NAPEBT HDHP

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2016-06/30/2017

Coverage for: Individual | **Plan Type:** HSA-Eligible PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.azblue.com** or by calling 928-526-7211 or 855-845-1875.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network and out-of-network combined: **$1,750/**individual	You must pay all costs up to the family **deductible** amount before this plan begins to pay for covered services for any covered family members. Your **deductible** is based on a calendar year and starts over each January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Unless a copay, fee or different percentage is shown, the coinsurance percentage of the **allowed amount** that you will pay for most services, after meeting any applicable **deductible**, is 20% in-network and 40% out of network. Copays, access fees, balance bills, excluded services and precertification charges don't count toward **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$4,500/**member Out-of-network: **$6,500/**member	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, precertification charges, balance bills, and costs for health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. You must keep paying them even if you reach your out-of-pocket limit.
Does this plan use a network of providers?	Yes. See www.azblue.com or call 928-526-7211 or 855-845-1875 for a list of in-network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your benefit book for more information about **excluded services**.

Questions: Call 928-526-7211 or 855-845-1875 or visit us at www.azblue.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at **www.cciio.cms.gov** or call 928-526-7211 or 855-845-1875 to request a copy.

- **Copays** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use **in-network providers** by charging you a lower cost-share for their services. A noncontracted provider can charge full billed charges, and the plan will reimburse you based only on the plan **allowed amount**, minus your cost share.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance & balance bill	Maximum of twelve (12) chiropractic visits per member, per calendar year. Plan doesn't cover acupuncture & services by naturopaths & homeopaths.
	Specialist visit			
	Other practitioner office visit			
	Preventive care/ screening/immunization	No charge	40% coinsurance & balance bill. Deductible waived for mammography services.	Provider's diagnosis and procedure codes determine whether service is preventive. Routine physical exam excluded out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance & balance bill	None
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or 1-877-456-0109.	Prescription drugs	20% coinsurance ($5 minimum) after deductible is met	40% coinsurance ($5 minimum) after deductible is met	Retail limited to 30 day supply Retail90 limited to 90 day supply Mail Order limited to 90 day supply Specialty Drug: 30 day maximum on Injectables only 90 day supply through specialty mail Calendar year deductible/out-of-pocket combined with medical
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance & balance bill	Additional $1,000 access fee for all bariatric surgeries.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$150 access fee per member/facility/day, then 20% coinsurance		Access fee is waived if you are admitted to the hospital.
	Emergency medical transportation	20% coinsurance		None
	Urgent care	20% coinsurance	40% coinsurance & balance bill	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance & balance bill	Precertification required & $500 charge applies if not obtained out-of-network. Additional $1,000 access fee for all bariatric surgeries.
	Physician/surgeon fee			
	Long-term acute care	20% coinsurance	40% coinsurance & balance bill	Precertification required & $500 charge applies if not obtained out-of-network. Benefit limit of 365 total days of long term acute care per member.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance & balance bill	None
	Mental/Behavioral health inpatient services	20% coinsurance		Precertification required for non-emergency admissions; $500 charge applies if not obtained out-of-network.
	Substance use disorder outpatient services	20% coinsurance		None
	Substance use disorder inpatient services	20% coinsurance		Precertification required for non-emergency admissions; $500 charge applies if not obtained out-of-network.
If you are pregnant	Prenatal and postnatal care Delivery and all inpatient services	Physician and Hospital: 20% coinsurance	40% coinsurance & balance bill	None
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	20% coinsurance	40% coinsurance & balance bill	Limited to 6 hours of care per member per day. Custodial care excluded. Certain drugs not covered without precertification.
	Rehabilitation services EAR = Extended Active Rehabilitation Facility PT/OT/ST = Physical therapy, occupational therapy, speech therapy	20% coinsurance except 50% coinsurance for days 61-120 of EAR inpatient stay	40% coinsurance except 50% coinsurance for days 61-120 of EAR inpatient stay. Balance bill applies to all services.	Precertification required for inpatient stay in EAR facility; $500 charge applies if not obtained out-of-network. Benefit limit of 120 days/member/calendar year for EAR inpatient stay. PT or OT performed by a chiropractor applies toward chiropractic limit.
	Habilitation services	Not covered		Excluded
	Skilled nursing care In skilled nursing facility (SNF)	20% coinsurance except 50% coinsurance for days 91-180	40% coinsurance except 50% coinsurance for days 91-180. Balance bill applies to all services.	Precertification required & $500 charge applies if not obtained out-of-network. Benefit limit of 180 days per member per calendar year. Private duty nursing not covered.
	Durable medical equipment	20% coinsurance	40% coinsurance & balance bill	No coverage for rental or repair charges that exceed purchase price or for deluxe models that aren't medically necessary.
	Hospice service	20% coinsurance	40% coinsurance & balance bill	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not covered		Excluded. Screening for members under age 5 covered under "Preventive care / screening / immunization."
	Glasses	Not covered		Excluded
	Dental check-up	Not covered		Excluded

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your benefit book for other excluded services.)

- Acupuncture
- Care that is not medically necessary
- Cosmetic surgery
- Dental care except dental accidents
- Experimental and investigational treatments
- Eye wear except after cataract surgery
- Habilitation care
- Hearing aids
- Infertility treatment
- Inpatient extended active rehabilitation treatment over 120 days per calendar year
- Long-term care (except 365 days of long-term acute care)
- Massage therapy other than allowed under medical coverage guidelines
- Out-of-network routine physicals
- Private-duty nursing
- Routine eye care
- Routine foot care
- Services from naturopathic and homeopathic physicians
- Sexual dysfunction
- Skilled nursing facility treatment over 180 days per calendar year
- Weight loss and gain programs

Other Covered Services (This isn't a complete list. Check your benefit book for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic services (up to 12 visits)
- Non-emergency care when travelling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 928-526-7211 or 855-845-1875. You may also contact your state insurance department at (602) 364-2499 or (800) 325-2548, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 928-526-7211 or 855-845-1875.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 602-864-4884.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 602-864-4884.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 602-864-4884.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-864-4884.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,530
- **Patient pays** $3,010

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,750
Copays	$0
Coinsurance	$1,110
Limits or exclusions	$150
Total	**$3,010**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,870
- **Patient pays** $2,530

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,750
Copays	$0
Coinsurance	$700
Limits or exclusions	$80
Total	**$2,530**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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