PAYER : BCBS OF ARIZONA
DOS : 06/17/2021 - 06/17/2021
VERIFICATION TYPE : Subscriber Verification

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SUBSCRIBER INFORMATION
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Name : JOHN SMITH
Address : 625 S 5th St
City-State-Zip : PHOENIX-AZ-85004
Gender : Male
Date Of Birth : 12/01/1990
Lastname_R : SMITH
Firstname : JOHN
Member ID : XBM00000000
Group Number : 029060
Issue Number : ABB
Plan : 01/01/2021
Term Date : 12/31/9999

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ELIGIBILITY & BENEFIT INFORMATION
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Service Type : Health Benefit Plan Coverage

Active Coverage (BLUE PREFERRED)
Policy Type : PPO
Benefit Description
*** TELEMEDICINE IS COVERED AT IN-NETWORK PLAN BENEFITS FOR IN NETWORK SERVICES AND FOR EMERGENCY CARE BY AN OUT OF NETWORK PROVIDER.

Benefit Description
*** EVICORE DELEGATED MEMBER FOR HIGH TECH IMAGING, GENETIC TESTS, ONCOLOGY, RADIATION THERAPY, SPECIALTY MEDS

In Plan-Network Status
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Individual Calendar Year Out of Pocket : $3500.00
*** EXCLUDES BALANCE BILLING AND NONCOVERED SERVICES

Individual Remaining Out of Pocket : $3493.87
*** EXCLUDES BALANCE BILLING AND NONCOVERED SERVICES

Family Calendar Year Out of Pocket : $7000.00
*** EXCLUDES BALANCE BILLING AND NONCOVERED SERVICES

Family Remaining Out of Pocket : $6993.87
*** EXCLUDES BALANCE BILLING AND NONCOVERED SERVICES

Out of Plan-Network Status
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Individual Calendar Year Out of Pocket : $5000.00
*** EXCLUDES BALANCE BILLING, NONCOVERED SERVICES AND PRECERTIFICATION CHARGES

Individual Remaining Out of Pocket : $5000.00
*** EXCLUDES BALANCE BILLING, NONCOVERED SERVICES AND PRECERTIFICATION CHARGES

Family Calendar Year Out of Pocket : $10000.00
*** EXCLUDES BALANCE BILLING, NONCOVERED SERVICES AND PRECERTIFICATION CHARGES

Family Remaining Out of Pocket : $10000.00
*** EXCLUDES BALANCE BILLING, NONCOVERED SERVICES AND PRECERTIFICATION CHARGES

Applies to In & Out Plan-Network Status
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Individual Calendar Year Deductible : $1000.00

Individual Remaining Deductible : $1000.00

Family Calendar Year Deductible : $2000.00

Family Remaining Deductible : $2000.00

Service Type : Misc. Info

Benefit Disclaimer
*** UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLE MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

Service Type : Physical Therapy

Benefit Description
*** TELEMEDICINE IS COVERED AT IN-NETWORK PLAN
BENEFITS FOR IN NETWORK SERVICES AND FOR EMERGENCY CARE BY
AN OUT OF NETWORK PROVIDER.

In Plan-Network Status
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Individual Co-Insurance : 0%

Individual Visit Co-Payment : $25.00

Individual Deductible : $0.00

Family Deductible : $0.00

Out of Plan-Network Status
==========
Individual Co-Insurance : 40%

I hereby attest the benefits information contained in this form are accurate and does not constitute a guarantee of payment. I understand I am financially responsible for charges associated with any and all services received.

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Sign Here DATE