# BlueSelect® Benefit Summary

## Plan 20

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

**Effective January 1, 2009**

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| **Network Providers** | **Except for emergencies, all covered services must be rendered by a network provider.** Network providers are Arizona health care providers who have a health maintenance organization (HMO) contract with Blue Cross Blue Shield of Arizona. Network providers will file your claims with Blue Cross Blue Shield of Arizona.<br><br>Network providers are independent contractors exercising independent medical judgment and are not employees, agents or representatives of Blue Cross Blue Shield of Arizona (BCBSAZ). BCBSAZ has no control over any diagnosis, treatment or service rendered by any provider.<br><br>When you travel outside Arizona, you can access network providers through the BlueCard® program. Outside of Arizona, this plan will cover only emergency services, as well as urgent care services and authorized follow-up care rendered by network providers. To locate BlueCard network providers, call (800) 810-BLUE or check the BlueCard Doctor and Hospital Finder at **bcbs.com.** |
| **Allowed Amount** | The allowed amount is the amount of reimbursement allocated to a covered service.<br><br>For most claims, BCBSAZ bases the allowed amount on the lesser of a provider's billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements BCBSAZ has negotiated with a network provider. For claims from out-of-state providers, BCBSAZ generally bases the allowed amount on the lesser of the provider's billed charges or the contractual price negotiated by the Blue plan in the state where services were rendered. For emergency services provided by an out-of-network provider, either in Arizona or out-of-state, BCBSAZ bases the allowed amount on billed charges. The allowed amount includes any BCBSAZ payment plus any member cost-sharing.<br><br>BCBSAZ reimburses network providers the allowed amount, minus any portion allocated to member cost-share. In a covered emergency situation where a member has seen an out of network provider, BCBSAZ reimburses the member the allowed amount, minus any portion allocated to member cost-share.<br><br>The allowed amount is the figure that BCBSAZ uses to calculate any deductible or coinsurance and to accumulate toward any out-of-pocket coinsurance maximum.<br><br>Network providers have agreed to accept the allowed amount for covered services. They will collect only the member's cost-share portion, such as deductible, coinsurance 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. |

# **BlueSelect®** Plan 20

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

| SUMMARY OF BENEFITS | |
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| **Out-of-Pocket Maximum** | **$2,500** per member, per calendar year.<br><br>The out-of-pocket maximum is based on the allowed amount rather than a provider's billed charges. Certain copays and amounts paid for noncovered services do not count toward meeting the maximum. You must continue to pay these charges even after meeting the maximum. |
| **Physician Services – Primary Care Physicians**<br>Primary Care Physicians (PCP) include Family Practice, General Practice, Internal Medicine and Pediatrics.<br>All other physicians are specialists. | **$20** copay (per member, per provider, per day) for most covered services performed in a physician's office. **Physician office visit copays do not count toward satisfaction of the out-of-pocket maximum.** |
| **Physician Services – Specialist Office Services** | **$30** 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. **Physician office visit copays do not count toward satisfaction of the out-of-pocket maximum.** |
| **Laboratory Services** | In a physician's office, BCBSAZ pays **100%**; office visit copay waived if the only services you receive during your visit are laboratory services. At contracted, freestanding, independent clinical labs, BCBSAZ pays **100%** for covered services. |
| **Radiology Services**<br>(Facility charges) | **$100** 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 an inpatient at an acute hospital or while receiving treatment in the emergency room.<br><br>For all other radiology services, BCBSAZ pays **100%** for covered services. |
| **Other Professional Services**<br>Other professional services include diagnostic, surgical and anesthesia services rendered outside a provider's office. | BCBSAZ pays **100%** for covered services. |
| **Inpatient – Hospital†** | **$250** copay per member, per day (for a maximum of three copays) per admission. |
| **Outpatient Services other than Radiology**<br>(Facility charges) | **$100** copay for outpatient surgery (per member, per day). BCBSAZ pays **100%** for all other covered outpatient services. |
| **Emergency** | **$150** copay (per member, per provider, per day); emergency room copay is waived if member is admitted to the hospital. |
| **Urgent Care** | **In-state network urgent care centers**: **$50 copay** (per member, per provider, per day) at facilities specifically contracted as urgent care providers.<br><br>**Out-of-state**: 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. |
| **Ambulance** | BCBSAZ pays **100%** for covered services. |
| **Bariatric Surgery†**<br>(Inpatient and Outpatient) | **$1,000** copay (per member, per surgery) in addition to **$250** inpatient copay per member, per day (for a maximum of three copays) per admission or **$100** copay for outpatient surgery (per member, per day) depending on where surgery is performed. |
| **Prescription Medications at Retail and Mail Order Pharmacy**<br>Retail and mail order prescription medication copays and coinsurance do not count toward satisfaction of the out-of-pocket maximum. | **Retail Prescription Medications:**<br>**$10** Level One copay<br>**$25** Level Two copay<br>**$50** Level Three copay<br>**$80** Level Four copay<br><br>**Mail Order Prescription Medications:**<br>**$ 20** Level One copay<br>**$ 50** Level Two copay<br>**$100** Level Three copay<br>**$160** Level Four copay<br><br>Precertification is required for certain medications covered under the retail and mail order pharmacy benefit. A list of medications that require precertification and the process for obtaining precertification is available on the BCBSAZ Web site at 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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| **Specialty Self-Injectable Medications Through Specialty Pharmacy†**<br>For certain specified self-injectable prescription biologic medications.<br><br>Specialty self-injectable medications are not covered under the home health or retail and mail order medication benefit.<br><br>Precertification is required for all medications obtained under this benefit. | **$ 30** Level A copay<br>**$ 60** Level B copay<br>**$ 90** Level C copay<br>**$120** Level D copay<br><br>**Specialty self-injectable medication copays do not count toward satisfaction of the out-of-pocket maximum.**<br><br>Please refer to azblue.com or call BCBSAZ for a listing of specialty self-injectable medications and contracted specialty pharmacies. |
| **Home Health** | BCBSAZ pays **100%** for covered services.<br><br>Precertification is required for certain medications provided through the Home Health benefit. A list of medications that require precertification is available on the BCBSAZ Web site at azblue.com or by calling BCBSAZ at (602) 864-4320 or (800) 232-2345, ext. 4320. Otherwise covered eligible medications will not be covered if precertification is not obtained when required. |
| **Preventive Services**<br>• Certain Screening Services<br>• Immunizations<br>• Routine Physicals<br>• Mammography<br><br>Preventive services are those services performed for screening purposes when the member does not have active signs or symptoms of a condition, but does 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. | **$20/$30** copay (per member, per provider, per day), depending on whether services are received from a PCP or specialist.<br>**Physician office visit copays do not count toward satisfaction of the out-of-pocket maximum.** |
| **Maternity** | **Physician**: Office visit copay applies only to first prenatal visit. **Physician office visit copays do not count toward satisfaction of the out-of-pocket maximum.**<br><br>**Hospital**: **$250** copay per member, per day (for a maximum of three copays) per admission. |
| **Physical, Occupational and Speech Therapy (PT, OT and ST)** | **Physical/Occupational Therapy**: BCBSAZ pays **100%** for first **80** modalities or therapeutic services per member, per calendar year.<br><br>**Speech Therapy**: BCBSAZ pays **100%** for first **20** visits per member, per calendar year.<br><br>After the first **80** modalities or **20** visits, BCBSAZ pays **50%**, member pays **50%**, of the BCBSAZ allowed amount up to the **$2,500** per member, per calendar year out-of-pocket maximum. After the out-of-pocket maximum is met, BCBSAZ pays **100%** for covered services for the remainder of the calendar year. |
| **Chiropractic†**<br>**Chiropractic services must be provided and authorized exclusively by the chiropractic services administrator.** | **Chiropractic: $30** copay (per member, per visit). Benefits are available for **12** medically necessary chiropractic visits per member, per calendar year for the treatment of neck and back pain through the chiropractic services administrator.<br><br>**Chiropractic services copays do not count toward satisfaction of the out-of-pocket maximum.** |
| **Behavioral/Mental Health†**<br>Behavioral health services must be provided and authorized **exclusively** by the behavioral services administrator (BSA). | **Inpatient: $250** copay per member, per day (for a maximum of three copays) per admission, up to a maximum of **30** days per member, per calendar year.<br><br>**Outpatient:** Unlimited psychotherapy and counseling – **$15** copay per member, per visit.<br><br>**Behavioral health inpatient and outpatient copays do not count toward satisfaction of the out-of-pocket maximum.** |

| SUMMARY OF BENEFITS | |
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| **Skilled Nursing Facility†**<br>Limited to **90** days per member, per calendar year. | **$250** copay per member, per day (for a maximum of three copays) per admission for up to **90** days per member, per calendar year. |
| **Inpatient Extended Active Rehabilitation (EAR)†**<br>Limited to **60** days per member, per calendar year. | **$250** copay per member, per day (for a maximum of three copays) per admission for up to **60** days per member, per calendar year. |
| **Vision Exams (Routine)** | **$30** copay for one routine vision exam per member, per calendar year.<br>**Routine vision exam copays do not count toward satisfaction of the out-of-pocket maximum.** |

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

### Other Information:

- 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 this 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. 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 an in-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 or by calling BCBSAZ. These limitations include, but are not limited to, quantity, age and gender limitations. BCBSAZ prescription medication limitations are subject to change at any time without prior notice.
- Benefits for employees who reside in Massachusetts may change 1/1/09 due to Massachusetts state regulations.

**NOTE: THIS IS ONLY A BRIEF SUMMARY OF THIS BENEFIT PLAN. MORE DETAILED INFORMATION REGARDING BENEFITS, LIMITATIONS AND EXCLUSIONS IS IN THE BENEFIT PLAN BOOKLET AND IS AVAILABLE PRIOR TO ENROLLMENT UPON REQUEST. IF THE BENEFITS ON THIS SUMMARY DIFFER FROM THOSE STATED IN THE BENEFIT PLAN BOOKLET, THE TERMS OF THE BENEFIT PLAN BOOKLET APPLY.**

## 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 plan booklet 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 plan booklet under particular benefits
- Biofeedback and hypnotherapy, except as stated in the benefit plan
- Body art, piercing, tattooing and any related complications
- 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 – 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
- 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
- Medications dispensed in a provider's office – prescription medications and over-the-counter medications, including pharmaceutical manufacturer's samples, dispensed to the member in a provider's office
- Medications – 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, 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 noncontracted providers, except for emergencies
- 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
- Treatment for behavioral and mental health conditions in a non-acute facility, (such as residential or skilled nursing facilities)
- 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
- 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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