

PPO \$500 Benefit Summary Buy-Up Plan



Northern Arizona Public Employees Benefit Trust (NAPEBT) Group #19676 Effective 07/01/2011

	COST SHARE									
	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER								
Calendar-Year Deductibles	\$500 per member, \$1,000 per family	\$1,000 per member, \$2,000 per family								
	Applicable deductible must be met for all covered services unless otherwise stated. Copays, access fees, precertification charges and noncontracted providers' balance bills do not count toward the deductible.									
Coinsurance This is a percentage members must pay for certain covered services after meeting the calendar-year deductible.	Plan pays 80%, member pays 20% (80%/20%) of the allowed amount for most covered services, after meeting deductible, unless a different coinsurance percentage is indicated.	Plan pays 60%, member pays 40% (60%/40%) of the allowed amount for most covered services, after meeting deductible, unless a different coinsurance percentage is indicated.								
Calendar-Year Out-of-Pocket Coinsurance Maximums	\$3,000 per member, \$6,000 family.	\$5,000 per member, \$10,000 family.								
How we calculate coinsurance and accumulations toward calendar year deductibles and out-of-pocket coinsurance maximums	<p>BCBSAZ calculates member coinsurance payments and accruals toward deductibles and the out-of-pocket coinsurance maximums, based on the BCBSAZ allowed amount and based on a calendar year. We do not use a provider's billed charges. In and out-of-network deductibles and maximums accumulate separately.</p> <p>Only the member's coinsurance payment counts towards the out-of-pocket coinsurance maximums. Many cost share payments do not count toward the out-of-pocket coinsurance maximum, including items indicated by "X" on the following list:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">X deductibles</td> <td style="width: 50%;">X copays</td> </tr> <tr> <td>X precertification charges</td> <td>X certain other charges specified in the benefit book</td> </tr> <tr> <td>X amounts paid for noncontracted providers' balance bills</td> <td>X amounts paid for noncovered services</td> </tr> <tr> <td>X access fees</td> <td></td> </tr> </table> <p>A member must continue to pay all the cost share amounts indicated above even after meeting the maximum.</p>		X deductibles	X copays	X precertification charges	X certain other charges specified in the benefit book	X amounts paid for noncontracted providers' balance bills	X amounts paid for noncovered services	X access fees	
X deductibles	X copays									
X precertification charges	X certain other charges specified in the benefit book									
X amounts paid for noncontracted providers' balance bills	X amounts paid for noncovered services									
X access fees										
Physician Office Services Primary Care Physicians (PCP) include Family Practice, General Practice, Internal Medicine and Pediatrics. All other physicians are specialists.	<p>PCP: \$25 copay Specialist: \$35 copay</p> <p>Copay applies per member, per provider, per day for most covered services provided in a physician's office.</p> <p>80%/20% for other covered physician services, after meeting deductible. Deductible and coinsurance always apply to services rendered by radiologists, pathologists and physical, occupational and speech therapy services.</p>	60%/40% after meeting deductible.								
Preventive Services	Plan pays 100% of allowed amount for covered preventive services; copays, deductible and coinsurance waived. Preventive services are those services performed for screening purposes when the member does not have active signs or symptoms of a condition but do 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.	60%/40%, after meeting deductible.								
Routine Physicals	100% deductible waived.	Not covered.								
Colonoscopy & Sigmoidoscopy	100% deductible waived.	60%/40% after meeting deductible.								
Mammography	100% deductible waived.	60%/40% deductible waived.								
Urgent Care	\$50 copay per member, per provider, per day at facilities specifically contracted for urgent care.	60%/40% after meeting deductible.								
Laboratory Services	<p>In a physician's office, Plan pays 100%; physician office visit copay waived, if the only services a member receives during the visit are laboratory services.</p> <p>At contracted, freestanding, independent clinical labs, Plan pays 100%, deductible and coinsurance waived.</p> <p>At all other facilities, 80%/20% after meeting deductible.</p>	60%/40% after meeting deductible.								
Other Professional Services	80%/20% after meeting deductible. Other professional services include diagnostic, surgical and anesthesia services rendered outside the physician's office.	60%/40% after meeting deductible.								
Outpatient Facility Services	80%/20% after meeting deductible.	60%/40% after meeting deductible.								
Radiology Facility Services	80%/20% after meeting deductible.	60%/40% after meeting deductible.								

Inpatient – Hospital	\$100 copay per admission, then 80%/20% after meeting deductible.	\$100 copay per admission, then 60%/40% after meeting deductible.
Emergency	\$100 access fee per member, per provider, per day; then 80%/20%, after meeting deductible; emergency room access fee is waived if member is admitted to the hospital.	
Ambulance	80%/20%, deductible waived	
Maternity	<p>Physician: One physician office visit copay covers physician's global delivery fee and other physician office visits for maternity services. For covered maternity services other than physician's global delivery fee, 80%/20% after meeting deductible.</p> <p>Hospital: \$100 copay per admission, then 80%/20% after meeting deductible.</p>	<p>Physician: 60%/40% after meeting deductible.</p> <p>Hospital: \$100 copay per admission, then 60%/40% after meeting deductible.</p>
Chiropractic	<p>\$35 copay per member, per provider, per day for most covered services 80%/20% for other covered services, after meeting deductible.</p> <p>Maximum of 12 chiropractic visits per person, per calendar year. Both in-and out-of-network visits count toward the 12 visit limit.</p>	60%/40% after meeting deductible.
Physical, Occupational & Speech Therapy	80%/20% after meeting deductible.	60%/40% after meeting deductible.
Behavioral/Mental Health Precertification is required for non-emergency inpatient services and outpatient services from the BSA.	<p>Inpatient: Two admissions per member, per calendar year (up to a combined total of 30 days). In-network provider: \$100 copay per admission, then 80%/20% after meeting deductible. Out-of-network provider: \$100 copay per admission, then Plan pays 50%, member pays 50%, after meeting deductible.</p> <p>Outpatient: Member may choose in-network or out-of-network providers or the behavioral services administrator (BSA).</p> <p>In-network/Out-of-network providers: Plan pays 50%, member pays 50%, after meeting deductible, with a maximum of 52 psychological sessions per member, per calendar year.</p> <p>BSA: unlimited psychotherapy and counseling: \$15 copay per member, per visit. BSA services are available only in Arizona.</p>	
Skilled Nursing Facility† Both in- and out-of-network admissions count toward the 180-day per member calendar year limit.	<p>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.</p> <p>Limited to 180 days per member, per calendar year.</p>	<p>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.</p>
Inpatient Extended Active Rehabilitation† Both in- and out-of-network admissions count toward the 120-day per member calendar year limit.	<p>\$100 copay per admission, 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.</p> <p>Limited to 120 days per member, per calendar year.</p>	<p>\$100 copay per admission, 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.</p>
Home Health	80%/20% after meeting deductible.	60%/40% after meeting deductible.
Bariatric Surgery (Inpatient and Outpatient)	\$1,000 access fee, plus 80%/20% after meeting deductible.	\$1,000 access fee, plus 60%/40% after meeting deductible.

IMPORTANT INFORMATION

Allowed Amount: All claims are processed using the BCBSAZ "Allowed Amount." BCBSAZ reimbursement, member cost share payments, and accumulations toward deductible and out of pocket limits are calculated on the BCBSAZ Allowed Amount and based on a calendar year. The allowed amount is the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost share payment. It does not include any balance bill. The allowed amount is based on BCBSAZ or other fee schedules. It is not tied to and does not necessarily reflect a provider's regular billed charges.

Providers, Claims, and Out of Pocket Costs: This plan allows members to go to in and out-of-network providers. 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. In-network providers will file members' claims and generally cannot charge more than the allowed amount for covered services. Members have lower out-of-pocket costs for covered services when they use in-network providers. Noncontracted providers can charge members full billed charges, which will include the difference between the BCBSAZ allowed amount and the provider's regular billed charges ("the balance bill"). Members are responsible for paying up to a noncontracted provider's billed charges for covered services, even though BCBSAZ will reimburse members' claims based on the allowed amount, less any deduction for the member's cost share portion. Any amounts paid for balance bills do not count toward any deductible, coinsurance or out-of-pocket coinsurance maximum.

Precertification: Some services and medications require precertification. Except for emergencies, urgent care, and maternity admissions, precertification is always required for inpatient admissions (acute care, behavioral health, long term acute care, extended active rehabilitation, and skilled nursing facilities) and specialty injectable medications. Precertification may be required for other covered services and medications. The member is responsible for making sure his or her physician obtains precertification approval if it is required. If precertification is not obtained, the member's benefits may be denied or the member may be subject to a precertification charge. Information on precertification requirements, including

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.

Preexisting Conditions

AN 12 MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS MAY APPLY FOR MEMBERS AGE 19 AND OLDER. 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. A condition exists when the member had signs or symptoms, whether or not a specific injury, illness or disease is diagnosed. For purposes of determining a pre-existing condition and pre-existing condition waiting periods, 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 the employer group's eligibility waiting period) during which a member was not covered under any creditable coverage. Creditable coverage includes the following: coverage provided under a group health plan (insured or self-insured), an individual insurance policy, Medicare, Medicaid, a federal or state public health plan, a health risk benefits pool, TRICARE, the Peace Corps, a Bonafide Association, Indian Health Services, the Federal Employee Health Benefits Plan or the State Children's 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 or (800) 232-2345, Ext. 4456 for additional information.

IMPORTANT WARNING

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, ON REQUEST. IF THE TERMS OF THIS SUMMARY DIFFER FROM THE TERMS OF THE BENEFIT PLAN BOOKLET, THE TERMS OF THE BOOKLET CONTROL AND 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 book 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; 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 book under particular benefits
- Biofeedback and hypnotherapy, except as stated in the benefit plan
- Body art, piercing, tattooing and any related complications
- Certain types of inpatient and outpatient facility charges by: group homes, wilderness programs, boarding schools, halfway houses, assisted living centers or shelters. Inpatient and outpatient facility charges for residential treatment facilities except for certain, very limited situations based upon BCBSAZ medical necessity criteria.
- 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 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
- Lifestyle education and management services, 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
- Medical equipment, supplies and medications sold on or through unregulated distribution channels as determined by BCBSAZ
- 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 as defined in the benefit plan. When a provider is also the covered person, services rendered by that provider for him/herself are excluded from coverage.
- Services from ineligible providers
- 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
- 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
- Vision therapy; routine vision exams; 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

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