

**BlueSelect**  
Plan Comparison



An Independent Licensee of the  
Blue Cross and Blue Shield Association

Benefits	BlueSelect HMO Plan 10	BlueSelect HMO Plan 20
PCP Office Visits	\$10 copayment	\$20 copayment
Specialist Office Visits	\$20 copayment	\$30 copayment
Lab & X-ray	100% for covered services	100% for covered services
Hospital Services Inpatient Outpatient	100% for covered services 100% for covered services	\$500 copayment per admission, \$1000 family maximum 100% for covered services
Emergency Room	\$100 access fee	\$100 access fee
Urgent Care	\$25 copayment	\$25 copayment
Prescription Drugs Generic	\$10 copayment	\$10 copayment
Preferred Brand	\$25 copayment	\$25 copayment
Non-Preferred Brand "A"	\$50 copayment	\$50 copayment
Non-Preferred Brand "B"	\$80 copayment	\$80 copayment
<b>Physical, Occupational &amp; Speech Therapy</b>	<p>Any combination of <b>Physical/Occupational Therapy</b>: 100% for covered services, up to 80 modalities and/or therapeutic services per calendar year (the average number of modalities or services performed per visit is four). Additional visits <u>exceeding these limits</u> are available, subject to 50% coinsurance, up to a \$500* out-of-pocket maximum per calendar year.</p> <p><b>Speech Therapy</b>: 100% for covered services, up to 20 visits per calendar year. Additional visits <u>exceeding these limits</u> are available, subject to 50% coinsurance, up to a \$500* out-of-pocket maximum per calendar year.</p> <p>*After the \$500 out-of-pocket maximum is met, benefits will be paid at 100% for covered services.</p>	
Preventive Care	100% for covered services, after office visit copayment	100% for covered services, after office visit copayment
Behavioral Health – Biodyne Exclusive Inpatient Outpatient	100% for covered services, up to 30 days per 24 months \$10 copayment per visit, up to a maximum of \$100 per person, \$200 maximum per family	Up to 30 days per 24 months; \$500 copayment per admission, \$10 copayment per visit, up to a maximum of \$100 per person, \$200 maximum per family
Vision - Avesis Exclusive	\$10 copayment, 1 exam per year Eyewear discounts available	\$20 copayment, 1 exam per year Eyewear discounts available

Note: Except for emergency/accident situations, in-network providers must be used for services to be covered.

Precertification is required for some services. If precertification is not obtained, benefits may be denied.

# Exclusions & 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 listing of all benefits, limitations and exclusions is in the benefit plan booklet and is available prior to enrollment upon request.

- Abortions (nonspontaneous, medically induced)
- Activity therapy
- Acupuncture
- Alternative medicine, including naturopathic and homeopathic medicine
- Biofeedback and/or hypnotherapy
- Cognitive and vocational therapy
- Complications of body piercing/tattooing
- Complications of noncovered benefits
- Cosmetic or aesthetic procedures, except for breast reconstruction following a medically necessary mastectomy in accordance with state and/or federal law
- Counseling or behavioral modification services
- Court-ordered services – testing, treatment or therapy, unless such services are otherwise covered under this benefit plan
- Custodial care, except for limited hospice benefits
- Dental/orthodontic services or supplies
- Dietary and nutritional supplements or special foods or diets, even if prescribed by a physician or other eligible provider, except for specific medical foods to treat inherited metabolic disorders in accordance with Arizona law, as described in the “Medical Foods” section of the benefit plan 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 government health program
- Hearing services or devices – hearing aid services and supplies, and hearing exams, except for routine hearing screening that may be included in covered physical exams, including external, semi-implantable middle ear and implantable bone conduction hearing aids
- Inpatient treatment for substance abuse, except for detoxification.
- Investigational treatments, procedures, equipment, drugs, devices or supplies, as determined by BCBSAZ, except as required by Arizona law
- Lodging and meals, except for covered transplant travel benefits
- 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. This does not include eligible injectable drugs administered in the physician’s office
- Nonmedically necessary services, as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Over-the-counter drugs – any drug, medicine, device, equipment, 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 this benefit plan
- Services or supplies delivered prior to the coverage effective date or after the coverage termination date
- Services or supplies related to or associated with a noncovered service or supply
- 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 a licensed professional
- Sexual dysfunction – evaluation and/or testing, diagnosis, treatment (surgical or non-surgical), or medication or devices for sexual dysfunction, regardless of the cause of the condition, including trauma
- Smoking cessation programs, medications or devices, except as otherwise stated in the benefit plan
- Telephonic or electronic consultations
- Therapy services, except as expressly provided in this benefit plan
- Training and education, except for certain diabetic 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 or radiation administered in conjunction with a noncovered transplant
- Transport services or travel expenses, except for covered ambulance services and covered transplant travel benefits
- Transsexual treatment or surgery and/or any related services
- Treatment for behavioral/mental health conditions in 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, except as otherwise stated as a benefit in the benefit plan
- Vitamins – except for certain vitamins when a prescription is written by a physician
- Weight loss/gain therapy or treatment, including but not limited to, Xenical® and Meridia® (except for certain surgical services)
- 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

**Note: This is only a brief summary of benefits and exclusions. Please refer to the specific provisions found within the benefit plan booklet for complete information on benefits, limitations and exclusions. If the benefits on this summary differ from those stated in the benefit plan booklet, the terms of the benefit plan booklet apply.**

When a service or supply is subject to coinsurance, the coinsurance amount is based on the BCBSAZ allowed amount.

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

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 BCBSAZ subscribers. This means that after payment of deductible, coinsurance or copayment amounts, these providers will not bill subscribers for the difference between the BCBSAZ allowed amount and the provider's billed charge for the service. However, when there is another source of payment, such as a liability insurer, government 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 charge, pursuant to A.R.S. § 33-931.

Certain injectable drugs are subject to precertification. Injectable drugs not covered at a retail pharmacy may be covered under medical benefits and are subject to BCBSAZ medical necessity guidelines.

If the plan has a tiered pharmacy benefit and the price BCBSAZ pays a contracted pharmacy for a drug is less than the copayment, most pharmacies will charge the BCBSAZ price. However, some pharmacies will charge their usual and customary price (if also less than the copayment), rather than the BCBSAZ price. When using the BCBSAZ ID card, a member will never be required to pay more than their copayment for a level 1, 2, 3 or 4 drug at a contracted pharmacy.

For certain prescription drugs indicated in the prescription medication guide, the quantity of medication covered per coinsurance/copayment may be limited by dose or by the number of units, even though a physician may prescribe a higher dose or greater number of units.