

# BlueSelect® Benefit Summary

## Plan 20

Effective 01/01/10



An Independent Licensee of the Blue Cross and Blue Shield Association

<b>Network Limitations</b>	<b>Except for emergencies, all covered services must be rendered by a network provider.</b> Outside Arizona, this plan covers only emergency services, and urgent care and authorized follow up care rendered by network providers.
<b>Network Providers</b>	<p>Network providers are: (1) eligible providers who have an HMO contract with BCBSAZ; and (2) eligible providers located out-of-state and licensed in the United States who are contracted with an out-of-state Blue Cross and/or Blue Shield Plan ("Host Blue") for emergency, urgent care and authorized follow-up care. Members who travel outside Arizona can access network providers through the BlueCard® program.</p> <p>Network providers will file member's claims with BCBSAZ or the Host Blue plan. Network providers cannot charge more than the allowed amount for covered services.*</p> <p>Network providers will collect only the member's cost-share portion, such as deductible, coinsurance, access fee or copay amounts. However, when there is another source of payment, such as a liability insurer or government payer, network providers may be entitled to collect their billed charges from the other source or from proceeds received from the other source.</p>
<b>Allowed Amount</b>	<p>The allowed amount is the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost share payment. It is not tied to and does not necessarily reflect the fees that providers in any given area usually charge for services.</p> <p>For claims from providers contracted with BCBSAZ, BCBSAZ generally bases the allowed amount on the lesser of a provider's billed charges or the applicable BCBSAZ fee schedule, with adjustments for any negotiated contractual arrangements and certain claims editing procedures. For claims from out-of-state providers contracted with a Host Blue plan, BCBSAZ generally bases the allowed amount on the lesser of the provider's billed charges or the contractual price the Host Blue plan has negotiated with that provider. For emergency services from a noncontracted provider, BCBSAZ bases the allowed amount on billed charges. BCBSAZ develops its proprietary fee schedules from annual reviews of numerous data sources.</p>
<b>Payment of Reimbursement</b>	BCBSAZ reimburses network providers the allowed amount, minus any portion allocated to member cost-share. When a member has received covered emergency care from a noncontracted provider, BCBSAZ reimburses the member the allowed amount, minus any portion allocated to member cost-share. The member is responsible for paying the provider.

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## Plan 20

EXCEPT FOR EMERGENCY SITUATIONS, NETWORK PROVIDERS MUST BE USED FOR SERVICES TO BE COVERED.

### SUMMARY OF BENEFITS

<b>Out-of-Pocket Maximum</b>	<b>\$2,500</b> per member, per calendar year. The out-of-pocket maximum is a maximum liability for certain member cost-share payments and is based on the allowed amount rather than a provider's billed charges. Many cost share payments do not count toward the out-of-pocket maximum, including: physician office visit copays, retail and mail order prescription medication copays, specialty self-injectable medication copays, chiropractic services copays routine vision exam copays, amounts for noncovered services and certain other charges listed in the benefit book. To determine whether a specific cost share payment counts toward the maximum, refer to the benefit book. A member must continue to pay all these cost share amounts even after meeting the maximum.										
<b>Physician Services – Primary Care Physicians</b>	<b>\$20</b> copay per member, per provider, per day for most covered services performed in a physician's office Primary Care Physicians (PCP) include Family Practice, General Practice, Internal Medicine and Pediatrics. All other physicians are specialists.										
<b>Physician Services – Specialist Office Services</b>	<b>\$30</b> copay per member, per provider, per day for most covered services performed in a physician's office; no referral from PCP is required by BCBSAZ.										
<b>Preventive Services</b> • Certain Screening Services • Immunizations • Routine Physicals • Mammography	<b>Services provided in the physician's office are subject to the office visit copay.</b> Preventive services are those services performed for screening purposes when the member does not have active signs or symptoms of a condition, but do not include diagnostic tests performed because the member has a condition or an active symptom of a condition. Whether something is preventive is determined by the diagnosis submitted by the provider.										
<b>Urgent Care</b>	<b>In-state network urgent care centers: \$50</b> copay per member, per provider, per day at facilities specifically contracted as urgent care providers. <b>Out-of-state:</b> Call (800) 810-BLUE (2583) for assistance in finding the closest BlueCard network provider. Services obtained through a BlueCard provider will be subject to the applicable copay, depending on where services are provided. Precertification may be required for some services.										
<b>Laboratory Services</b>	In a physician's office, BCBSAZ pays <b>100%</b> ; office visit copay waived if the only services a member receives during the visit are laboratory services. At contracted, independent clinical labs, BCBSAZ pays <b>100%</b> for covered services.										
<b>Radiology Services</b>	<b>In a physician's office</b> , applicable office visit copay applies. <b>\$100</b> copay per procedure type, per member, per provider, per day for CT, MRI, MRA and PET scans. Copays are waived for high tech radiology services performed while the member is inpatient at an acute hospital or while receiving treatment in the emergency room. For all other radiology services, BCBSAZ pays <b>100%</b> for covered services.										
<b>Outpatient Services other than Radiology (Facility charges)</b>	<b>\$100</b> copay for outpatient surgery per member, per day. BCBSAZ pays <b>100%</b> for all other covered outpatient services.										
<b>Other Professional Services</b>	BCBSAZ pays <b>100%</b> for covered services. Other professional services include diagnostic, surgical and anesthesia services rendered outside a provider's office.										
<b>Prescription Medications at Retail and Mail Order Pharmacy<sup>2</sup></b>	<table border="0"> <thead> <tr> <th><u>Retail Pharmacy</u></th> <th><u>Mail Order Pharmacy</u></th> </tr> </thead> <tbody> <tr> <td>Level One: <b>\$10</b> copay</td> <td><b>\$ 20</b> copay</td> </tr> <tr> <td>Level Two: <b>\$25</b> copay</td> <td><b>\$ 50</b> copay</td> </tr> <tr> <td>Level Three: <b>\$50</b> copay</td> <td><b>\$100</b> copay</td> </tr> <tr> <td>Level Four: <b>\$80</b> copay</td> <td><b>\$160</b> copay</td> </tr> </tbody> </table>	<u>Retail Pharmacy</u>	<u>Mail Order Pharmacy</u>	Level One: <b>\$10</b> copay	<b>\$ 20</b> copay	Level Two: <b>\$25</b> copay	<b>\$ 50</b> copay	Level Three: <b>\$50</b> copay	<b>\$100</b> copay	Level Four: <b>\$80</b> copay	<b>\$160</b> copay
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<b>Inpatient – Hospital<sup>1</sup></b>	<b>\$250</b> copay per member, per day, for a maximum of three copays, per admission.										
<b>Emergency</b>	<b>\$150</b> copay per member, per provider, per day; emergency room copay is waived if member is admitted to the hospital.										
<b>Ambulance</b>	BCBSAZ pays <b>100%</b> for covered services.										
<b>Maternity</b>	<b>Physician:</b> Office visit copay applies only to first prenatal visit. <b>Hospital:</b> <b>\$250</b> copay per member, per day, for a maximum of three copays per admission.										

## SUMMARY OF BENEFITS

<b>Chiropractic<sup>1</sup></b>	<b>\$30</b> copay per member, per visit. Benefits are available for <b>12</b> medically necessary chiropractic visits per member, per calendar year for treatment of neck and back pain. <b>Chiropractic services must be provided and authorized exclusively by the chiropractic services administrator.</b>
<b>Physical, Occupational and Speech Therapy (PT, OT and ST)</b>	<b>Physical/Occupational Therapy:</b> BCBSAZ pays <b>100%</b> for first <b>80</b> modalities or therapeutic services per member, per calendar year. <b>Speech Therapy:</b> BCBSAZ pays <b>100%</b> for first <b>20</b> visits per member, per calendar year. After the first <b>80</b> modalities or <b>20</b> visits, BCBSAZ pays <b>50%</b> , member pays <b>50%</b> of the allowed amount up to the out-of-pocket maximum. After the out-of-pocket maximum is met, BCBSAZ pays <b>100%</b> for covered services for the remainder of the calendar year.
<b>Vision Exams (Routine)</b>	<b>\$30</b> copay for one routine vision exam per member, per calendar year.
<b>Behavioral/Mental Health<sup>1</sup></b>	<b>Inpatient:</b> <b>\$250</b> copay per member, per day for a maximum of three copays per admission. <b>Outpatient:</b> Unlimited psychotherapy and counseling – <b>\$15</b> copay per member, per visit. <b>Behavioral health services must be provided and authorized exclusively by the behavioral services administrator (BSA).</b>
<b>Inpatient Rehabilitation Services<sup>1</sup></b>	<b>\$250</b> copay per member, per day for a maximum of three copays per admission for up to <b>60</b> days per member, per calendar year.
<b>Skilled Nursing Facility<sup>1</sup></b>	<b>\$250</b> copay per member, per day for a maximum of three copays per admission for up to <b>90</b> days per member, per calendar year.
<b>Home Health<sup>2</sup></b>	BCBSAZ pays <b>100%</b> for covered services.
<b>Specialty Self-Injectable Medications Through Specialty Pharmacy<sup>2</sup></b> For certain specified self-injectable prescription biologic medications. Specialty self-injectable medications are not covered under the Home Health or Retail and Mail Order Pharmacy benefit.	Level A: <b>\$30</b> copay    Level B: <b>\$ 60</b> copay Level C: <b>\$90</b> copay    Level D: <b>\$120</b> copay  Please refer to <a href="http://azblue.com">azblue.com</a> or call BCBSAZ for a listing of specialty self-injectable medications and contracted specialty pharmacies.
<b>Bariatric Surgery<sup>1</sup></b> (Inpatient and Outpatient )	<b>\$1,000</b> copay per member, per surgery, in addition to inpatient or outpatient surgery copay depending on where surgery is performed.

1 Precertification is required. If precertification is not obtained, services will not be covered.

2 Precertification is required for certain medications including all specialty self-injectable medications. Lists of medications that require precertification and the process for obtaining precertification is available on the BCBSAZ Web site at [azblue.com](http://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.

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**Other Information:**

- 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. 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.
- When the price BCBSAZ pays a network pharmacy for a medication is less than the member's cost-sharing, some pharmacies will charge the member the BCBSAZ price. However, most pharmacies will charge the member the retail price (if also less than the cost-sharing) rather than the BCBSAZ price. The member will not be required to pay more than the applicable cost-sharing for covered medications at a network pharmacy.
- BCBSAZ applies limitations to certain prescription medications obtained through the retail and mail order pharmacy benefit. A list of these medications and limitations is available online at [azblue.com](http://azblue.com) or by calling BCBSAZ. These limitations include, but are not limited to, quantity, refill, age and gender limitations. BCBSAZ prescription medication limitations are subject to change at any time without prior notice.
- 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.

**NOTE:** THIS IS ONLY A BRIEF SUMMARY OF BENEFITS AND EXCLUSIONS. PLEASE REFER TO THE SPECIFIC PROVISIONS FOUND WITHIN THE BENEFIT BOOK FOR DETAILED INFORMATION ABOUT BENEFITS, LIMITATIONS AND EXCLUSIONS. IF THE BENEFITS IN THIS SUMMARY DIFFER FROM THOSE STATED IN THE BENEFIT BOOK, THE TERMS OF THE BENEFIT BOOK APPLY.

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## Exclusions and Limitations

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. Detailed information about benefits, limitations and exclusions is in the benefit book and is available prior to enrollment, upon request.

- Abortions, except as stated in the benefit plan
- Activity therapy
- Acupuncture
- Alternative medicine, non-traditional and alternative medical therapies; interventions; services and procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; nutritional and lifestyle therapies; aromatherapy
- Autism spectrum disorders (ASD) – services related to treatment of ASD, except as stated in the benefit plan
- Benefit-specific exclusions and limitations listed in the benefit book under particular benefits
- Body art, piercing, tattooing and any related complications
- Certain types of inpatient and outpatient facility charges by: group homes, wilderness programs, boarding schools, halfway houses, assisted living centers or shelters. Inpatient and outpatient facility charges for residential treatment facilities except for certain, very limited situations based upon BCBSAZ medical necessity criteria.
- Charges associated with the preparation, copying or production of health records
- Cognitive and vocational therapy
- Complications of noncovered benefits
- Computer speech training and therapy programs and devices
- Cosmetic services and any related complications – surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy.
- Counseling and behavioral modification services, except as stated in the benefit plan
- Court-ordered services, except as stated in the benefit plan
- Custodial care
- Dental, except as stated in the benefit plan
- Dietary and nutritional supplements, except as stated in the benefit plan
- Expenses for services that exceed benefit limitations
- Experimental or investigational services
- Fees other than for medically appropriate in-person, direct member services, except as stated in the benefit plan
- Fertility and infertility services
- Flat feet
- Foot care, except as stated in the benefit plan
- Free services
- Genetic and chromosomal testing and screening
- Government services provided at no charge to the member through a governmental program or facility
- Growth Hormone except as specified in the BCBSAZ Medical Coverage Guidelines, and growth hormone to treat Idiopathic Short Stature (ISS)
- Hearing services and devices, except as stated in the benefit plan
- Lifestyle education and management services, biofeedback and hypnotherapy, except as stated in the benefit plan
- Lodging and meals, except as stated in the benefit plan
- Maintenance Services – services rendered after a member has met functional goals; services rendered when no objectively measurable improvement is reasonably anticipated, services to prevent regression to a lower level of function, services to prevent future injury and services to improve or maintain posture
- Manipulations of the spine under anesthesia
- Massage therapy, except in limited circumstances as described in the BCBSAZ Medical Coverage Guidelines
- Medical equipment, supplies and medications sold on or through unregulated distribution channels as determined by BCBSAZ
- Medications dispensed in certain settings – prescription medications given to the member by any person or entity that is not a licensed pharmacy, home health agency, specialty pharmacy or hospital emergency room
- Medications which are:
  - Not FDA approved
  - Not required by the FDA to be obtained with a prescription
  - Not used in accordance with the BCBSAZ Medical Coverage Guidelines
  - Used to treat a condition not covered by BCBSAZ
  - Off-label, unlabeled and orphan medications, except as stated in the benefit plan
- Neurofeedback
- Non-medically necessary services, as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Over-the-counter items, except as stated in the benefit plan
- Personal comfort items
- Reversal of sterilization
- Screening tests, except as stated in the benefit plan
- Services for Idiopathic Environmental Intolerance
- Services for sexual dysfunction, regardless of the cause/related to organic disease, and all medications for the treatment of sexual dysfunction
- Services for weight loss and gain, except as stated in the benefit plan
- Services from a family member – services that are provided by an eligible provider who is part of the member's immediate family. When a provider is also the covered person, services rendered by that provider for him/herself are excluded from coverage.
- Services from ineligible providers
- Services paid for by other organizations
- Services provided after the member's coverage termination date, except as stated in the benefit plan
- Services provided by a proficient substitute for a professional caregiver
- Services provided prior to effective date
- Services related to or associated with noncovered services
- Services without a prescription, when a prescription is required
- Smoking cessation programs, medications, aids and devices
- Spinal decompression or vertebral axial decompression therapy
- Strength training, except as stated in the benefit plan
- Telephonic and electronic consultations, except as stated in the benefit plan
- Therapy services, except as stated in the benefit plan
- Training and education, except as stated in the benefit plan
- Transplants and related services not precertified by BCBSAZ
- Transportation services and travel expenses, except as stated in the benefit plan
- Transsexual treatment, surgery, medications and related services
- Vision therapy; all types of refractive keratoplasties; any other procedures, treatments and devices for refractive correction; eyeglasses and contact lenses; vision examinations for fitting of eyeglasses and contact lenses, except as stated in the benefit plan
- Vitamins, except as stated in the benefit plan
- Workers' Compensation – illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election



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