

HMO Plan

BlueSelect® Plan Two and Plan Three

Provider Information



An Independent Licensee of the Blue Cross and Blue Shield Association

BlueSelect is a Blue Cross Blue Shield of Arizona (BCBSAZ) Health Maintenance Organization (HMO) plan. **With BlueSelect, you are not required to have a primary care physician (PCP) direct your care.** You do not need a referral to see a specialist or other ancillary provider within the BlueSelect network. However, except for emergencies, all covered services must be provided by BlueSelect network providers. BlueSelect providers will file all claims for you. To see if your physician is in the BlueSelect network, check the provider directory on azblue.com or call BCBSAZ.

While traveling outside of Arizona, the BlueCard® Access program is available when you need urgent care services and/or authorized follow-up care.

- Contracted 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.
- BCBSAZ has negotiated various reimbursement methods with contracted providers. These providers have agreed to accept the BCBSAZ allowed amount for covered services provided to BCBSAZ members. This means that after payment of deductible, coinsurance or copay amounts, these providers will not bill you for the difference between the provider's billed charges and the BCBSAZ allowed amount for the services. However, when there is another source of payment, such as a liability insurer or government payer, providers may be entitled to collect from the other source or from proceeds received from the other source any difference between the providers billed charges and the BCBSAZ allowed amount.
- Reimbursement is based on the BCBSAZ allowed amount. The BCBSAZ allowed amount is generally calculated using the lesser of billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements.

BlueSelect Plan Two and Plan Three | HMO PLAN Benefit Summary

Except for emergency/accident situations, BlueSelect providers must be used for services to be covered.

	PLAN TWO	PLAN THREE
Deductible (Calendar-year) Applies to certain services as listed. Coinsurance applies after the deductible is met. Copays are not applied toward the deductible.	None.	Per person: \$1,000 Family maximum: \$2,000 Applies to inpatient facility charges.
Coinsurance ¹	Coinsurance applies to additional level of coverage on inpatient and outpatient rehabilitation services and skilled nursing facilities.	For certain services where indicated, BCBSAZ pays 80% , you pay 20% after meeting deductible, unless a different coinsurance percentage is indicated.
Out-of-Pocket Coinsurance Maximum ^{1,2} (Calendar-year)	A \$500 annual out-of-pocket coinsurance maximum per person applies to the additional level of coverage on physical, occupational and speech therapy services.	Per person: \$3,000 Family maximum: \$6,000
Physician Services – Office Visits ³ Primary care physician (PCP) – internal medicine, family practice, general practice or pediatrics. (OB/GYN physicians are specialists)	PCP: \$25 copay Specialist: \$40 copay	PCP: \$30 copay Specialist: \$40 copay
Preventive Care, Mammography, Routine Physical Exams	Services provided in the physician's office are subject to your office visit copay.	
Laboratory Services	BCBSAZ pays 100% .	

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Other Professional Services	BCBSAZ pays 100% . Covered services include diagnostic, surgical and anesthesia services rendered outside the doctor's office.																					
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Inpatient Hospital ⁵	\$ 750 copay per admission. \$1,500 calendar-year copay maximum per family.	Facility charges are subject to deductible and coinsurance.																				
Outpatient Surgery	\$200 copay per surgery.	You pay the lesser of a \$300 copay or the BCBSAZ price for the facility charge per surgery.																				
Urgent Care	In-state network urgent care centers: \$45 copay. Out-of-state: Call (800) 810-BLUE (2583) for assistance in finding the closest BlueCard® Access network provider. Services obtained through a BlueCard provider will be subject to the applicable urgent care copay. Services at non-network providers are not covered.	In-state network urgent care centers: \$50 copay.																				
Emergency or Accident	\$150 access fee (waived if admitted to hospital).	\$150 access fee (waived if admitted to hospital).																				
Maternity	Inpatient hospital copay per admission. Physician: office visit copay applies only to the first prenatal office visit. Normal prenatal, delivery and postpartum maternity care are covered only if the delivery occurs after the contract has been in force for 12 months. Complications of pregnancy are covered regardless of the delivery date.	Inpatient hospital deductible and coinsurance apply to facility admissions.																				
Physical, Occupational and Speech Therapy	Physical/Occupational Therapy: BCBSAZ pays 100% for covered services for first 80 modalities or therapeutic services per calendar year. Speech therapy: BCBSAZ pays 100% for first 20 visits per calendar year. After the first 80 modalities or 20 visits, BCBSAZ pays 50% ; you pay 50% of the BCBSAZ allowed amount up to the \$500 out-of-pocket coinsurance maximum per person per calendar year. After the out-of-pocket coinsurance maximum is met, BCBSAZ pays 100% for the remainder of the calendar year.	After the first 80 modalities or 20 visits, BCBSAZ pays 50% ; you pay 50% of the BCBSAZ allowed amount up to the out-of-pocket coinsurance maximum per person per calendar year. After the out-of-pocket coinsurance maximum is met, BCBSAZ pays 100% for the remainder of the calendar year.																				
Chiropractic Services	\$25 copay. Up to 12 visits per calendar year available only through the chiropractic services administrator.	\$30 copay.																				
Vision Exams (Routine) and Eyewear Discounts	PCP office visit copay for one routine eye exam per year when received through the vision services administrator ⁶ (VSA); discounts on eyewear.																					
Ambulance Services	BCBSAZ pays 100% .																					
Behavioral and Mental Health Services ⁵	Behavioral health services must be provided and authorized exclusively by the behavioral services administrator ⁶ (BSA). Outpatient: unlimited psychotherapy and counseling – \$15 copay per visit.																					
Inpatient: up to a maximum of 30 days per calendar year.	Inpatient: \$750 copay per admission.	Inpatient: Facility charges are subject to deductible and coinsurance. Coinsurance paid does not apply to the coinsurance maximum.																				

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Inpatient Rehabilitation Services ⁵	BCBSAZ pays 100% for up to 60 days. After 60 days, BCBSAZ pays 50% , you pay 50% up to an additional 60 days.	Facility charges: 80%/20% after meeting deductible, up to 60 days. After 60 days, BCBSAZ pays 50% ; you pay 50% , up to an additional 60 days which will not count toward the out-of-pocket coinsurance maximum.
	Limited to 120 days per calendar year.	
Home Health Services and Home Infusion - Medication Administration Therapy ⁷ Including specialty self-injectable medications.	BCBSAZ pays 100% .	
Skilled Nursing Facility ⁵	BCBSAZ pays 100% , up to 90 days. After 90 days, BCBSAZ pays 50% , you pay 50% up to an additional 90 days.	Facility charges: 80%/20% after meeting deductible, up to 90 days. After 90 days, BCBSAZ pays 50% ; you pay 50% , up to an additional 90 days which will not count toward the out-of-pocket coinsurance maximum.
	Limited to 180 days per calendar year.	
Specialty Self-Injectable Medications ⁵ For certain specified self-injectable prescription biologic medications. Specialty injectable medications are not covered under the retail or mail order medication benefit. (Also see Home Health.)	<u>Contracted Specialty Pharmacy (30-day supply)</u> BCBSAZ pays 100% . Please refer to azblue.com for a listing of specialty injectable medications and contracted specialty pharmacies or call BCBSAZ. Injectable medications are also available from home health providers.	

- 1 Coinsurance is a percentage you must pay after you have met any applicable calendar-year deductible. Coinsurance is based on the BCBSAZ allowed amount.
- 2 The coinsurance maximum is the maximum amount you pay in coinsurance each year before BCBSAZ pays 100 percent of the BCBSAZ allowed amount for covered services. Copays still apply, even if the coinsurance maximum has been reached. Copays, access fees and deductibles are not applied toward the out-of-pocket coinsurance maximum.
- 3 Office visit copays are required for covered services in a physician's office except as otherwise specified. Immunizations and allergy injections received in the physician's office will be paid at 100 percent of the BCBSAZ allowed amount and do not require a copay unless other services are received during the same visit. Only one copay per person, per provider, per day will be collected.
- 4 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.
- 5 Precertification is required. If precertification is not obtained, services will be subject to denial of benefits.
- 6 Services are available only in Arizona.
- 7 Precertification is required for certain medications provided through the Home Health and Home Infusion - Medication Administration Therapy benefit. A list of medications requiring 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.

Exclusions and Limitations – Examples of Services and Supplies Not Covered

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. A complete list of all benefits, limitations and exclusions is in the contract booklet and is available prior to enrollment upon request.

- Abortions except as stated in the contract
- Activity therapy
- Acupuncture
- Alternative medicine, non-traditional 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
- Cosmetic or aesthetic surgery and services, except for breast reconstruction following a medically necessary mastectomy in accordance with state and/or federal law
- Costs paid by other organizations - costs/services customarily paid for by an employer, the government, biotechnical, pharmaceutical or medical device industry sources or other individuals or organizations including, but not limited to worksite or ergonomic evaluations
- Counseling or behavioral medication services except as stated in the contract.
- Court-ordered services – testing, treatment or therapy except as stated in the 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 stated in the contract
- Environmental medicine
- Fees other than for medically appropriate in-person, direct patient treatment, tests, services, medications, supplies or equipment
- Fertility or infertility treatment, medications or procedures
- Foot care
- Genetic/chromosome testing and screening
- Government services – services available under a governmental health program
- Growth hormone(s) – Growth hormone except as determined medically necessary by BCBSAZ to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat Idiopathic Short Stature (ISS) is expressly excluded
- Hearing services or devices
- Inpatient treatment for substance abuse, except for detoxification
- Investigational treatments, procedures, equipment, medications, devices or supplies, as determined by BCBSAZ and only as required by Arizona law
- Lodging and meals
- Manipulations of the spine under anesthesia
- Massage therapy except as stated in the contract
- Medications dispensed in a physician's/provider's office – prescription medications and over-the-counter medications, including pharmaceutical manufacturer's samples, dispensed to the patient in a physician's/provider's office by any mode of administration
- Medications for off-label, unlabeled or orphan medications (orphan medications are used for diagnosis, treatment or prevention of a rare disease or condition) unless otherwise specified by BCBSAZ medical or prescription medication coverage guidelines. This does not include medications used for the treatment of cancer.
- Nonmedically necessary services as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Normal maternity services when delivery occurs prior to completion of the 12-month waiting period
- Over-the-counter medications – any medication, device, equipment or supply (except for certain diabetic supplies and inhaler spacers, as described in the pharmacy benefit) that is lawfully obtainable without a prescription
- Personal comfort items
- Screening tests, except as specifically described in the contract
- 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 without a prescription, when a prescription is required
- Services of ineligible providers
- Services not requiring licensed professional
- Services or supplies delivered prior to the coverage effective date or after coverage termination date
- Services or supplies related to or associated with a noncovered service or supply
- Sexual dysfunction – evaluation and/or testing, diagnosis, treatment (surgical or nonsurgical), or medication or devices for sexual dysfunction, regardless of the cause of the condition, including trauma
- Smoking cessation programs, medications, aids or devices
- Strength training, cardiovascular endurance training, fitness/strengthening programs and/or other services primarily designed to improve or increase fitness
- Telephonic or electronic consultations
- Therapy services except as stated in the contract
- Training and education, except for certain diabetes and asthma training or training related to BCBSAZ-established disease management program(s)
- Transplants (organ, tissue, bone marrow/peripheral stem cell rescue procedures) not approved by BCBSAZ; nor high-dose chemotherapy, radiation administered or other related services administered in conjunction with a noncovered transplant
- Transport services or travel expenses, except as stated in the contract
- Transsexual treatment or surgery, and/or any related services
- Treatment for behavioral or mental health conditions at non-acute facilities (e.g., residential, skilled nursing)
- Vision therapy, radial keratotomy, all types of refractive keratoplasties, eyeglasses and contact lenses and the vision examination for prescribing and fitting of the same
- Vitamins – except for certain vitamins, as determined by BCBSAZ, when a prescription is written by a physician
- Weight loss/gain therapy or treatment except as stated in the contract
- When a provider is also the covered person, services rendered by that provider for him/herself are excluded from coverage
- Workers' Compensation – services for an illness or injury covered by Workers' Compensation or similar benefits, unless you are exempt from such coverage or have made a statutory opt-out election
- **AN 11-MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS APPLIES.** A pre-existing condition is defined as a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months before your effective date. Services for pre-existing conditions are not covered until 11 consecutive months after the contract effective date.

Important Note

This is only a brief summary of benefits and exclusions. Please refer to the specific provisions found within the contract booklet for complete information on benefits, limitations and exclusions. If the benefits on this summary differ from those stated in the contract booklet, the terms of the contract booklet apply. There is no guarantee of continued benefits outlined in this summary 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.