

# HMO Plan - Benefit Summary

BlueSelect®			
<b>Providers</b>	<p>Except for emergencies, all services must be provided by BlueSelect network providers to be covered. If you are traveling outside Arizona and need urgent medical treatment for a condition that is not an emergency, you can be treated at a physician's office or urgent care facility that is part of the BlueCard Access program.</p> <p><b>Unlike some HMO plans, BlueSelect does not require that you obtain a referral from a primary care physician (PCP) for visits to network specialists.</b></p>		
<b>Deductibles</b>	None		
<b>Physician office visits</b>		PCP (general practice, family practice, internal medicine or pediatric physician)	Specialist
	BENEFIT PLAN ONE	<b>\$10 copay</b>	<b>\$15 copay</b>
	BENEFIT PLAN TWO	<b>\$25 copay</b>	<b>\$30 copay</b>
<b>Other professional services</b>	Inpatient consultations, surgeon and anesthesiologist services, diagnostic lab and X-ray services: Plan pays <b>100% for covered services.</b>		
<b>Preventive care</b>	Annual physical exams and related tests and screenings, well-child care, routine immunizations, annual gynecologic exams, routine mammograms, routine sigmoidoscopy or colonoscopy. Services are subject to any applicable office visit copays.		
<b>Maternity care</b>	Normal prenatal, delivery and postpartum maternity care are covered if the delivery occurs after the contract has been in force for 12 months. Complications of pregnancy are covered, regardless of the delivery date. The office visit copay only applies to the initial prenatal office visit. The inpatient hospital copay applies to the hospital admission.		
<b>Prescription drugs</b>	BENEFIT PLAN ONE	Participating pharmacy (30-day supply)	Mail order (90-day supply)
For certain prescription drugs, the quantity of medication covered may be limited by BCBSAZ. FDA dosage limitations also apply.	Generic:	<b>\$7 copay</b>	<b>\$7 copay</b>
	Preferred brand:*	<b>\$20 copay</b>	<b>\$40 copay</b>
	Non-preferred brand "A":	<b>\$40 copay</b>	<b>\$120 copay</b>
	Non-preferred brand "B":*	<b>\$80 copay</b>	<b>\$240 copay</b>
	BENEFIT PLAN TWO	Participating pharmacy (30-day supply)	Mail order (90-day supply)
	Generic:	<b>\$10 copay</b>	<b>\$10 copay</b>
	Preferred brand:*	<b>\$30 copay</b>	<b>\$60 copay</b>
	Non-preferred brand "A":	<b>\$60 copay</b>	<b>\$180 copay</b>
	Non-preferred brand "B":*	<b>\$120 copay</b>	<b>\$360 copay</b>
		*Please refer to the Prescription Medication Guide for a list of Preferred brand drugs and Non-preferred brand "B" drugs. Most injectable drugs are only available from home health agencies and require recertification. When the price BCBSAZ pays a contracted pharmacy for a drug is less than your copay, some pharmacies will charge you the BCBSAZ price. However, most pharmacies will charge you their usual and customary price (if it is also less than your copay), rather than the BCBSAZ price. You will never be charged more than your copay. Prescription drugs must be purchased at a participating pharmacy or through the prescription drug mail service. Prescriptions for emergencies are also covered.	
<b>Inpatient hospital services</b> (Must be precertified except for emergencies.)	BENEFIT PLAN ONE	<b>\$250 copay per admission, \$500 calendar-year copay maximum per family</b>	
	BENEFIT PLAN TWO	<b>\$500 copay per admission, \$1,000 calendar-year copay maximum per family</b>	
	Room and board, special care units, operating and recovery room, diagnostic testing, blood transfusions, radiation therapy or chemotherapy, and anesthesia. Inpatient substance abuse coverage is limited to one three-day admission per 24 months for detoxification.		

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<b>Outpatient hospital services</b> (Must be precertified.)	Radiation therapy or chemotherapy, blood transfusions and diagnostic testing: Plan pays <b>100% for covered services</b> .
<b>Outpatient surgery</b> (Must be precertified.)	Surgeries performed in a hospital's outpatient surgery department or a free-standing ambulatory surgical center BENEFIT PLAN ONE <b>\$100 copay per surgery</b> BENEFIT PLAN TWO <b>\$200 copay per surgery</b>
<b>Urgent care facility services</b>	In-state network urgent care centers: BENEFIT PLAN ONE <b>\$25 copay</b> BENEFIT PLAN TWO <b>\$35 copay</b> Out-of-state: Call (800) 810-BLUE (2583) for assistance in finding the closest BlueCard <i>Access</i> network provider. Services obtained through a BlueCard provider will be subject to the applicable office visit or urgent care copay. Services at non-network providers are not covered.
<b>Emergency room services</b>	If immediate treatment is necessary, go to the nearest source of medical care. Follow-up services received after the emergency treatment must be provided by BlueSelect providers. BENEFIT PLAN ONE <b>\$75 copay (waived if admitted)</b> BENEFIT PLAN TWO <b>\$100 copay (waived if admitted)</b>
<b>Ambulance</b>	Plan pays <b>100% for covered services</b> .
<b>Behavioral and mental health services</b> (Inpatient care must be precertified.)	All services must be provided or authorized by the behavioral services administrator. Outpatient benefits: <b>\$10 copay per visit. Your annual copay maximum is \$100 per person, \$200 per family.</b> Includes psychotherapy and counseling for substance abuse, personal and family problems, lifestyle education and stress management. Inpatient mental health benefits: <b>Maximum benefit of \$7,500 per 24-month period</b> BENEFIT PLAN ONE <b>\$250 copay per admission</b> BENEFIT PLAN TWO <b>\$500 copay per admission</b>
<b>Inpatient Rehabilitation</b> (Must be precertified.)	You pay your hospital copay; benefit is limited to <b>60 days per calendar year</b> .
<b>Outpatient Rehabilitation</b> "Modalities" are physical agents such as traction and ultrasound. "Therapeutic services" means the application of clinical skills/services such as exercise and gait training.	<b>Outpatient physical and/or occupational therapy: 100% for covered services, up to 80 modalities and/or therapeutic services per calendar year.*</b> The average number of modalities or services performed per visit is 4. <b>Outpatient speech therapy:</b> Plan pays <b>100% for covered services, up to 20 visits per calendar year.</b> *Additional modalities/therapeutic services for physical/occupational therapy and additional visits for speech therapy exceeding these limits are available, subject to 50% coinsurance up to a \$500 annual out-of-pocket maximum. <b>Chiropractic services: Up to 12 visits per calendar year</b> for neck and back pain at American Specialty Health Networks providers. BENEFIT PLAN ONE <b>\$10 copay</b> BENEFIT PLAN TWO <b>\$25 copay</b>
<b>Home health/skilled nursing care</b> (Must be precertified.)	Home health care: Plan pays <b>100% for covered services, up to 3 visits of 2 hours or less per day.</b> Skilled nursing facility care: Plan pays <b>100% for covered services, up to 90 days per calendar year.</b>
<b>Routine vision care</b>	Eye exam at vision services administrator providers: BENEFIT PLAN ONE <b>\$10 copay</b> BENEFIT PLAN TWO <b>\$25 copay</b> One refractive eye exam for prescription glasses or contact lenses per calendar year. If the initial order of contacts is not purchased through the examining provider, a professional contacts fitting fee of up to \$50 may be charged. Discounts available on frames and lenses, including contact lenses, at vision services administrator providers. For information on vision services administrator providers, call (800) 952-6674.
<b>Contract benefit maximum</b>	None

## Medical necessity

For services to be covered by these benefit plans, they must be considered medically necessary by BCBSAZ, based on specific criteria that is available to you upon request. Where benefits are provided by a third-party administrator such as the behavioral services administrator, the third-party administrator may determine medical necessity based on its own criteria.

### *Precertification is required for some services*

If precertification is not obtained, your benefits will be subject to an additional \$300 deductible or denial of benefits. Your provider must call for precertification at (602) 864-4320 or (800) 232-2345. Please refer to the precertification requirements in your contract booklet, which will be sent to you upon enrollment, or upon request prior to enrollment.

## Exclusions and Limitations

The following is a list of conditions and services that are limited or excluded. A complete list of exclusions can also be found in the contract booklet, which will be sent to you when you enroll, or upon request prior to enrollment. Expenses for services that exceed benefit limitations are not covered. In addition, no benefits will be paid for expenses associated with the following:

- Abortions (nonspontaneous, medically induced, except when fetus/newborn not expected to be viable)
- Activity therapy
- Acupuncture
- Alternative medicine, nontraditional 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
- Contraceptive management, medications or devices (except for oral contraceptives)
- Cosmetic or aesthetic surgery and services, except for breast reconstruction following a medically necessary mastectomy in accordance with state and/or federal law, or for congenital defects for newborns and adopted children
- Counseling (except as may be available through the behavioral services administrator)
- Court-ordered services – testing, treatment or therapy, unless such services are otherwise covered under this 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 otherwise specifically provided under the “Medical Foods” section of the contract booklet.
- Environmental medicine
- Fees other than for medically appropriate in-person, direct patient treatment, tests, services, medications, supplies or equipment
- Fertility or infertility treatment, drugs or procedures
- Foot care, except when medically appropriate for diabetics or neurological involvement or peripheral vascular disease of the foot or lower leg
- Genetic/chromosome testing and screening – genetic/chromosomal testing of an asymptomatic or unaffected individual or an individual not displaying signs or symptoms of a suspected or specific inherited disorder
- Government services – services available under a governmental health program
- Hearing services – hearing aid services and supplies and routine hearing exams except for hearing screening that may be included in covered physical exams
- Investigational treatments, procedures, equipment, drugs, devices or supplies, as determined by BCBSAZ and only as required by Arizona law
- Lodging and meals, except for covered transplant travel benefits
- Nonmedically necessary services, as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Over-the-counter medications; medications from provider’s office – any drug, medicine, device, equipment or supply (except for certain diabetic supplies as described in the pharmacy benefit) that is lawfully obtainable without a prescription; vitamins and minerals; and drugs, medicine, devices, equipment or supplies dispensed by or from a provider’s office
- Personal comfort items
- Screening tests, except as specifically as described in the contract booklet
- Providers who are also the covered person, services rendered by that provider for him/herself.
- 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 not requiring a licensed professional
- Services of ineligible providers
- Services or supplies after termination
- Services or supplies prior to effective date
- Services or supplies related to or associated with a noncovered service or supply
- Sexual dysfunction – evaluation and/or testing, diagnosis, treatment (surgical or non-surgical), medication or devices for sexual dysfunction, regardless of the cause of the condition
- Smoking cessation programs, medications, aids or devices
- Telephonic or electronic consultations
- Therapy services, except as expressly provided in the contract
- Training and education, except for certain diabetic nutritional training specifically approved in advance by BCBSAZ, or training related to BCBSAZ-established disease management program(s), with advance BCBSAZ approval
- Transplants (organ, tissue, bone marrow/peripheral stem cell rescue procedures) not approved by BCBSAZ; nor high-dose chemotherapy/radiation administered in conjunction with a noncovered transplant, expenses related to donation of an organ to a recipient who is not covered by BCBSAZ.
- Transportation – transport services or travel expenses, except as described in the ambulance or in the contract booklet
- Transsexual treatment or surgery and/or any related services
- Vision therapy, radial keratotomy, all types of refractive keratoplasties, eyeglasses and contact lenses and the vision examination for prescribing and fitting of the same, except as otherwise stated as a benefit in the contract booklet
- Vitamins – vitamins (except for prenatal vitamins when a prescription is written by a physician)
- Weight loss/gain therapy, treatment or medications including but not limited to Xenical® and Meridia® (except for medically necessary, covered surgical services)
- Worker’s Compensation – services for an illness or injury covered by Worker’s Compensation or similar benefits, unless you are exempt from such coverage or have made a statutory opt-out election

### **Additional exclusions for BlueSelect only**

- Inpatient treatment for substance abuse, except for detoxification
- Normal maternity services when delivery occurs prior to completion of the 12-month waiting period

## Important note

This brochure is only a general summary of benefits. A complete listing and description of all benefits, limitations and exclusions that govern determinations of coverage are found in the contract, which will be sent to you upon enrollment, or upon request prior to enrollment.

There is no guarantee of continued benefits as outlined in this brochure 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.

### Network providers

All BlueSelect network providers are independent contractors who have an agreement with BCBSAZ regarding reimbursement and administrative policies.

BCBSAZ has negotiated various reimbursement methods with contracted network providers. These providers have agreed to accept the BCBSAZ allowed amount for covered services provided to our customers. This means that after you pay any deductible, coinsurance or copay amounts, these providers will not bill you for any difference between that allowed amount and their regular charge for the service. However, when there is another source of payment – such as a liability insurer, government payer or uninsured and/or underinsured motorist coverage – network providers may be entitled to collect from the other source or from proceeds received from the other source any difference between the BCBSAZ allowed amount and their billed charges.

The contracted networks of providers are subject to change at any time. Every specialty type may not be available in the networks.

### Portability/Conversion Coverage

**Notice to applicants who have lost group health coverage or who are transferring from a Blue Cross or Blue Shield Plan in another state:** If you terminated your group health plan (employer provided health coverage) or COBRA continuation coverage within the past 63 days, you may be eligible for **Individual Portability Coverage**. If you terminated BCBSAZ group coverage or any coverage from another Blue Cross or Blue Shield Plan within the past 31 days, you may be eligible for **Conversion Coverage**.

Individual Portability Coverage and Conversion Coverage do not require medical underwriting. There is no waiting period for pre-existing conditions or normal maternity services on Individual Portability Coverage. However, the premiums are higher for these health plans. If you think you may qualify for Individual Portability Coverage or Conversion Coverage, contact us for a special brochure and application.