracted independent clinical labs.
Maternity care	Complications of pregnancy only; services are subject to the Plan deductible and coinsurance. Normal maternity care and delivery is not covered.
Hospital services (Must be precertified except for emergencies.)	Room and board, special care units, operating and recovery room, diagnostic testing, blood transfusions, radiation therapy or chemotherapy, and anesthesia. Services are subject to the Plan deductible and coinsurance.
Outpatient surgery (Must be precertified.)	Services are subject to the Plan deductible and coinsurance.
Urgent care facility services	Services are subject to the Plan deductible and coinsurance.
Emergency room services	Services are subject to the Plan deductible and coinsurance. There is also a $75 copay per visit, but it does not apply if you are admitted. Follow up care is paid as any other non-emergency services.
Ambulance	Services are subject to the Plan coinsurance, but the deductible does not apply.
Behavioral and mental health services (Inpatient care must be precertified.)	Outpatient psychotherapy and counseling services from the behavioral services administrator: **$10 copay** per visit (deductible does not apply). Your annual **copay maximum is $100 per person, $200 per family.** Includes psychotherapy and counseling for substance abuse, personal and family problems, lifestyle education and stress management. Inpatient and outpatient services of professionals (e.g., psychiatrists and psychologists) who are contracted with BCBSAZ and outpatient facility charges: After you meet your deductible, the Plan pays **50% of the allowed amount.** There is a maximum benefit of **$1,000** per calendar year. Inpatient facility charges: After you meet your deductible, the Plan pays **50% of the allowed amount.** Benefits are limited to **one admission** per calendar year. There is a maximum benefit of **$4,500 for out-of-state admissions.** **$25,000 maximum** benefit while the contract is in force.
Inpatient rehabilitation (Must be precertified.)	Limited to 60 days per calendar year. Services are subject to the Plan deductible and coinsurance.
Outpatient rehabilitation therapy "Modalities" are physical agents such as traction and ultrasound. "Therapeutic services" means the application of clinical skills/services such as exercise and gait training.	**Outpatient physical and/or occupational therapy:** The first 80 modalities and/or therapeutic services per calendar year are subject to the Plan coinsurance (deductible does not apply). Modalities and/or services exceeding this limit are subject to 50% coinsurance up to the annual out-of-pocket maximum (deductible does not apply). The average number of modalities or services performed per visit is 4. **Chiropractic services:** Physical and/or occupational therapy services performed by a chiropractor count toward the limit described above up to the annual out-of-pocket maximum (deductible does not apply). **Outpatient speech therapy:** The first 20 visits per calendar year are subject to the Plan coinsurance (deductible does not apply). Visits exceeding this limit are subject to 50% coinsurance up to the annual out-of-pocket maximum (deductible does not apply).
Home health/skilled nursing care (Must be precertified.)	Home health services, up to 3 visits of 2 hours or less per day. Skilled nursing facility care, up to 90 days per calendar year. Services are subject to the Plan deductible and coinsurance.
Routine vision care	Eye exam at vision services administrator providers: **$15 copay (deductible does not apply).** One refractive eye exam per calendar year for prescription glasses or contact lenses. If the initial order of contacts is not purchased through the examining provider, a professional contacts fitting fee of up to $50 may be charged. If a provider not contracted with the vision services administrator performs the routine eye exam, a reimbursement of up to $25 per calendar year is allowed. Discounts on frames and lenses, including contact lenses at vision services administrator providers. For information on vision services administrator providers, call (800) 952-6674.
Contract benefit maximum	$3,000,000 maximum benefit per person while the contract is in force.

Medical necessity

For services to be covered by these benefit plans, they must be considered medically necessary by BCBSAZ, based on specific criteria that is available to you upon request. Where benefits are provided by a third-party administrator such as the behavioral services administrator, the third-party administrator may determine medical necessity based on its own criteria.

Precertification is required for some services

If precertification is not obtained, your benefits will be subject to an additional $300 deductible or denial of benefits. Your provider must call for precertification at (602) 864-4320 or (800) 232-2345. Please refer to the precertification requirements in your contract booklet, which will be sent to you upon enrollment, or upon request prior to enrollment.

Exclusions and Limitations

The following is a list of conditions and services that are limited or excluded. A complete list of exclusions can also be found in the contract booklet, which will be sent to you when you enroll, or upon request prior to enrollment. Expenses for services that exceed benefit limitations are not covered. In addition, no benefits will be paid for expenses associated with the following:

- Abortions (nonspontaneous, medically induced, except when fetus/newborn not expected to be viable)
- 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
- Biofeedback and/or hypnotherapy
- Cognitive and vocational therapy
- Complications of body piercing/tattooing
- Complications of noncovered benefits
- Contraceptive management, medications or devices (except for oral contraceptives)
- Cosmetic or aesthetic surgery and services, except for breast reconstruction following a medically necessary mastectomy in accordance with state and/or federal law, or for congenital defects for newborns and adopted children
- Counseling (except as may be available through the behavioral services administrator)
- Court-ordered services – testing, treatment or therapy, unless such services are otherwise covered under this contract
- Custodial care except for limited hospice benefits
- Dental/orthodontic services or supplies
- 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 otherwise specifically provided under the "Medical Foods" section of the contract booklet.
- Environmental medicine
- Fees other than for medically appropriate in-person, direct patient treatment, tests, services, medications, supplies or equipment
- Fertility or infertility treatment, drugs or procedures
- Foot care, except when medically appropriate for diabetics or neurological involvement or peripheral vascular disease of the foot or lower leg
- Genetic/chromosome testing and screening – genetic/chromosomal testing of an asymptomatic or unaffected individual or an individual not displaying signs or symptoms of a suspected or specific inherited disorder
- Government services – services available under a governmental health program
- Hearing services – hearing aid services and supplies and routine hearing exams except for hearing screening that may be included in covered physical exams
- Investigational treatments, procedures, equipment, drugs, devices or supplies, as determined by BCBSAZ and only as required by Arizona law
- Lodging and meals, except for covered transplant travel benefits
- Nonmedically necessary services, as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Over-the-counter medications; medications from provider's office – any drug, medicine, device, equipment or supply (except for certain diabetic supplies as described in the pharmacy benefit) that is lawfully obtainable without a prescription; vitamins and minerals; and drugs, medicine, devices, equipment or supplies dispensed by or from a provider's office
- Personal comfort items
- Screening tests, except as specifically as described in the contract booklet
- Providers who are also the covered person, services rendered by that provider for him/herself.
- Services from family member(s) – services that are provided by an eligible provider who is a member of your immediate family, or services for which you have no legal obligation to pay
- Services not requiring a licensed professional
- Services of ineligible providers
- Services or supplies after termination
- Services or supplies prior to effective 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), medication or devices for sexual dysfunction, regardless of the cause of the condition
- Smoking cessation programs, medications, aids or devices
- Telephonic or electronic consultations
- Therapy services, except as expressly provided in the contract
- Training and education, except for certain diabetic nutritional training specifically approved in advance by BCBSAZ, or training related to BCBSAZ-established disease management program(s), with advance BCBSAZ approval
- 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.
- Transportation – transport services or travel expenses, except as described in the ambulance or in the contract booklet
- Transsexual treatment or surgery and/or any related services
- Vision therapy, radial keratotomy, all types of refractive keratoplasties, eyeglasses and contact lenses and the vision examination for prescribing and fitting of the same, except as otherwise stated as a benefit in the contract booklet
- Vitamins – vitamins (except for prenatal vitamins when a prescription is written by a physician)
- Weight loss/gain therapy, treatment or medications including but not limited to Xenical® and Meridia® (except for medically necessary, covered surgical services)
- Worker's Compensation – services for an illness or injury covered by Worker's Compensation or similar benefits, unless you are exempt from such coverage or have made a statutory opt-out election

Additional exclusions for BlueClassic

- Normal maternity services
- **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 months after the contract effective date.

Important note

This brochure is only a general summary of benefits. A complete listing and description of all benefits, limitations and exclusions that govern determinations of coverage are found in the contract, which will be sent to you upon enrollment, or upon request prior to enrollment.

There is no guarantee of continued benefits as outlined in this brochure or your contract booklet. The contract may be amended, and benefits may be added, deleted or changed by BCBSAZ upon 31 days' notice to the contract holder.

Network providers

All Participating network providers are independent contractors who have an agreement with BCBSAZ regarding reimbursement and administrative policies.

BCBSAZ has negotiated various reimbursement methods with contracted network providers. These providers have agreed to accept the BCBSAZ allowed amount for covered services provided to our customers. This means that after you pay any deductible, coinsurance or copay amounts, these providers will not bill you for any difference between that allowed amount and their regular charge for the service. However, when there is another source of payment – such as a liability insurer, government payer or uninsured and/or underinsured motorist coverage – network providers may be entitled to collect from the other source or from proceeds received from the other source any difference between the BCBSAZ allowed amount and their billed charges.

The contracted networks of providers are subject to change at any time. Every specialty type may not be available in the networks.

Portability/Conversion Coverage

Notice to applicants who have lost group health coverage or who are transferring from a Blue Cross or Blue Shield Plan in another state: If you terminated your group health plan (employer provided health coverage) or COBRA continuation coverage within the past 63 days, you may be eligible for **Individual Portability Coverage.** If you terminated BCBSAZ group coverage or any coverage from another Blue Cross or Blue Shield Plan within the past 31 days, you may be eligible for **Conversion Coverage.**

Individual Portability Coverage and Conversion Coverage do not require medical underwriting. There is no waiting period for pre-existing conditions or normal maternity services on Individual Portability Coverage. However, the premiums are higher for these health plans. If you think you may qualify for Individual Portability Coverage or Conversion Coverage, contact us for a special brochure and application.

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