



## Health plans for you and your family

- Decide which plan is best for you
- Compare plan benefits
- Learn how to apply for coverage

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# The real value of health insurance



## A name you know and trust

One in three Americans is covered by a Blue Cross Blue Shield health plan so you can be confident in knowing that you are in good company when you are with Blue. It is the largest insurance company based in Arizona and serves more than 1.3 million people.\*

The security and peace-of-mind that come with health coverage are just as important as the financial protection. By making your health and your family's health a priority, you can feel more confident about the future, and focus on enjoying other important things in life.

Facing a serious illness or injury without any health insurance can be both emotionally and financially devastating. In addition, research shows that people who go uninsured skip important medical care like preventive exams, doctor visits, and may even go without important prescription medications. That can have a serious negative impact on your overall health and wellness.

Many people are unaware of how much medical services actually cost without health insurance. In addition to the coverage provided by your health insurance plan, you also benefit from the discounts a company like Blue Cross Blue Shield of Arizona (BCBSAZ) has negotiated with contracted providers (network doctors and hospitals). That means when a contracted provider submits a bill for "billed charges," BCBSAZ will reduce that amount to the "allowed amount" and apply your benefits to the lower amount. If you are responsible for part of the bill, your cost-share will be lower because of BCBSAZ's negotiated discounts. It's another great reason you should always try to choose a provider from BCBSAZ's vast network in Arizona and nationwide. For more information, see the definitions on page 3.

\* 2009 Blue Cross Blue Shield Association, [bcbs.com/About](http://bcbs.com/About).

# Health insurance terms you need to know

Following are definitions that will help you better understand the plan information on the following pages:



**Allowed Amount:** The allowed amount is the total amount of reimbursement allowed for a covered service. It includes both what BCBSAZ pays and what the member pays. The allowed amount is generally developed from BCBSAZ fee schedules, and is not the same as a provider's billed charges. BCBSAZ contracted providers have agreed to accept the allowed amount and not "balance bill" members. Coinsurance and deductible are based on the allowed amount. If you see a noncontracted provider, BCBSAZ will reimburse you only for the allowed amount, less your member cost share.

**Balance Bills:** A balance bill refers to the amount members may be charged for the difference between a noncontracted provider's billed charges and the allowed amount. Balance bills can be substantial.

**Coinsurance:** Coinsurance is the percentage you must pay for covered services after meeting the calendar-year deductible. It includes your share of the cost and the share that is paid for by the insurance carrier. For example, 80%/20% coinsurance means that you are responsible for 20 percent of the cost and the insurance carrier covers 80 percent. You pay a higher coinsurance percentage when using an out-of-network provider. Coinsurance and deductibles are based on the allowed amount.

**Copayment:** A copayment is the fixed dollar amount you will pay for certain covered services at the time you receive care. Services that often require copayments include prescription drugs and doctor's office visits—although this will vary based on a plan's specific benefits.

**Deductible (Calendar-Year):** A deductible is the amount you pay before your insurance benefits begin to kick in. For example, if you choose a plan with a \$1,000 deductible, you must pay for the first \$1,000 before the benefits that require a deductible, such as hospitalization, begin to apply. In-network deductibles are accumulated separately from out-of-network deductibles, and out-of-network deductibles are always higher.



**In-Network Providers:** These providers have a contract with BCBSAZ. You pay lower out-of-pocket costs when you receive covered services from in-network providers. In-network providers are also available outside Arizona through the BlueCard® program.

**Out-of-Network Providers:** These providers have no contract with BCBSAZ. You pay higher out-of-pocket costs when you receive covered services from out-of-network providers.

**Primary Care Physician (PCP):** Primary Care Physicians include internal medicine, family practice, general practice and pediatrics. All other physicians are specialists.

**Preventive Services:** These include certain screening services, immunizations, routine physicals and mammography.



## Deductibles versus premiums

A **deductible** is the amount you pay for covered services before your insurance benefits kick in and is based on a calendar year. In-network deductibles are accumulated separately from out-of-network deductibles. A **premium** is the monthly cost you pay for your health insurance plan.

For more details about deductibles and rates, contact your broker for a free instant quote.

# Choosing the health plan that is right for you

Finding a health plan that works for your health care needs and your budget can be challenging. That's why BCBSAZ has developed this easy-to-use guide to take some of the guesswork out of choosing a health plan. To start out, you'll need to understand the basic types of plans that are offered and how they work. BCBSAZ offers four different PPO plans, including a high deductible PPO option qualified for use with a Health Savings Account (HSA).



## Blue Cross Blue Shield of Arizona's PPO Plans

With a PPO plan from BCBSAZ, you can choose any doctor or hospital, either in-network or out-of-network. Keep in mind, you will pay higher out-of-pocket costs for services from out-of-network providers.

BCBSAZ offers different PPO plans with a range of deductibles, copayments and coinsurance. Plan costs vary based on cost-share type, level and mix. The lowest-premium PPO plan requires more out-of-pocket expenses because the benefits are not as comprehensive as some of the higher-premium plans. Generally speaking, plans with lower premiums have higher member cost-share requirements, while plans with higher premiums have lower member cost share.

A low cost premium plan such as BlueEssential Plus may be ideal if you don't frequently utilize health care services and don't expect to spend a lot on medical services, prescriptions and procedures. If you're looking for more security, choose BlueValue Plus which has lower out-of-pocket costs for many medical services, but still offers affordable premiums for many members. BlueOptimum Plus, the most comprehensive PPO option, typically has the highest premiums but provides the most comprehensive level of coverage so that your medical costs are more predictable.



## Blue Cross Blue Shield of Arizona's HSA-Qualified PPO Health Plan

There are two parts that make up an HSA-qualified health plan: a Health Savings Account (HSA), which is a special savings account set up specifically to pay for medical expenses, and a high deductible PPO or other HSA-qualified health insurance plan. Each year, you can make pretax or tax-deductible contributions to your Health Savings Account. Money from this account can be used to pay for doctor visits, lab tests, prescription medicines and other medical expenses, or you can pay these expenses out-of-pocket, and let your account funds accrue. Any unused dollars in your HSA roll over to the next year. You can grow the account to help meet future health care needs.

BCBSAZ offers a high-deductible PPO plan option that is qualified for use with an HSA. Because of the high deductible, you enjoy low premiums that can save you money every month. And because you pay for your own health care from your Health Savings Account, you control how your health care dollars are spent. There are specific tax advantages to HSA-qualified plans, so you should consult with your tax or legal advisor to learn more.

# Health plans at a glance

Benefit highlights from different BCBSAZ plan types are shown below. This is not a complete list of benefits and you should also read the Exclusions and Limitations on the back page of this brochure. For more detailed benefit information, please review the benefit information enclosed in this packet or visit your BCBSAZ Broker Marketing Web site.

## BlueOptimum Plus PPO Plan: Benefit Highlights for *In-Network* Services

**Deductible Options** — Individual: Range from **\$250–\$10,000**; Family: Range from **\$500–\$20,000**

**Coinsurance** — (after meeting deductible) **80%/20%** applies to services such as:

- Laboratory and Other Professional Services
- Home Health
- Ambulance Services
- Behavioral and Mental Health Facilities
- Inpatient Hospital and Outpatient Services
- Physical, Occupational and Speech Therapy
- Inpatient Rehabilitation Services
- Skilled Nursing Facilities

**Out-of-Pocket Coinsurance Maximum** — (Calendar-year) **\$2,500** per member

### Physician Services<sup>1</sup> —

- Primary Care Physician **\$30** Office Visit Copay
- Specialist **\$50** Office Visit Copay
- Urgent Care **\$60** Copay
- Preventive Services – BCBSAZ pays **100%** for covered services, deductible and coinsurance are waived

### Prescription Medications<sup>1</sup> —

#### Retail Pharmacy

Level 1: **\$ 15** Copay      Level 3: **\$ 70** Copay  
 Level 2: **\$ 40** Copay      Level 4: **\$120** Copay

#### Mail Order

Level 1: **\$ 15** Copay      Level 3: **\$195** Copay  
 Level 2: **\$ 70** Copay      Level 4: **\$360** Copay

## BlueValue Plus PPO Plan: Benefit Highlights for *In-Network* Services

**Deductible Options** — Individual: Range from **\$250–\$10,000**; Family: Range from **\$500–\$20,000**

**Coinsurance** — (after meeting deductible) **70%/30%** applies to services such as:

- Laboratory and Other Professional Services
- Home Health
- Ambulance Services
- Behavioral and Mental Health Facilities
- Inpatient Hospital and Outpatient Services
- Physical, Occupational and Speech Therapy
- Inpatient Rehabilitation Services
- Skilled Nursing Facilities

**Out-of-Pocket Coinsurance Maximum** — (Calendar-year) **\$3,000** per member

### Physician Services<sup>1</sup> —

- Primary Care Physician **\$30** Office Visit Copay\*
- Specialist **\$50** Office Visit Copay\*
- Urgent Care **\$60** Copay
- Preventive Services – BCBSAZ pays **100%** for covered services, deductible and coinsurance are waived

**Prescription Medications<sup>1</sup>** — Prescription copays apply to Level 2, 3 and 4 medications only after the member meets a separate, per member, calendar-year prescription deductible of **\$500**.

#### Retail Pharmacy

Level 1: **\$ 15** Copay      Level 3: **\$ 70** Copay  
 Level 2: **\$ 40** Copay      Level 4: **\$120** Copay

#### Mail Order

Level 1: **\$ 15** Copay      Level 3: **\$195** Copay  
 Level 2: **\$ 70** Copay      Level 4: **\$360** Copay

<sup>1</sup> Copays don't count toward calendar-year deductibles or out-of-pocket coinsurance maximums. Members keep paying them throughout the year.  
 \*Copay is limited to six physician office visits (combined PCP and specialist) per calendar year, then 70%/30% coinsurance after deductible is met.

# Health plans at a glance

## BlueEssential Plus PPO Plan: Benefit Highlights for In-Network Services

**Deductible Options** — Individual: Range from **\$250–\$10,000**; Family: Range from **\$500–\$20,000**

**Coinsurance** — (after meeting deductible) **60%/40%** applies to services such as:

- Laboratory and Other Professional Services
- Home Health
- Ambulance Services
- Behavioral and Mental Health Facilities
- Inpatient Hospital and Outpatient Services
- Physical, Occupational and Speech Therapy
- Inpatient Rehabilitation Services
- Skilled Nursing Facilities

**Out-of-Pocket Coinsurance Maximum** — (Calendar-year) **\$4,000** per member

### Physician Services<sup>1</sup> —

- Primary Care Physician **\$30** Office Visit Copay\*\*
- Specialist **\$50** Office Visit Copay\*\*
- Urgent Care **\$60** Copay
- Preventive Services – BCBSAZ pays **100%** for covered services, deductible and coinsurance are waived

### Prescription Medications<sup>1</sup> —

	<b>Retail Pharmacy</b>	<b>Mail Order</b>
Generic Medications:	<b>\$ 15</b> Copay	<b>\$ 15</b> Copay
Brand Name Medications:	<b>\$125</b> Copay	<b>\$250</b> Copay

## BluePortfolio Plus HSA-Qualified PPO Plan:

### Benefit Highlights for In-Network Services

**Deductible Options** — Self-only<sup>†</sup>: **\$1,750, \$3,000, \$5,500**; Family<sup>†</sup>: **\$3,500, \$6,000, \$11,000**

**Coinsurance** — (after meeting deductible) **100%** applies to services such as:

- Laboratory and Other Professional Services
- Home Health
- Ambulance Services
- Behavioral and Mental Health Facilities
- Inpatient Hospital and Outpatient Services
- Physical, Occupational and Speech Therapy
- Inpatient Rehabilitation Services
- Skilled Nursing Facilities

**Out-of-Pocket Coinsurance Maximum** — (Calendar-year) **\$5,500** per member; **\$11,000** family

### Physician Services —

- Primary Care Physician – BCBSAZ pays **100%** of covered services
- Specialist – BCBSAZ pays **100%** of covered services
- Urgent Care – BCBSAZ pays **100%** of covered services
- Preventive Care – BCBSAZ pays **100%** of covered services, deductible is waived

**Prescription Medications** — BCBSAZ pays **100%** after meeting deductible.<sup>‡</sup>

<sup>1</sup> Copays don't count toward calendar-year deductibles or out-of-pocket coinsurance maximums. Members keep paying them throughout the year.

\*\*Copay is limited to three physician office visits per year (PCP and specialist combined), then 60%/40% coinsurance after deductible is met.

<sup>†</sup>Unless otherwise stated, the self-only deductible must be met on single policies and the family deductible must be met on family policies before BCBSAZ will pay for covered services.

<sup>‡</sup>Payment for mail order must be made with a debit or credit card and is only available through the contracted mail order provider.

# How to apply for coverage

## No application fee when you apply online

Applications may be completed online through your broker's BCBSAZ Broker Marketing Web site or on paper. However, a \$20 non-refundable fee is required for applications submitted on paper, with the exception of applications from current BCBSAZ members. No fee is required for applications completed online and submitted electronically.

Additionally when you apply online, BCBSAZ can review your application more quickly; you can track the progress of your application; and you will receive a confirmation email when BCBSAZ completes its underwriting decision. You are eligible to apply for BCBSAZ's individual health coverage if you are a permanent Arizona resident age 18–64 and you are not receiving Medicare benefits. You can apply for dependent coverage for your spouse and children who are younger than age 30.

BCBSAZ will review your medical history to determine if you meet certain medical underwriting guidelines and are eligible for coverage. For specific information about how your medical history may affect your coverage, you can call the BCBSAZ Medical Risk Assessment department at (602) 864-4040 or (800) 232-2345, ext. 4040 or call your BCBSAZ broker.



## Ready to apply?



Save \$20 by applying online through your broker's BCBSAZ Broker Marketing Web site.

## Still have questions?



Call your BCBSAZ broker or visit your broker's BCBSAZ Broker Marketing Web site for more information.

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## 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 may 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
- Body art, piercing and tattooing and any related complications
- Certain types of inpatient and outpatient facility charges by: group homes, wilderness programs, boarding schools, halfway houses, assisted living centers or shelters. Inpatient and outpatient facility charges for residential treatment facilities except for certain, very limited situations based upon BCBSAZ medical necessity criteria.
- Charges associated with the preparation, copying or production of health records
- Cognitive and vocational therapy
- Complications of noncovered benefits
- Computer speech training and therapy programs and devices
- Cosmetic services and any related complications – surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy.
- Counseling and behavioral modification services, except as stated in the benefit plan
- Court-ordered services, except as stated in the benefit plan
- Custodial care
- Dental, except as stated in the benefit plan
- Dietary and nutritional supplements, except as stated in the benefit plan
- Expenses for services that exceed benefit limitations
- Experimental or investigational services
- Fees other than for medically appropriate, in-person, direct member services, except as stated in the benefit plan
- Fertility and infertility services
- 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
- Lifestyle education and management services, biofeedback and hypnotherapy, 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
- Medical equipment, supplies and medications sold on or through unregulated distribution channels as determined by BCBSAZ
- Medications dispensed in certain settings – prescription medications given to the member by any person or entity that is not a licensed pharmacy, home health agency, specialty pharmacy or hospital emergency room
- Medications which are:
  - Not FDA approved
  - Not required by the FDA to be obtained with a prescription
  - Not used in accordance with 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
- 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 TO MEMBERS AGE 19 AND OLDER.** A pre-existing condition is defined as a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months before your effective date. Services for pre-existing conditions are not covered until 11 consecutive months after the benefit plan effective date.

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