

# HMO Plan

## BlueSelect® Plan Three

### NETWORK PROVIDERS

Except for emergencies, all covered services must be rendered by a network provider. Network providers are health care providers who have an HMO contract with BCBSAZ. Network providers will file your claims with BCBSAZ.

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.

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.

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.

BCBSAZ reimburses network providers the allowed amount, minus any portion allocated to member cost-share. 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.

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 Three | HMO Benefit Summary

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

<b>Deductible (Calendar-year)</b> Copays do not count toward meeting the deductible.	<b>\$1,000 per member \$2,000 family</b>  Applies to certain services as listed. Coinsurance applies after the deductible is met.
<b>Coinsurance</b> Coinsurance is based on the allowed amount and not on a provider's billed charges.	For certain services where indicated, BCBSAZ pays <b>80%</b> , you pay <b>20% (80%/20%)</b> of the allowed amount after meeting deductible, unless a different coinsurance percentage is indicated.
<b>Out-of-Pocket Coinsurance Maximum (Calendar-year)</b>	<b>\$3,000 per member \$6,000 per family</b> The out-of-pocket coinsurance maximum is a maximum liability for coinsurance only 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 coinsurance maximum. The cost share obligations that do not count include deductibles, copays, certain other charges listed in the benefit plan booklet, and amounts paid for noncovered services. To determine whether a specific cost share payment counts toward the maximum, refer to the benefit plan booklet. You must continue to pay all these cost share amounts even after meeting the maximum.
<b>Physician Services - Office Services</b> Primary care physicians (PCP) include internal medicine, family practice, general practice and pediatrics. All other physicians are specialists.	PCP: <b>\$30</b> copay per member, per provider, per day. Specialist: <b>\$40</b> copay per member, per provider, per day.  BCBSAZ does not require your PCP to refer you to specialists. Some specialists may still require a referral.
<b>Urgent Care</b>	<b>In-state network urgent care centers:</b> \$50 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>Preventive Services</b> <ul style="list-style-type: none"> <li>Certain Screening Services</li> <li>Immunizations</li> <li>Routine Physicals</li> <li>Mammography</li> </ul>	Services provided in the physician's office are subject to the office visit copay.  Preventive services are those services performed for screening purposes when the member does not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition. This is determined by the diagnosis submitted by the provider.

## BlueSelect Plan Three | HMO Benefit Summary

<b>Laboratory Services</b>	In a physician's office BCBSAZ pays <b>100%</b> , office visit copay waived if the only services you receive during your visit are laboratory services. At contracted, free standing, independent clinical labs, BCBSAZ pays <b>100%</b> for covered 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 the physician's office.										
<b>Retail and Mail Order Pharmacy<sup>1</sup></b> 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 the BCBSAZ Prescription Benefits Unit. 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.	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><u>Retail pharmacy</u></td> <td style="width: 50%;"><u>Mail order pharmacy</u></td> </tr> <tr> <td>Level 1: \$ <b>15</b> copay</td> <td>\$ <b>15</b> copay</td> </tr> <tr> <td>Level 2: \$ <b>40</b> copay</td> <td>\$ <b>80</b> copay</td> </tr> <tr> <td>Level 3: \$ <b>70</b> copay</td> <td>\$<b>210</b> copay</td> </tr> <tr> <td>Level 4: \$<b>120</b> copay</td> <td>\$<b>360</b> copay</td> </tr> </table> <p>If a pharmacy's regular price for a prescription medication is less than your copay, some pharmacies may charge you the lower price. You will never have to pay more than your copay.</p>	<u>Retail pharmacy</u>	<u>Mail order pharmacy</u>	Level 1: \$ <b>15</b> copay	\$ <b>15</b> copay	Level 2: \$ <b>40</b> copay	\$ <b>80</b> copay	Level 3: \$ <b>70</b> copay	\$ <b>210</b> copay	Level 4: \$ <b>120</b> copay	\$ <b>360</b> copay
<u>Retail pharmacy</u>	<u>Mail order pharmacy</u>										
Level 1: \$ <b>15</b> copay	\$ <b>15</b> copay										
Level 2: \$ <b>40</b> copay	\$ <b>80</b> copay										
Level 3: \$ <b>70</b> copay	\$ <b>210</b> copay										
Level 4: \$ <b>120</b> copay	\$ <b>360</b> copay										
<b>Inpatient Hospital<sup>2</sup></b>	<b>80%/20%</b> after meeting deductible.										
<b>Radiology</b>	In a physician's office, applicable office visit copay applies. BCBSAZ pays <b>100%</b> for covered services at other facilities.										
<b>Outpatient Services Other than Radiology</b>	\$ <b>300</b> copay for outpatient surgery per member, per day. BCBSAZ pays <b>100%</b> for all other covered outpatient services.										
<b>Emergency</b>	\$ <b>150</b> copay per member, per provider, per day. Emergency room copay is waived if you are admitted to hospital.										
<b>Maternity</b>	<b>Inpatient: 80%/20%</b> after meeting deductible. <b>Physician:</b> office visit copay applies only to the first prenatal office visit. Normal prenatal, delivery and postpartum maternity care are covered only for maternity services received <u>after</u> the benefit plan has been in force for <b>12</b> months. Services to treat complications of pregnancy, as defined by BCBSAZ medical coverage guidelines, are not subject to the 12-month waiting period.										
<b>Physical, Occupational and Speech Therapy</b>	<b>Physical/Occupational Therapy:</b> BCBSAZ pays <b>100%</b> for covered services 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> , you pay <b>50%</b> of the allowed amount up to the out-of-pocket coinsurance maximum per member, per calendar year. After the out-of-pocket coinsurance maximum is met, BCBSAZ pays <b>100%</b> for the remainder of the calendar year.										
<b>Chiropractic</b>	\$ <b>30</b> copay per member, per visit. Benefits are available for <b>12</b> medically necessary chiropractic visits for treatment of neck and back pain. Chiropractic services must be provided and authorized exclusively by the chiropractic services administrator.										
<b>Vision Exams (Routine)</b>	\$ <b>30 copay</b> for one routine eye exam per member, per calendar year.										
<b>Ambulance Services</b>	BCBSAZ pays <b>100%</b> for covered services.										
<b>Behavioral and Mental Health Services<sup>2</sup></b> Behavioral health services must be provided and authorized <b>exclusively</b> by the behavioral services administrator <sup>3</sup> (BSA).	<b>Outpatient:</b> psychotherapy and counseling - \$ <b>15</b> copay per member, per visit.  <b>Inpatient:</b> <b>80%/20%</b> after meeting deductible, up to a maximum of <b>30</b> days per member, per calendar year. Coinsurance paid does not count toward the out-of-pocket coinsurance maximum.										
<b>Inpatient Rehabilitation Services<sup>2</sup></b>	<b>80%/20%</b> after meeting deductible up to <b>60</b> days. After <b>60</b> days, BCBSAZ pays <b>50%</b> , you pay <b>50%</b> up to an additional <b>60</b> days which will not count toward the out-of-pocket coinsurance maximum. Coverage is limited to <b>120</b> days per member, per calendar year.										
<b>Home Health<sup>1</sup></b>	BCBSAZ pays <b>100%</b> for covered services. Certain injectable medications are also available through the specialty injectable medication benefit.										
<b>Skilled Nursing Facility<sup>2</sup></b>	<b>80%/20%</b> after meeting deductible up to <b>90</b> days. After <b>90</b> days, BCBSAZ pays <b>50%</b> , you pay <b>50%</b> up to an additional <b>90</b> days which will not count toward the out-of-pocket coinsurance maximum. Coverage is limited to <b>180</b> days per member, per calendar year.										
<b>Specialty Self-Injectable Medications through Specialty Pharmacy<sup>1</sup></b> For certain specified self-injectable prescription biologic medications. Specialty self-injectable medications are not covered under the retail and mail order medication benefit.	Contracted Specialty Pharmacy BCBSAZ pays <b>100%</b> .  Please refer to azblue.com for a listing of specialty self-injectable medications and contracted specialty pharmacies or call BCBSAZ.										
<b>Bariatric Surgery<sup>2</sup></b>	\$ <b>1,000</b> copay per member, per surgery in addition to deductible and coinsurance or outpatient surgery copay depending on where surgery is performed.										

## BlueSelect Plan Three | HMO Benefit Summary

- <sup>1</sup> 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.
- <sup>2</sup> Precertification is required. If precertification is not obtained, services will not be covered.
- <sup>3</sup> Services are available only in Arizona.

### Explanatory Notes:

- 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.
- This is only a brief summary of benefits and exclusions. Please refer to the specific provisions found within the benefit plan booklet for detailed information about benefits, limitations and exclusions. If the benefits listed in this summary differ from those stated in the benefit plan booklet, the terms of the benefit plan booklet apply. There is no guarantee of continued benefits outlined in this summary or the benefit plan booklet. The benefit plan may be amended, and benefits may be added, deleted or changed by BCBSAZ upon 31 days' notice to the policy holder.

## 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. 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
- 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 and 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 provided at no charge to the member through a governmental program or facility
- Growth hormone, except as specified in BCBSAZ Medical Coverage Guidelines, and growth hormone to treat Idiopathic Short Stature (ISS)
- Hearing services and devices, except as stated in the benefit plan
- Inpatient treatment for substance abuse, except for detoxification
- 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
- Manipulation of the spine under anesthesia
- Massage therapy, except in limited circumstances as described in the BCBSAZ Medical Coverage Guidelines
- Maternity, except as stated in the benefit plan
- Medications dispensed in a provider's office – prescription medications and over-the-counter medications, including pharmaceutical manufacturers' samples, dispensed to the member in a provider's office
- Medications which are:
  - Not FDA approved
  - Not required by the FDA to be obtained with a prescription
  - Not used in accordance with 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 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/her are excluded from coverage.
- Services from ineligible providers
- Services paid for by other organizations
- Services provided prior to effective date
- 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 related to or associated with noncovered services
- Services without a prescription when a prescription is required
- Services for sexual dysfunction, regardless of the cause, and all medications for the treatment of sexual dysfunction
- 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, 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