MEDICAL COVERAGE FAQ'S

What is an Exclusive Provider Organization (EPO)?

An EPO plan offers coverage when you utilize the services of the contracted EPO network of medical providers. AzMT has contracted with Blue Cross Blue Shield of Arizona (BCBSAZ) as its EPO network of providers. ***No benefits are payable for services obtained outside of the EPO network except in the case of a life-threatening emergency that occurs while you are traveling outside of the EPO network.***

What is a Preferred Provider Organization (PPO)?

A PPO plan generally offers two (2) levels of coverage – in-network and out-of-network. The "in-network" level of coverage is applicable when you utilize the services of the contracted PPO network of medical providers. AzMT has contracted with Blue Cross Blue Shield of Arizona (BCBSAZ) as its PPO network of providers. The "in-network" level of benefits is the highest level of benefit offered by the Plan. "Out-of-network" benefits apply when a provider that is not contracted with BCBSAZ is utilized for care or treatment. The "out-of-network" benefits are not as rich as the "in-network" benefits, and therefore utilization of "out-of-network" providers will increase your out-of-pocket costs for medical care and treatment.

What is a High Deductible Health Plan (HDHP)?

A High Deductible Health Plan is a plan with a minimum annual deductible and a maximum out-of-pocket limit. These minimums and maximums are determined annually by the Internal Revenue Service (IRS).

What is a deductible?

A deductible is the amount of medical expenses you are responsible for paying before your insurance starts covering you. The deductible amount can be found in the AzMT Summary Plan Description (SPD) booklets, which are available through your Human Resources Department, and also on this website.

What is a co-payment?

A co-payment is a fixed-dollar amount that you are responsible for paying for a particular medical service. Co-payment services generally do not require the satisfaction of a deductible before payment can be made. AzMT co-pay amounts can be found in the AzMT Summary Plan Description (SPD) booklets, which are available through your Human Resources Department, and also on this website.

Do my copayments count toward the annual deductible?

Yes.

What is coinsurance?

Coinsurance is the cost of a medical service that you are responsible for paying after satisfaction of the annual deductible. Unlike a co-payment, which is a fixed-dollar amount, coinsurance is expressed as a percentage. AzMT's coinsurance amounts can be found in the AzMT Summary Plan Description (SPD) booklets, which are available through your Human Resources Department, and also on this website.

What's an out-of-pocket expense?

An out-of-pocket expense is any cost you have to pay yourself when receiving medical care. This includes your deductible, co-payments, and coinsurance. Most health insurance policies have an annual maximum out-of-pocket expense. Once you've paid out enough money to meet that maximum, your insurance company will pay the rest of your eligible major medical expenses for the remainder of that plan year. There separate out-of-pocket maximums for medical claims and prescriptions, as outlined in your Summary Plan Description (SPD).

Is there a network of medical providers that I must use in order to receive medical benefits or can I use any provider?

It depends on which Plan you have selected to participate in, however, AzMT contracts with medical providers through Blue Cross Blue Shield of Arizona (BCBSAZ) for all of the plans it offers.

How do I find a BCBSAZ participating provider?

You can easily locate a provider by searching the provider directory at www.azblue.com/CHSnetwork or by calling (800) 232-2345.

What does "Usual, Customary and Reasonable (UCR)" mean?

This is the average cost a medical provider charges for services in a given geographical area. In an emergency, out-of-network provider services are payable based upon UCR.

Do I have to choose a Primary Care Physician (PCP) under the AzMT medical benefit plan?

No. None of the AzMT medical plans require the utilization of a primary care physician. At the time you need a medical service you determine which type of provider is most appropriate for the condition being treated.

What is coordination of benefits?

When a person is covered by more than one benefit plan (for example, a child who is covered by both parents' programs), which is known as dual coverage, the two sets of benefits are coordinated so that no more than 100 percent of the total covered expense is paid.

Who is AmeriBen?

The Trust has contracted with AmeriBen as its Claims Administrator. AmeriBen's responsibilities include, but are not limited to, loading and verifying member eligibility, paying eligible claims and answering customer service related questions for AzMT members.

What is an Explanation of Benefits (EOB)?

An EOB is a statement which lists the codes of the procedures performed, along with the date of service, amount billed, discount amount (if any), and the amounts payable by AzMT and the patient. EOB's are sent for every claim processed by AmeriBen.

Can I obtain claim information online?

Yes, this is an option available to you through AmeriBen. You may access your claims information by registering as a member at www.myameriben.com.

Do I have to get authorization, or a referral, for any services?

The medical benefit plan does require pre-certification of certain services. This program is designed as a cost containment measure through AmeriBen to maximize the Plan benefits and reduce unnecessary hospitalizations, surgical procedures, diagnostic and other services. Failure to comply with the pre-certification requirements will result in a $300 penalty. It is always up to you, and the physician you choose, to determine what services you need and who will provide your care, regardless of what this Plan will pay for. Once a pre-certification is received, it is valid for ninety (90) days.

IMPORTANT: Pre-certification of a procedure does <u>not</u> guarantee benefits. All benefit payments are determined by AmeriBen in accordance with the provisions of this Plan.

Pre-certification is required for the following:

- Inpatient pre-admission and continued stay reviews (all ages, all diagnoses):
    - Surgical and non-surgical (excluding routine vaginal or cesarean deliveries);
    - Long-term acute care facility (LTAC), not custodial care;
    - Skilled nursing facility/rehabilitation facility; and
    - Inpatient mental health/substance abuse disorder treatment (includes residential treatment facility services)
- Inpatient and outpatient surgery including pain management injections and intra-articular hyaluronic acid injections ***(Pre-certification is not required for office surgeries and all colonoscopies/sigmoidoscopies (screening and diagnostic)***;
- Advanced imaging (CT studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans) and PET scans (excluding services rendered in an ER setting);
- Outpatient rehabilitation services (physical, occupational and speech therapy) in excess of twenty (20) visits per plan year per therapy type;
- Chemotherapy drugs/infusions and radiation treatments for oncology diagnoses;
- Home health care services and supplies;
- Transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high dose chemotherapy;
- Orthotics/Prosthetics over three thousand dollars ($3,000);
- Durable Medical Equipment over three thousand dollars ($3,000) (purchase/rental price);
- Genetic testing/genomic testing (excluding amniocentesis) in excess of one thousand dollars ($1,000);
- Clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition ***(This Plan does not cover clinical trials related to other diseases or conditions.)***;
- Non-emergent air ambulance;
- Intensive outpatient program in excess of twenty (20) visits per benefit year, for mental health and substance abuse disorder treatment;
- Specialty infusion/injectable medications over three thousand dollars ($3,000) per infusion/injection which are covered under the medical benefit and not obtained through the prescription benefit program (i.e., provided in an outpatient facility, physician's office, or home infusion); and
- Dental services required for medical procedures.

PLEASE REFER TO THE SUMMARY PLAN DOCUMENT FOR MORE INFORMATION!

What is the procedure for obtaining pre-certification?

For all non-emergency procedures that require pre-certification, the Covered Person or his/her Physician must contact AmeriBen prior to the admission or in advance of the procedure at 855.778.9053 at least forty eight (48) hours before services are scheduled to be rendered. AmeriBen will review the request for services and contact the Physician for any records or additional information necessary to thoroughly evaluate the need for services. **Benefit eligibility for the pre-certified procedures must be verified with AmeriBen prior to completing services.**

For emergency procedures or hospital admissions, the Covered Person, his/her Physician, the hospital admissions clerk, or anyone associated with the Covered Person's treatment, must notify AmeriBen by telephone within forty-eight (48) hours of the procedure or the admission.

What is Case Management?

In certain complex medical situations where many different doctors and/or treatments may be needed, case management may become necessary. A nurse case manager from AmeriBen may be assigned to work with the patient, the family, the Physician and the claims payor to coordinate an effective treatment plan.

What is considered a medical emergency?

A medical emergency means a sudden unexpected onset of a medical condition, which manifests itself by acute symptoms of sufficient severity that requires urgent and immediate medical attention (without regard to the hour of day or night) to prevent significant impairment in bodily functions or serious and/or permanent dysfunction of any bodily organ or part and is not normally treatable in the provider's office.

If I am traveling outside of the United States am I covered if a medical emergency should occur?

If emergency medical care is rendered by a provider that is not part of the BCBSAZ participating provider network, as would be the case if you are traveling outside of Arizona or outside of the United States, services may be considered under the “In-Network” level of benefits, if it is determined by AmeriBen that immediate medical attention was required due to an accident or illness which is serious enough to constitute a medical emergency as outlined directly above.

Who do I contact if I have questions on how or why a medical billing was processed the way it was?

You may contact AmeriBen Customer Care at (855) 350-8699.

What are my options if I do not agree with how a medical invoice was processed or paid by AmeriBen?

The AzMT benefit plans include a benefit appeal process that is included in the Summary Plan Description (SPD) booklets, which are available through your Human Resources Department, and also on this website (see Plan Provisions).

Whom do I call to request additional ID cards?

You can request replacement cards by calling AmeriBen Customer Care toll-free at (855) 350-8699. You should receive your new card within 7 to 10 calendar days from the date of your request.