Health Plans at a Glance

	BCBS SAVER'S CHOICE	BCBS PPO		BANNER | AETNA HMO
	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
Networks	BCBS PPO	BCBS PPO	Not applicable	Banner | Aetna HMO Broad / Performance
Local or National Network?	National	National	Not Applicable	National
Out-of-Network Coverage?	For emergency services	For emergency services	Yes, with out-of-pocket costs	For emergency services
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Calendar Year Deductible	$1,700 for single, $3,400 for all covered family members combined	$600 per covered member to a maximum of $1,800 per family	$1,200 per covered member to a maximum of $3,600 per family	No deductible
Coinsurance	10%	20%	30%	10% applicable to Home Healthcare and Skilled Nursing
Calendar Year Out-of-Pocket Maximum for Medical Services	Single Coverage $3,400 (deductible plus pharmacy copays) Family Coverage $6,800 (deductible plus pharmacy copays)	Medical $1,200 per covered member to a maximum of $3,600 per family Pharmacy $1,500 per covered member to a maximum of $3,000 per family	Medical $2,000 per covered member to a maximum of $6,000 per family Pharmacy Not covered	Medical Performance Network Single: $1,500 Family: $3,000 Broad Network Single: $2,500 Family: $5,000 Pharmacy Single: $1,500 Family: $3,000
Virtual Health Care Banner | Aetna 98point6 BCBSAZ BlueCare Anywhere	$20 copay per visit until the deductible is met, and then is available at 10% coinsurance	$0	N/A	$0
Health Savings Account?	Yes	No	No	No
Prenatal Office Visits	Plan pays 90% of the contracted rate after the calendar year deductible is met	PCMH providers: $10 copay, deductible does not apply Other providers: $30 copay, deductible does not apply, or 20% coinsurance	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay	No charge for office visits. Maximum copay for additional maternity tests and services: Performance Network $600/year Broad Network $900/year

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	BCBS SAVER'S CHOICE	BCBS PPO		BANNER | AETNA HMO
	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
Office Visit, Primary Care	Plan pays 90% of the contracted rate after the calendar year deductible is met.	PCMH providers: $10 copay, deductible does not apply Other providers: 20% coinsurance	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay.	Performance Network: PCP: $25 Broad Network PCP: $50
Office Visit, Specialist		PCMH providers: $10 copay, deductible does not apply Other providers: 20% coinsurance		Performance Network: $50 Broad Network: $80
Office Visit, Mental Health		Plan pays 80% of the contracted rate after the calendar year deductible is met.		Performance Network: $25 Broad Network: $50
Outpatient Procedure				$200
Inpatient Hospitalization				Performance Network: $200 per admit, Max $600 per year Broad Network: $300 per admit, Max $900 per year
Lab and X-rays (Medically necessary)				Covered 100%
Physical Therapy / Occupational Therapy*				Plan pays 100% with no deductible or copay
Home Healthcare / Skilled Nursing				Plan pays 90%
Hearing Aids				One hearing aid per ear every 2 years
Urgent Care Facility				$75
Hospital Emergency Room	Plan pays 80% of the contracted rate after the calendar year deductible is met.*	Plan pays 70% of the contracted rate after the calendar year deductible is met.*		$500 (waived if admitted)
Eye Exam with Optometrist once every plan year	See page 35			
Chiropractic	36 visits per year paid at 100% of the contracted rate after the calendar year deductible is met	36 visits per year covered at 100% with no member cost share	Plan pays 70% of the BCBS allowed amount after the calendar year deductible is met. The difference between the allowed amount and the billed amount is your responsibility to pay	36 visits per year
Generic Drugs	$10, after deductible	$10	Not covered	$10
Brand-name Drugs	$40, after deductible	$40	Not covered	$40
Non-formulary Drugs	$80, after deductible	$80	Not covered	$80
Specialty Drugs	$100, after deductible	$100	Not covered	$100
Mandatory Mail Order for Maintenance Medication	Yes, with certain retail pharmacies (CVS, Target, and Fry's)		Not applicable	Yes, with certain retail pharmacies (CVS, Target, and Fry's)

*If admitted, the coinsurance for inpatient hospitalization will be applied.
Please go to phoenix.gov/benefits for detailed health coverage information. Information on the website supersedes information found in this document.