

PPO

Base Plan 500

Northern Arizona Public Employee Benefit Trust
(NAPEBT)

Group #19676

Effective 07/01/08

Summary of Benefits



PPO Base Plan 500

Provider Alternatives - Out-of-pocket costs will differ depending on which type of provider is selected.

<p>PPO Providers (in-network providers)</p>	<p>These providers have agreed to accept the BCBSAZ allowed amount for covered services and will file claims to BCBSAZ for members. Out-of-pocket costs are lower when Preferred providers are used.</p> <p>Preferred providers are also available outside Arizona through the BlueCard® program. To locate BlueCard PPO providers, call (800) 810-BLUE or check the BlueCard Doctor and Hospital Finder at bcbs.com.</p>
<p>NonPreferred Providers (out-of-network providers)</p> <p style="text-align: center;">Participating Providers (Non-Preferred)</p> <p style="text-align: center;">Noncontracted Providers (Non-Preferred)</p>	<p>Members pay higher cost-sharing when they use nonPreferred providers. There are two types of nonPreferred providers.</p> <p>Arizona health care providers who are not contracted for BCBSAZ's PPO plans but are part of the BCBSAZ Participating provider network. Although members will pay higher cost-sharing, these providers have agreed to accept the BCBSAZ allowed amount for covered services and will file claims to BCBSAZ for members.</p> <p>Participating providers are also available outside Arizona through the BlueCard program, and some Participating hospitals are available outside the U.S. To locate BlueCard providers, call (800) 810-BLUE or check the BlueCard Doctor & Hospital Finder at bcbs.com.</p> <p>Providers who have no contract with BCBSAZ. In addition to any applicable coinsurance and deductible, noncontracted providers may charge members their full billed charges. After insurance reimbursement based on the BCBSAZ allowed amount, members are responsible to pay the difference between the provider's billed charges and the BCBSAZ allowed amount ("the balance bill"). The obligation to pay this difference continues even after the member reaches the out-of-pocket coinsurance maximum. Members will have more out-of-pocket expense, and noncontracted providers are not obligated to file claims for members.</p>

- 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. Contracted 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 covered services. However, when there is another source of payment, such as a liability insurer or government payer, contracted providers may be entitled to collect from the other source or from proceeds received from the other source, any difference between the provider's billed charges and the BCBSAZ allowed amount.
- Reimbursement to both members and providers is based on the BCBSAZ allowed amount and not on billed charges or a customary fee. For Arizona providers, the BCBSAZ allowed amount is generally calculated using the lesser of billed charges or the applicable BCBSAZ fee schedule, including any contractual arrangements. For out-of-state providers, the BCBSAZ allowed amount is generally calculated using the prevailing fee from the Blue Cross and/or Blue Shield plan in the state where services are received. For emergency services only: When the provider is a noncontracted provider (either in Arizona or out-of-state), the BCBSAZ allowed amount is based on billed charges. **All noncontracted providers may bill you up to their full billed charges.**

Summary of Benefits

Summary of Benefits	Preferred Provider In-Network	NonPreferred Provider Out-of-Network
Deductible Deductible must be met for all covered services unless otherwise stated.	\$500 per person calendar-year deductible; \$1,000 family calendar-year deductible maximum.	\$1,000 per person calendar-year deductible; \$2,000 family calendar-year deductible maximum.
Coinsurance * This is a percentage members must pay for covered services after meeting the calendar-year deductible. Members will pay a higher coinsurance percentage when using a nonPreferred provider. Coinsurance is based on the BCBSAZ allowed amount and not on a provider's billed charges.	Plan pays 80%/ member pays 20% of the BCBSAZ allowed amount for most covered services , after meeting deductible, unless a different coinsurance percentage is indicated below.	Plan pays 60%/ member pays 40% of the BCBSAZ allowed amount for most covered services , after meeting deductible, unless a different coinsurance percentage is indicated below.
Out-of-Pocket Coinsurance Maximum*	\$3,000 per person, \$6,000 family , per calendar year. The out-of-pocket coinsurance maximum is a maximum liability for coinsurance only, and is based on the BCBSAZ allowed amount rather than a provider's billed charges. Deductibles, copays, access fees, and amounts paid for noncovered services and noncontracted providers' balance bills, do not count toward satisfaction of the maximum. Even after reaching the maximum, the member remains responsible for noncontracted providers' balance bills (the difference between a noncontracted provider's billed charges and the BCBSAZ allowed amount).	\$5,000 per person, \$10,000 family , per calendar year.
Physician Services- Primary Care Physician (PCP) Office Services Primary Care Physicians (PCP) includes Family Practice, General Practice, Internal Medicine and Pediatrics. All other physicians are specialists.	\$20 copay (per person, per provider, per day) for most covered services provided in a physician's office. 80%/20% for other covered services, after meeting deductible.	60%/40% after meeting deductible
Physician Services- Specialist Office Services	\$40 copay (per person, per provider, per day) for most covered services provided in a physician's office. 80%/20% for other covered services, after meeting deductible.	
Laboratory Services	In a physician's office, applicable office visit copay applies. At contracted, freestanding, independent clinical labs, Plan pays 100% for covered services, deductible waived. At all other facilities, deductible and coinsurance apply.	60%/40% after meeting deductible
Radiology Services	In a physician's office, applicable office visit copay applies. At all other facilities, 80%/20% after meeting deductible	60%/40% after meeting deductible
Other Professional Services Covered services include diagnostic, surgical and anesthesia services rendered outside the physician's office.	80%/20% after meeting deductible	60%/40% after meeting deductible
Inpatient – Hospital†	80%/20% after meeting deductible	60%/40% after meeting deductible
Outpatient Services (Facility charges)	80%/20% after meeting deductible	60%/40% after meeting deductible
Emergency Room	\$100 access fee (per person, per provider, per day); then 80%/20% , after meeting deductible; emergency room access fee is waived if member is admitted to the hospital.	
Urgent Care	\$50 copay (per person, per provider, per day)	60%/40% after meeting deductible
Ambulance	80%/20% , deductible waived	
Bariatric Surgery†	\$1,000 access fee, 80%/20% after meeting deductible	\$1,000 access fee, 60%/40% after meeting deductible

<p>Prescription Medications at Retail and Mail Order Pharmacy</p>	<p>\$7 Level One copay \$20 Level Two copay \$40 Level Three copay \$80 Level Four copay</p> <p>Mail order is only available through the Preferred mail order provider.</p> <p>Mail Order Prescription Medications: 2X the applicable copay level for up to a 90-day supply of a maintenance medication.</p> <p>†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.</p>	<p>When a member fills a prescription at a noncontracted retail pharmacy, in addition to the applicable prescription medication copay, the member is also responsible for the difference between a noncontracted pharmacy's price and BCBSAZ's allowed amount.</p> <p>Mail order is not covered through a nonPreferred provider.</p>
<p>Specialty Self-Injectable Medications Through Specialty Pharmacies† For certain specified self-injectable prescription biologic medications.</p> <p>Specialty self-injectable medications are not covered under the retail and mail order pharmacy benefit.</p>	<p>\$30 Level A copay \$60 Level B copay \$90 Level C copay \$120 Level D copay</p> <p>Please refer to azblue.com or call BCBSAZ for a listing of specialty-self injectable medications and contracted specialty pharmacies. Injectable medications are also available from home health providers subject to deductible and coinsurance. See Home Health.</p>	<p>Not covered at nonPreferred specialty pharmacies.</p> <p>Specialty self-injectable medications are only available from nonPreferred providers through the home health benefit. See Home Health.</p>
<p>Home Health</p>	<p>80%/20% after meeting deductible Certain injectable medications are also available through the specialty self-injectable medication benefit.</p> <p>†Precertification is required for certain medications provided through the Home Health 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.</p>	<p>60%/40% after meeting deductible</p>
<p>Preventive Care</p> <ul style="list-style-type: none"> Well child care Well woman care Well man care 	<p>\$20/\$40 copay (per person, per provider, per day) for covered services provided in a physician's office, depending on whether services are received from a PCP or specialist.</p> <p>100% for covered services provided outside the physician's office deductible waived</p>	<p>60%/40% after meeting deductible</p>
<p>Routine Physicals</p>	<p>\$20/\$40 copay (per person, per provider, per day) for covered services provided in a physician's office, depending on whether services are received from a PCP or specialist.</p> <p>100% for covered services provided outside the physician's office deductible waived</p>	<p>Not covered.</p>
<p>Colonoscopy & Sigmoidoscopy</p>	<p>100% deductible waived</p>	<p>60%/40% after meeting deductible</p>
<p>Mammography</p>	<p>100% deductible waived</p>	<p>60%/40% deductible waived</p>
<p>Maternity</p> <p>Physician</p> <p>Hospital</p>	<p>Office visit copay applies only to first prenatal visit. Calendar-year deductible and coinsurance are waived on physician's global delivery fee.</p> <p>80%/20% after meeting deductible</p>	<p>Physician and Hospital: 60%/40% after meeting deductible</p>

Skilled Nursing Facility† Both in- and out-of-network admissions count toward the 180-day per person calendar year limit.	80%/20% after meeting deductible, for up to 90 days. After 90 days, Plan pays 50% , member pays 50% up to an additional 90 days, which will not count toward out-of-pocket coinsurance maximum. Limited to 180 days per person, per calendar year.	60%/40% after meeting deductible, for up to 90 days. After 90 days, Plan pays 50% , member pays 50% , up to an additional 90 days, which will not count toward out-of-pocket coinsurance maximum.
Inpatient Extended Active Rehabilitation† Both in- and out-of-network admissions count toward the 120-day per person calendar year limit.	80%/20% after meeting deductible, for up to 60 days. After 60 days, Plan pays 50% , member pays 50% , up to an additional 60 days, which will not count toward out-of-pocket coinsurance maximum. Limited to 120 days per person, per calendar year.	60%/40% after meeting deductible, for up to 60 days. After 60 days, Plan pays 50% , member pays 50% , up to an additional 60 days, which will not count toward out-of-pocket coinsurance maximum.
Physical -Occupational & Speech Therapy	80%/20% after meeting deductible	60%/40% after meeting deductible
Chiropractic	\$40 copay (per person, per provider, per day) for most covered services provided in a chiropractic physician's office. 80%/20% for other covered services, after meeting deductible. Maximum of 12 chiropractic visits per person, per calendar year. Both in- and out-of-network visits count toward the 12 visit limit.	60%/40% after meeting deductible
Behavioral/Mental Health† Both in- and out-of-network admissions count toward the 2-admission, 30 day per person, per calendar year limit. Cost-sharing for behavioral/mental health does not apply to any out-of-pocket coinsurance maximum.	Inpatient: Two admissions per person, per calendar year (up to a combined total of 30 days). Preferred provider: 80%/20% after meeting deductible NonPreferred provider: Plan pays 50% , member pays 50% , after meeting deductible Outpatient: Member may choose Preferred or NonPreferred providers or the behavioral services administrator (BSA). Preferred/NonPreferred providers: Plan pays 50% , member pays 50% , after meeting deductible, with a maximum of 52 psychological sessions per person, per calendar year BSA: unlimited psychotherapy and counseling: \$15 copay per person, per visit. Services are available only in Arizona.	
Benefit Plan Maximum	\$5,000,000 maximum benefit while the benefit plan is in force. All payments by Plan (for both Preferred and NonPreferred providers) apply toward the benefit plan maximum.	

†Precertification is required. If precertification is not obtained, services will be subject to an additional \$300 deductible or denial of benefits.
* In addition to any applicable deductible and coinsurance, noncontracted providers may charge members their full billed charges. After insurance reimbursement based on the BCBSAZ allowed amount, members are responsible to pay the difference between the noncontracted provider's billed charges and the BCBSAZ allowed amount (the balance bill). The obligation to pay this difference continues even after the member's out-of-pocket coinsurance maximum is met. Deductibles, copays, access fees and amounts the member pays for noncovered services and noncontracted providers' balance bills do not count toward the out-of-pocket coinsurance maximum.

Important Information:

- 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 specific criteria that is 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.
- The "out-of-pocket coinsurance maximum" is a maximum liability for coinsurance only, and is based on the BCBSAZ allowed amount rather than a provider's billed charges. Deductibles, copays, access fees, and amounts paid for noncovered services and noncontracted providers' balance bills, do not count toward satisfaction of the maximum. Even after reaching the maximum, the member remains responsible for noncontracted providers' balance bills (the difference between a noncontracted provider's billed charges and the BCBSAZ allowed amount).
- Precertification is the process BCBSAZ uses to determine eligibility for certain requested procedures or services. For example: Except for an emergency, hospital services require precertification. Member is responsible for making sure his/her physician obtains appropriate precertification approval. If precertification is not obtained, the member's benefits may be subject to an additional \$300 deductible or denial of benefits. 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 contracted 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 contracted 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 on-line 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.

A 12 MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS MAY APPLY. 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 six (6) month period immediately preceding the member's enrollment date. For purposes of determining a pre-existing condition waiting period, enrollment date means the member's effective date of coverage under this benefit plan or the first day of the group's eligibility waiting period, whichever is earliest. IMPORTANT: Pregnancy is not considered a pre-existing condition. Credit will be given for periods of prior creditable coverage as long as there was no period of sixty-three (63) days or more (excluding group eligibility waiting periods) during which members were not covered under any creditable coverage. Creditable coverage is coverage provided under a group health plan (insured or self-insured), an individual insurance policy, Medicare, Medicaid, a public health plan (i.e., AHCCCS), a health risk benefits pool, TRICARE, Peace Corps, bonafide association, Indian Health Service, the Federal Employee Health Benefits Plan or the State Childrens Health Insurance Plan. Members have the right to demonstrate to BCBSAZ that they have had prior creditable coverage by providing a Certificate of Creditable Health Coverage or other documentation of such coverage. BCBSAZ can calculate creditable coverage prior to member's effective date upon request. Please call our Membership Services Department at 602-864-4456 if you need additional information.

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 & 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, nontraditional or alternative medical therapies, including but not limited to naturopathic and homeopathic medicine, diet therapies, nutritional or lifestyle therapies, aromatherapy
- Biofeedback and 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 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 modification services, except as stated in the benefit plan
- Court-ordered services – testing, treatment or therapy, except as stated in the benefit plan
- Custodial care except for limited hospice benefits
- Dental/orthodontic services and 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 benefit plan
- Environmental medicine
- Fees other than for medically appropriate in-person, direct patient treatment, tests, services, medications, supplies and 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 and devices, except as stated in the benefit plan
- Investigational treatments, procedures, equipment, medications, devices and supplies, as determined by BCBSAZ, unless required by Arizona law
- Lodging and meals, except for covered transplant travel benefits.
- Manipulations under anesthesia. This does not include reductions of fractures and/or dislocations done under anesthesia.
- Massage therapy, except as stated in the benefit plan.
- 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.
- 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 medications – any medication, device, equipment, supply (except for certain diabetic supplies and inhaler spacers as described in the retail pharmacy benefit), that is lawfully obtainable without a prescription
- Personal comfort items
- Screening tests, except as stated in the benefit plan
- Services from family member(s) – services that are provided by an eligible provider who is part of the member's immediate family
- Services for which the member has no legal obligation to pay
- Services without a prescription, when a prescription is required
- Services of ineligible providers
- Services not requiring a licensed professional
- Services and supplies delivered prior to the coverage effective date or after the coverage termination date
- Services and supplies related to or associated with a non-covered service or supply
- Sexual dysfunction – evaluation, testing, diagnosis, treatment (surgical or non-surgical), medication and devices for sexual dysfunction regardless of the cause of the condition, including trauma
- Smoking cessation programs, aids and devices
- Strength training, cardiovascular endurance training, fitness/strengthening programs and other services designed to improve or increase fitness
- 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 (organ, tissue, bone marrow/peripheral stem cell rescue procedures) not approved by BCBSAZ; nor high-dose chemotherapy, radiation administered in conjunction with a non-covered transplant, expenses related to donation of an organ to a recipient who is not covered by BCBSAZ
- Transport services and travel expenses, except as stated in the benefit plan
- Transsexual treatment and surgery and any related services
- Treatment for behavioral/mental health conditions at non-acute facilities, (e.g., residential, skilled nursing)
- Vision therapy, routine vision exams, 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 when a prescription is written by a physician
- Weight loss/gain therapy and treatment, except as stated in the benefit plan
- 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 the member is exempt from such coverage or has made a statutory opt-out election