

PINAL COUNTY - SCHEDULE OF MEDICAL BENEFITS

The following benefits are provided to employees that have elected the Medical Plan.

The benefits listed as ***In-Network*** are available in Arizona only through BlueCross® BlueShield® of Arizona (BCBSAZ) contracted providers. **If a Plan member uses a provider within Arizona that is not a contracted BCBSAZ provider, no benefits will be available.** The ***Out-of-State*** benefits are available when a Plan Member is traveling outside Arizona or is living in another state. All Out-of-State benefits are subject to the deductible(s) except when defined by the Plan as a life threatening emergency.

MEDICAL PLAN		
	NETWORK PROVIDERS	OUT OF STATE BENEFITS
MAXIMUM LIFETIME BENEFIT AMOUNT, PER COVERED PERSON	\$2,000,000 (Combined In-Network and Out of State Maximum)	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$0	\$250
Per Family Unit	\$0	\$750
CO-INSURANCE MAXIMUM AMOUNT, PER CALENDAR YEAR		
For eligible charges that are payable at 80%, the first \$10,000 per Person, or \$20,000 per Family in a Calendar Year are payable at 80%. Eligible charges over these amounts are payable at 100% for remainder of Calendar Year.		
COVERED CHARGES	NETWORK PROVIDERS	OUT OF STATE BENEFITS
Note: The maximums listed below are the total for Network and Out of State expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Out of State Providers.		
Common Accident Provision		
If more than one person is involved in an accident, then only one deductible must be satisfied for the accident.		
Hospital Services		
Room and Board	80%	80% after deductible
Intensive Care Unit	80%	80% after deductible
Emergency Room	\$50 copay (copay waived if admitted to hospital)	80% after deductible
The Emergency Room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
Urgent Care (Free standing and Hospital based)	\$20 copay	80% after deductible
Note: Covered Charges from a Non-Network Provider for a Life Threatening Emergency will be payable at the Network level of benefits.		
Skilled Nursing Facility 60 Day Calendar Year Maximum (Combined In-Network and Out of State Maximum)	80%	80% after deductible
Physician Services		
Inpatient visits	\$20 copay	80% after deductible

MEDICAL PLAN

	NETWORK PROVIDERS	OUT OF STATE BENEFITS
Office visits	\$20 copay	80% after deductible
Outpatient diagnostic x-ray & lab	\$20 copay	80% after deductible
Anesthesiologist	100%	80% after deductible
Allergy serum, injections and testing	\$20 copay per day of service	80% after deductible
Outpatient Surgery		
Facility Charges	\$75 copay per day	80% after deductible
Physician	100%	80% after deductible
Home Health Care 100 Visits Calendar Year Maximum	100%	80% after deductible
Hospice Care	\$20 copay 100 Day Lifetime Maximum (Combined In-Network and Out of State Maximum)	80% after deductible 100 Day Lifetime Maximum (Combined In-Network and Out of State Maximum)
Ambulance Service	100%	80% after deductible
Jaw Joint/TMJ \$300 Calendar Year Limit	80%	80% after deductible
Wig After Chemotherapy	80%	80% after deductible
Occupational Therapy	80%	80% after deductible
Physical Therapy	\$20 copay Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximums)	80% after deductible Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximums)
Physiotherapy	80% Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximum)	80% after deductible Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximum)
Speech Therapy	80% Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximum)	80% after deductible Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximum)
Durable Medical Equipment	\$20 copay per item per month \$750 Per Item Maximum (Combined In-Network and Out of State Maximum)	80% after deductible \$750 Per Item Maximum (Combined In-Network and Out of State Maximum)
Prosthetics	80%	80% after deductible

MEDICAL PLAN		
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Orthotics	80% Limited to once in each 12 month period for ages 19 and older and once in each 6 month period for under age 19 if necessitated by growth. (Combined In-Network and Out of State Maximum)	80% after deductible Limited to once in each 12 month period for ages 19 and older and once in each 6 month period for under age 19 if necessitated by growth. (Combined In-Network and Out of State Maximum)
Spinal Manipulation Chiropractic	\$20 copay \$1,000 Calendar year Limit	80% after deductible \$1,000 Calendar year Limit
Skilled Nursing/Rehab Facility	80% 60 day Calendar Year Maximum	80% after deductible 60 day Calendar Year Maximum
Mental Disorders		
Inpatient Physician	\$25 copay per day	80% after deductible
Inpatient Facility	80%	80% after deductible
30 days Calendar Year Maximum and 60 days Lifetime Maximum Combined for Inpatient Mental Disorders and Inpatient Substance Abuse (Combined In-Network and Out of State Maximum)		
Outpatient	\$20 copay 30 Visits Calendar Year Maximum(Combined In-Network and Out of State Maximum)	80% after deductible 30 Visits Calendar Year Maximum(Combined In-Network and Out of State Maximum)
Substance Abuse		
Inpatient Physician	\$25 copay per day	80% after deductible
Inpatient Facility	80%	80% after deductible
30 days Calendar Year Maximum and 60 days Lifetime Maximum Combined for Inpatient Mental Disorders and Inpatient Substance Abuse (Combined In-Network and Out of State Maximum)		
Outpatient	\$20 copay	80% after deductible
Preventive Care		
Routine Well Care	\$20 copay (Age 2 through Adult) \$500 Calendar Year Maximum (Combined In-Network and Out of State Maximum)	80% after deductible (Age 2 through Adult) \$500 Calendar Year Maximum (Combined In-Network and Out of State Maximum)
Includes: mammogram, routine physical examination, x-rays, laboratory blood tests, and immunizations/flu shots.		
Colonoscopy Screening (Frequency Limits Apply)	\$20 Copay	80% after deductible
Frequency limits for Colonoscopy Ages 50 and over Colonoscopy once every Ten (10) years		
Routine Well Baby Care (to age 2) \$750 Calendar Year Maximum (Combined In- Network and Out of State Maximum)	\$20 copay	80% after deductible
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests and immunizations through age 1.		
Eye Examinations (under age 17)	\$20 copay	Not Covered
Hearing Examinations	80%	80% after deductible

MEDICAL PLAN		
	NETWORK PROVIDERS	OUT OF STATE BENEFITS
Hearing Aides	50% \$1,500 per Calendar Year Maximum (Combined In-Network and Out of State Maximum)	50% after deductible \$1,500 per Calendar Year Maximum (Combined In-Network and Out of State Maximum)
Pregnancy Dependent daughters not covered.		
Inpatient Hospital Charges	80%	80% after deductible
Pre & Postnatal Care & Delivery	\$20 co-pay at Initial Visit Only	80% after deductible
Limits: One routine maternity ultrasound per Pregnancy; \$750 maximum per epidural per pregnancy (Combined In-Network and Out of State Maximum)		
All other covered services	80%	80% after deductible

Prescription Drug Program		
Network Provider: WHI Health initiatives		
Retail Pharmacy Option (Maximum 30 Day Supply)		
Copayment, per Prescription:		
	Mandatory Generic (including Diabetic Supplies/Drugs)	\$7 copay
	Brand Name (when Generic not available)	\$20 Copay
	Non-Preferred Brand Name or Brand with Generic available	\$35 co-pay plus cost difference between Generic and Brand Name
Mail Order Option (90 Day Supply)		
	Mandatory Generics (including Diabetic Supplies/Drugs)	\$14 copay
	Brand Name (when Generic not available)	\$40 Copay
	Non-Preferred Brand Name or Brand with Generic available	\$70 co-pay plus cost difference between Generic and Brand Name
Retail 90 Advantage 90® Pharmacy Option (Maximum 90 Day Supply)		
	Mandatory Generics (including Diabetic Supplies/Drugs)	\$14 copay
	Brand Name (when Generic not available)	\$40 Copay
	Non-Preferred Brand Name or Brand with Generic available	\$70 co-pay plus cost difference between Generic and Brand Name