

# Select from a variety of plans created so you can decide what's best.

## BlueOptimum

BlueOptimum is a preferred provider organization (PPO) plan with copays covering in-network services such as office visits and urgent care. Choose from eight deductible levels.

Choose **BlueOptimum** if you want...

- Set copays for in-network office visit services
- First dollar coverage for in-network preventive care services
- A monthly premium that's lower than the BluePreferred plan premium for plans with comparable deductibles

## BlueValue

BlueValue is a PPO plan with a mix of copay and coinsurance cost sharing, and the flexibility of fixed generic prescription copays. Choose from eight deductible levels.

Choose **BlueValue** if you want...

- To pay for services with a blend of copays and coinsurance that result in a lower monthly premium
- No deductible for preventive care services

## BlueEssential

BlueEssential is a low cost PPO plan with basic coverage and copays for a limited number of office visits per year. Choose from eight deductible levels.

Choose **BlueEssential** if you want...

- A plan with low monthly payments designed for low utilization of services – about three PCP visits per year usually will do
- \$15 copays for generic prescriptions at in-network retail pharmacies
- No deductible for preventive care services

## BluePortfolio

BluePortfolio is a qualified high deductible PPO plan for use with a health savings account (HSA). Choose from three deductible levels.

Choose **BluePortfolio** if you want...

- More control over your health care expenses
- 100% in-network coverage after your deductible is met for most covered services
- A plan that can be paired with a Health Savings Account

## BluePreferred®

BluePreferred is a PPO plan that includes copays for certain covered services such as physician office visits with in-network providers. Choose from nine deductible levels.

Choose **BluePreferred** if you want...

- Copays for in-network services, including physician office visits, urgent care, and prescription medications from retail pharmacies

## BluePreferred Basic

BluePreferred Basic is a high-deductible PPO plan with limited copays for some services. Choose from six deductible levels.

Choose **BluePreferred Basic** if you want...

- Copays for in-network PCP and urgent care visits
- Deductible and coinsurance for most other services

## BlueSecure and BlueSecure Plus

BlueSecure and BlueSecure Plus are two options for a Health Maintenance Organization (HMO) plan. Copays apply to many covered services. Primary Care Physician (PCP) referrals are not required for visits to network specialists. Except for emergencies, all covered services must be rendered by BlueSecure network providers.

Choose **BlueSecure** or **BlueSecure Plus** if you want...

- An HMO plan that covers routine maternity after a 12-month waiting period
- Copays covering most services

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Benefits for each PPO Plan and HMO plan are listed in the Benefit Summary for each plan. The following apply to each plan:

- Exclusions and Limitations: These plans do not cover all health care expenses and have exclusions and limitations. All plans generally exclude coverage for services, medications, and supplies that are experimental, investigational, cosmetic, for treatment of sexual dysfunction, or which BCBSAZ deems not medically necessary. Except for BlueSecure HMO plans, which cover maternity after a 12-monthly waiting period, all PPO plans cover only complications of pregnancy and exclude routine maternity. All plans require precertification for inpatient surgery, specialty injectable and certain other medications. Except for mammography, preventive services are covered only at network providers. All plans impose member cost share requirements.
- Network 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 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 a 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.

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