

Indemnity Plan

BlueClassic®



An Independent Licensee of the Blue Cross and Blue Shield Association

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

PARTICIPATING PROVIDERS

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 through the BlueCard® program. To locate BlueCard providers, call (800) 810-BLUE or check the BlueCard Doctor & Hospital Finder at bcbs.com.

NONCONTRACTED PROVIDERS

Noncontracted providers have no agreement with BCBSAZ and may not accept the BCBSAZ allowed amount as payment in full nor file claims for you. With noncontracted providers, in addition to your deductible and coinsurance, you are responsible for the difference between the provider's billed charges and the BCBSAZ allowed amount. This difference may be substantial.

- Participating providers are independent contractors exercising independent medical judgment and are not employees, agents or representatives of BCBSAZ. BCBSAZ has no control over any diagnosis, treatment or service rendered by any provider.
- BCBSAZ has negotiated various reimbursement methods with contracted providers. These providers have agreed to accept the BCBSAZ allowed amount for covered services provided to BCBSAZ members. This means that after payment of deductible, coinsurance or copay amounts, these providers will not bill you for the difference between the provider's billed charges and the BCBSAZ allowed amount for the services. However, when there is another source of payment, such as a liability insurer or government payer, providers may be entitled to collect from the other source or from proceeds received from the other source any difference between the provider's billed charges and the BCBSAZ allowed amount.
- Reimbursement is based on the BCBSAZ allowed amount. The BCBSAZ allowed amount is generally calculated using the lesser of billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements.

Below is an example of how out-of-pocket coinsurance expenses can differ depending on the provider chosen. This example is for services that do not have a copay and assumes the deductible has been met. The example also assumes your coinsurance is 20 percent of the BCBSAZ allowed amount.

Financial Responsibility Example

Billed Charges	BCBSAZ Allowed Amount	Financial Responsibility	BCBSAZ Participating Contracted Providers	Noncontracted Providers
\$1,000	\$400	BCBSAZ pays:	\$320	\$320
		You pay:	\$ 80 coinsurance amount	\$ 80 coinsurance +600 balance bill \$680

The above figures are for demonstration only. Your savings may vary, depending on your benefit plan and the providers from whom you receive services.

Billed charges: what the provider bills BCBSAZ.

BCBSAZ allowed amount: the amount contracted providers agree to accept as the basis of payment.

You pay: what you must pay after BCBSAZ has paid its share of the BCBSAZ allowed amount.

Balance bill: noncontracted providers may bill you the difference between billed charges and the BCBSAZ allowed amount.

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Deductible (Calendar-year) Copays are not applied toward the deductible.	Per person: \$250, \$500, \$750, \$1,250, \$2,500 and \$5,000 Family maximum: \$500, \$1,000, \$1,500, \$2,500, \$5,000 and \$10,000										
Coinsurance ^{1,2}	BCBSAZ pays 80% ; you pay 20% after meeting deductible, unless a different coinsurance percentage is indicated.										
Out-of-Pocket Coinsurance Maximum ² (Calendar-year)	<u>Per person</u> \$5,000										
Physician Services – Office Visits	Subject to deductible and coinsurance.										
Preventive Care, Mammography, Routine Physical Exams	Subject to deductible and coinsurance.										
Laboratory services	During an office visit, deductible and coinsurance apply as specified. At contracted, freestanding independent clinical labs, BCBSAZ pays 100% for covered services, deductible waived. At all other facilities 80%/20% after meeting deductible.										
Other professional services	Subject to deductible and coinsurance. Covered services include diagnostic, surgical and anesthesia services rendered outside the doctor's office.										
Retail and Mail Order Pharmacy ³ Expenses do not apply toward any applicable medical benefit plan deductible or out-of-pocket coinsurance maximum. Mail order is only available through the contracted mail order provider.	<p>\$2,500 deductible option: \$250 prescription medication deductible \$5,000 deductible option: \$500 prescription medication deductible</p> <table border="0"> <tr> <td><u>Contracted pharmacy (30-day supply)</u></td> <td><u>Mail order (90-day supply)</u></td> </tr> <tr> <td>Level 1: \$ 15 copay</td> <td>\$ 15 copay</td> </tr> <tr> <td>Level 2: \$ 35 copay</td> <td>\$ 70 copay</td> </tr> <tr> <td>Level 3: \$ 65 copay</td> <td>\$195 copay</td> </tr> <tr> <td>Level 4: \$120 copay</td> <td>\$360 copay</td> </tr> </table> <p>When you fill a prescription at a noncontracted pharmacy, in addition to the applicable prescription medication copay and any applicable prescription medication deductible, you are also responsible for the difference between a noncontracted pharmacy's price and BCBSAZ's allowed amount.</p>	<u>Contracted pharmacy (30-day supply)</u>	<u>Mail order (90-day supply)</u>	Level 1: \$ 15 copay	\$ 15 copay	Level 2: \$ 35 copay	\$ 70 copay	Level 3: \$ 65 copay	\$195 copay	Level 4: \$120 copay	\$360 copay
<u>Contracted pharmacy (30-day supply)</u>	<u>Mail order (90-day supply)</u>										
Level 1: \$ 15 copay	\$ 15 copay										
Level 2: \$ 35 copay	\$ 70 copay										
Level 3: \$ 65 copay	\$195 copay										
Level 4: \$120 copay	\$360 copay										
Inpatient Hospital ⁴	Subject to deductible and coinsurance.										
Outpatient Services (Facility charges)	Subject to deductible and coinsurance.										
Urgent Care	Subject to deductible and coinsurance.										
Emergency or Accident	\$150 access fee per visit, then subject to deductible and coinsurance. Emergency room access fee is waived if you are admitted to the hospital.										
Maternity – Complications of Pregnancy Only	Subject to deductible and coinsurance.										
Physical, Occupational and Speech Therapy	Subject to deductible and coinsurance.										
Chiropractic Services	Subject to deductible and coinsurance.										
Vision Exams (Routine) and Eyewear Discounts	One routine eye exam per year when received through the vision services administrator ⁵ (VSA): \$15 copay. Discounts on eyewear. Reimbursement up to \$25 for one routine eye exam per year from a nonVSA provider. No eyewear discounts.										
Ambulance Services	Subject to coinsurance, but the deductible does not apply.										

BlueClassic® | INDEMNITY PLAN Benefit Summary

<p>Behavioral and Mental Health Services ⁴</p> <p>Cost sharing for behavioral/mental health does not apply to any out-of-pocket coinsurance maximum.</p>	<p>Outpatient: You may choose Participating or noncontracted providers or the behavioral services administrator ⁵ (BSA). BSA: \$15 copay per visit. Participating and Noncontracted Providers: BCBSAZ pays 50% and you pay 50% after meeting deductible for 20 psychological visits per calendar year.</p> <p>Inpatient facility: Subject to deductible and coinsurance. Two admissions per calendar year, up to a combined total of 30 days. Inpatient professional services: 50%/50% after meeting deductible.</p> <p>\$25,000 maximum benefit while the contract is in force.</p>
<p>Inpatient Rehabilitation Services ⁴</p>	<p>80%/20% after meeting deductible, 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. Limited to 120 days per calendar year.</p>
<p>Home Health Services and Home Infusion - Medication Administration Therapy ⁶</p> <p>Including specialty self-injectable medications</p>	<p>Subject to deductible and coinsurance.</p>
<p>Skilled Nursing Facility ⁴</p>	<p>80%/20% after meeting deductible, 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. Limited to 180 days per calendar year.</p>
<p>Specialty Self-Injectable Medications ⁴</p> <p>For certain specified self-injectable prescription biologic medications. Specialty injectable medications are not covered under the retail or mail order medication benefit. (Also see Home Health.)</p>	<p><u>Contracted Specialty Pharmacy (30-day supply)</u> Noncontracted pharmacies are not covered.</p> <p>Level A: \$30 copay Level B: \$ 60 copay</p> <p>Level C: \$90 copay Level D: \$120 copay</p> <p>Please refer to azblue.com for a listing of specialty injectable medications and contracted specialty pharmacies or call BCBSAZ. Injectable medications are also available from home health providers subject to deductible and coinsurance.</p>
<p>Contract Maximum</p>	<p>\$4,000,000 maximum benefit per person while the contract is in force. All payments by BCBSAZ (for both Participating and noncontracted providers) apply toward the contract maximum.</p>

- 1 Coinsurance is a percentage you must pay for covered services after you have met the calendar-year deductible. Coinsurance is based on the BCBSAZ allowed amount.
- 2 In addition to any applicable deductible and coinsurance, noncontracted providers may charge you for the difference between their billed charges and the BCBSAZ allowed amount. This obligation to pay the difference between the provider's billed charges and the BCBSAZ allowed amount continues even after the member's out-of-pocket coinsurance maximum is met. Copays, access fees and deductibles are not applied toward the out-of-pocket coinsurance maximum.
- 3 Precertification is required for certain medications covered under the retail and mail order pharmacy benefit. A list of medications that require precertification and the process for obtaining precertification is available on the BCBSAZ Web site at azblue.com or by calling BCBSAZ at (602) 864-4273 or (800) 232-2345, ext. 4273. Otherwise covered eligible medications will not be covered if precertification is not obtained when required.
- 4 Precertification is required. If precertification is not obtained, services will be subject to an additional \$300 deductible or denial of benefits.
- 5 Services are available only in Arizona.
- 6 Precertification is required for certain medications provided through the Home Health and Home Infusion - Medication Administration Therapy benefit. A list of medications requiring precertification is available on the BCBSAZ Web site at azblue.com or by calling BCBSAZ at (602) 864-4320 or (800) 232-2345, ext. 4320. Otherwise covered eligible medications will not be covered if precertification is not obtained when required.

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. A complete list of all benefits, limitations and exclusions is in the contract booklet and is available prior to enrollment upon request. **Pre-existing condition waiting periods apply to BlueClassic plans.**

- Abortions except as stated in the contract
- Activity therapy
- Acupuncture
- Alternative medicine, non-traditional 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
- Cosmetic or aesthetic surgery and services, except for breast reconstruction following a medically necessary mastectomy in accordance with state and/or federal law
- Costs paid by other organizations - costs/services customarily paid for by an employer, the government, biotechnical, pharmaceutical or medical device industry sources or other individuals or organizations including, but not limited to worksite or ergonomic evaluations
- Counseling or behavioral medication services except as stated in the contract.
- Court-ordered services – testing, treatment or therapy except as stated in the 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 stated in the contract
- Environmental medicine
- Fees other than for medically appropriate in-person, direct patient treatment, tests, services, medications, supplies or equipment
- Fertility or infertility treatment, medications or procedures
- Foot care
- Genetic/chromosome testing and screening
- Government services – services available under a governmental health program
- Growth hormone(s) – Growth hormone except as determined medically necessary by BCBSAZ to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat Idiopathic Short Stature (ISS) is expressly excluded
- Hearing services or devices
- Investigational treatments, procedures, equipment, medications, devices or supplies, as determined by BCBSAZ and only as required by Arizona law
- Lodging and meals
- Manipulations of the spine under anesthesia
- Massage therapy except as stated in the contract
- Medications dispensed in a physician's/provider's office – prescription medications and over-the-counter medications, including pharmaceutical manufacturer's samples, dispensed to the patient in a physician's/provider's office by any mode of administration
- Medications for off-label, unlabeled or orphan medications (orphan medications are used for diagnosis, treatment or prevention of a rare disease or condition) unless otherwise specified by BCBSAZ medical or prescription medication coverage guidelines. This does not include medications used for the treatment of cancer.
- Nonmedically necessary services as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Normal maternity services
- Over-the-counter medications – any medication, device, equipment or supply (except for certain diabetic supplies and inhaler spacers, as described in the pharmacy benefit) that is lawfully obtainable without a prescription
- Personal comfort items
- Screening tests, except as specifically described in the contract
- 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 without a prescription, when a prescription is required
- Services of ineligible providers
- Services not requiring licensed professional
- Services or supplies delivered prior to the coverage effective date or after coverage termination date
- Services or supplies related to or associated with a noncovered service or supply
- Sexual dysfunction – evaluation and/or testing, diagnosis, treatment (surgical or nonsurgical), or medication or devices for sexual dysfunction, regardless of the cause of the condition, including trauma
- Smoking cessation programs, medications, aids or devices
- Strength training, cardiovascular endurance training, fitness/strengthening programs and/or other services primarily designed to improve or increase fitness
- Telephonic or electronic consultations
- Therapy services except as stated in the contract
- Training and education, except for certain diabetes and asthma training or training related to BCBSAZ-established disease management program(s)
- Transplants (organ, tissue, bone marrow/peripheral stem cell rescue procedures) not approved by BCBSAZ; nor high-dose chemotherapy, radiation administered or other related services administered in conjunction with a noncovered transplant
- Transport services or travel expenses, except as stated in the contract
- Transsexual treatment or surgery, and/or any related services
- Treatment for behavioral or mental health conditions at non-acute facilities (e.g., residential, skilled nursing)
- Vision therapy, radial keratotomy, all types of refractive keratoplasties, eyeglasses and contact lenses and the vision examination for prescribing and fitting of the same
- Vitamins – except for certain vitamins, as determined by BCBSAZ, when a prescription is written by a physician
- Waivered conditions
- Weight loss/gain therapy or treatment except as stated in the contract
- When a provider is also the covered person, services rendered by that provider for him/herself are excluded from coverage
- Workers' Compensation – services for an illness or injury covered by Workers' Compensation or similar benefits, unless you are exempt from such coverage or have 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 contract effective date.

Important Note

This is only a brief summary of benefits and exclusions. Please refer to the specific provisions found within the contract booklet for complete information on benefits, limitations and exclusions. If the benefits on this summary differ from those stated in the contract booklet, the terms of the contract booklet apply. There is no guarantee of continued benefits outlined in this summary 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.