Arizona Technology Council AHP
PPO 100 5000 Plan Attachment

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BlueCross BlueShield of Arizona

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PLAN NETWORK

Know your provider's network and eligibility status before you receive services. See your Summary of Benefits and Coverage (SBC) and ID card for the name of the Plan Network applicable to your Benefit Plan. Check the Plan Network Provider directory at www.azblue.com to locate an in-network Provider. If you do not have Internet access, would like to request a paper copy of the directory, or have questions about a provider's network participation, please call BCBSAZ Customer Service at the number on your ID card before you receive services.

MEMBER COST SHARING & OTHER PAYMENTS

Members pay part of the costs for benefits received under this plan. Depending on your particular Benefit Plan, the Service you receive and the Provider you choose, you may have an Access Fee, Balance Bill, Coinsurance, Copay, deductible, or some combination of these payments. Each Cost Share and other payment type is explained below. This section, the *"Cost-Share Table"* section that follows, and your SBC will explain which Cost-share types and other payments apply to each benefit. BCBSAZ uses your claims to track whether you have met some Cost-share obligations. We apply claims based on the order in which we process the claims and not based on date of Service.

Access Fee

An Access Fee is a fixed fee you pay to a Provider for certain Covered Services, usually at the time of Service. If an Access Fee applies to a particular Service, you must pay the Access Fee plus any other applicable Cost Share for the Service. Access fees do not count toward meeting your Calendar-year Deductible.

Balance Bill

The Balance Bill refers to the amount you may be charged for the difference between a noncontracted provider's Billed Charges and the Allowed Amount. Any amounts paid for balance bills do not count toward deductible, Coinsurance, or the Out-of-pocket Maximum.

Noncontracted Providers have no obligation to accept the Allowed Amount. You are responsible to pay a noncontracted provider's Billed Charges, even though BCBSAZ will reimburse your claims based on the Allowed Amount. Depending on what billing arrangements you make with a noncontracted Provider, the Provider may charge you for full Billed Charges at the time of Service or seek to Balance Bill you for the difference between Billed Charges and the amount that BCBSAZ reimburses you on a claim.

Benefit Maximums

Some benefits may have a specific benefit maximum or limit based on the number of days or visits, type, timeframe (calendar year or Benefit Plan), age, gender, or other factors. If you reach a benefit maximum, any further services are not covered under that benefit, and you may have to pay the provider's Billed Charges for those services. However, if you reach the benefit maximum on a particular line of a claim, you will be responsible for paying only up to the Allowed Amount for the remaining charges on that line of the claim. All Benefit Maximums are included in the applicable benefit description.

Calendar-Year Deductible (Individual and Family)

A Calendar-year Deductible is the amount each Member must pay for Covered Services each January through December before the Benefit Plan begins to pay for Covered Services. The deductible applies to every covered Service unless the specific benefit section says it does not apply. The deductible is calculated based on the Allowed Amount. Amounts you pay for copays and access fees do not count toward the deductible.

If you have family coverage, there is also a Calendar-year Deductible for the family. Amounts counting toward an individual's Calendar-year Deductible will also count toward any family deductible. When the family satisfies its Calendar-year Deductible, it also satisfies the deductible for all the individual members. An individual Member cannot contribute more than his or her individual deductible toward the family's deductible.

Coinsurance

Coinsurance is a percentage of the Allowed Amount that you pay for certain Covered Services after meeting any applicable deductible. BCBSAZ subtracts any applicable access fees and Precertification Charges from the Allowed Amount before calculating Coinsurance. Coinsurance applies to every covered Service unless the specific benefit section says it does not apply. In most cases, your Coinsurance percentage is higher when you use an out-of-network Provider.

BCBSAZ normally calculates Coinsurance based on the Allowed Amount. There is one exception. If a hospital provider's Billed Charges are less than the hospital's reimbursement, BCBSAZ will calculate your Coinsurance based on the lesser billed charge.

Copay

A Copay is a specific dollar amount you must pay to the Provider for some Covered Services. If a Copay applies to a covered Service, you must pay it when you receive services. Different services may have different Copay amounts and are shown in the *"Cost-Share Table"* section that follows and on your SBC. Usually, if a Copay does not apply, you will pay applicable deductible and Coinsurance.

Out-of-Pocket Maximum (Individual and Family)

An Out-of-pocket Maximum is the amount each Member must pay each year before the plan begins paying 100 percent of the Allowed Amount on Covered Services, for the remainder of the calendar year. The payments listed below do not count toward the Out-of-pocket Maximum. You must keep paying them even after you reach your Out-of-pocket Maximum:

- Amounts above a benefit maximum
- Any amounts for balance billing
- Any amounts for noncovered services
- Any charges for lack of Precertification

If you have family coverage, there is an Out-of-pocket Maximum for your family. Amounts applied to each member's Out-of-pocket Maximum also apply to the family Out-of-pocket Maximum. The family maximum is applied in the same way as the individual maximum described above and is subject to the same rules. When the family has met its family Out-of-pocket Maximum, it also satisfies the Out-of-pocket Maximum requirements for all the individual members.

Precertification Charges

If your out-of-network Provider does not obtain Precertification from BCBSAZ for a Service that requires it, you are subject to a precertification charge or complete loss of benefit as shown on your SBC. Amounts applied as Precertification Charges do not count toward the Calendar-year Deductible or Out-of-pocket Maximum.

COST-SHARE TABLE

Description	In-Network Cost Share	Out-of-Network Cost Share
CALENDAR-YEAR DEDUCTIBLE	$5,000 per Member $10,000 per family	
OUT-OF-POCKET MAXIMUM	$5,000 per Member $10,000 per family	$10,000 per Member $20,000 per family

Benefit	In-Network Cost Share	Out-of-Network Cost Share
AMBULANCE SERVICES	You pay deductible up to $5,000.	
BEHAVIORAL AND MENTAL HEALTH SERVICES (Inpatient Facility and Professional Services)	You pay deductible up to $5,000	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
BEHAVIORAL AND MENTAL HEALTH SERVICES (Outpatient Facility and Professional Services)	You pay 1 Copay per Member, per Provider, per day for services provided during an office, home, or walk-in clinic visit. Your Copay will vary depending on whether you see a PCP ($30) or a Specialist ($60). You pay deductible up to $5,000 for services in other locations.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
BEHAVIORAL THERAPY SERVICES FOR THE TREATMENT OF AUTISM SPECTRUM DISORDER	You pay 1 Copay per Member, per Provider, per day for services provided during an office, home, or walk-in clinic visit. Your Copay will vary depending on whether you see a PCP ($30) or a Specialist ($60). You pay deductible up to $5,000 for services in other locations.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES	You pay deductible up to $5,000 for professional services provided in a facility and for outpatient facility charges. For Physician office visits, you pay a PCP Copay ($30) or a Specialist Copay ($60).	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
CATARACT SURGERY AND KERATOCONUS	You pay deductible up to $5,000 for professional services provided in a facility and for inpatient and outpatient facility charges. For Physician office visits, you pay a PCP Copay ($30) or a Specialist Copay ($60).	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
CHIROPRACTIC SERVICES	You pay a Specialist Copay ($60) per Member, per Provider, per day for services provided during an office, home, or walk-in clinic visit. The Copay does not apply if you receive only physical medicine and rehabilitation services and no other covered Service during your visit. You pay deductible up to $5,000 for physical medicine and rehabilitation services and for Chiropractic Services in other locations.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
CLINICAL TRIALS	You pay deductible up to $5,000 for professional services provided in a facility and for inpatient and outpatient facility charges. For Physician office visits, you pay a PCP Copay ($30) or a Specialist Copay ($60).	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
DENTAL SERVICES – MEDICAL	You pay deductible up to $5,000	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.

Benefit	In-Network Cost Share	Out-of-Network Cost Share
DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES, AND PROSTHETIC APPLIANCES AND ORTHOTICS	For Physician visits, you pay a PCP Copay ($30) or a Specialist Copay ($60). When DME is picked up in the physician's office but billed through a DME supplier, you pay deductible up to $5,000. If you have a Physician office visit at the time you pick up your DME, Medical Supplies, or Prosthetic Appliances or Orthotics, you also pay a PCP Copay or a Specialist Copay. You pay deductible up to $5,000 for services received outside a physician's office. Your Cost Share is waived for one FDA-approved manual or electric breast pump and breast pump supplies per Member, per calendar year.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
EDUCATION AND TRAINING (Diabetes and Asthma Education and Training; Nutritional Counseling and Training)	Your Cost Share is waived.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
EMERGENCY SERVICES	You pay your in-network Cost Share for Emergency Services, even for services from out-of-network Providers. Emergency Room: You pay 1 emergency room Copay ($400) per Member, per facility, per day for emergency room facility and ancillary charges. Deductible and in-network Coinsurance are waived for professional services provided while in the emergency room. Admission to the Hospital From the Emergency Room *If you are admitted as an inpatient:* • The emergency room Copay is waived. • You pay deductible up to $5,000 for facility and ancillary services related to the emergency, including facility and ancillary services provided while you were in the emergency room. • You pay deductible up to $5,000 for emergency professional services provided after admission. *If you are admitted for observation or as an outpatient:* • You pay the emergency room Copay. • You pay deductible up to $5,000 for professional, facility, and ancillary services related to the emergency and provided after admission for observation or as an outpatient. If you receive Emergency Services from a noncontracted facility or professional Provider, BCBSAZ will base the Allowed Amount used to calculate your Cost Share on the highest of the three following amounts, not to exceed the applicable provider's Billed Charges: • The median in-network Provider negotiated rate for the emergency service furnished, • The amount for the emergency service calculated using the same method BCBSAZ generally uses to determine reimbursement for non-emergency out-of-network services, or • The amount that would be paid by Medicare Part A or B. For all non-emergency services following the emergency treatment and stabilization, the Cost Share will depend on the provider's network status and the place you receive services. The provider's Billed Charges often exceed the above amounts, which leaves a Balance Bill. You will be responsible for the Balance Bill, which may be substantial.	
EOSINOPHILIC GASTROINTESTINAL DISORDER	Deductible is waived.	Deductible is waived. You pay 25% for the Cost of Formula.
	"Cost" is defined as either Billed Charges, if the Formula is purchased from an out-of-network Provider, or the Allowed Amount, if purchased from an in-network Provider.	
FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)	Implanted Devices: Your Cost Share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved implanted	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	contraceptive devices when the purpose of the procedure is contraception, as documented by your Provider on the claim. Sterilization Procedures: Your Cost Share is waived for professional and facility charges for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your Provider on the claim. You pay deductible up to $5,000 for FDA-approved male sterilization procedures. Hormonal Contraceptive Methods: Your Cost Share is waived for oral contraceptives, patches, rings, and contraceptive injections. Emergency Contraception: Your Cost Share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a Physician or other Provider. Barrier Contraceptive Methods: Your Cost Share is waived for diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides.	from noncontracted Providers.
HOME HEALTH SERVICES If you believe you have paid more for a self-administered version of a Cancer Treatment Medication than for an injected or intravenously administered version of a Cancer Treatment Medication, please call the Pharmacy Benefit Customer Service number on your ID card.	You pay deductible up to $5,000	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
HOSPICE SERVICES	Your Cost Share is waived.	Your Cost Share is waived. You pay the Balance Bill for services from noncontracted Providers.
INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES	You pay a PCP Copay ($30) or a Specialist Copay ($60) for services in a physician's office or walk-in clinic. You pay deductible up to $5,000 for services in other locations.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
INPATIENT HOSPITAL	You pay deductible up to $5,000. Your Cost Share is waived for facility charges for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your Provider on the claim.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
	You pay a $1,000 Bariatric Surgery Access Fee for all bariatric surgeries, in addition to deductible and Coinsurance. The Bariatric Surgery Access Fee applies toward the professional charges for Bariatric Surgery.	
INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR) SERVICES	First 60 Days of Services in a Calendar Year: You pay deductible up to $5,000. Second 60 Days of Services in a Calendar Year: You pay deductible up to $5,000 and 50% Coinsurance. However, if your claim is submitted with a primary mental health and/or substance abuse diagnosis, you will pay the Cost Share applicable to the first 60 days of services in a calendar year.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.

Benefit	In-Network Cost Share	Out-of-Network Cost Share
LONG-TERM ACUTE CARE (INPATIENT)	First 100 Days of Services: You pay deductible up to $5,000. 101-365 Days of Services**:** You pay deductible up to $5,000 and 50% Coinsurance. However, if your claim is submitted with a primary mental health and/or substance abuse diagnosis, you will pay the Cost Share applicable to the first 100 days of services.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
MATERNITY **"Global Charge"** is a fee charged by the delivering Provider that includes certain prenatal, delivery, and postnatal services.	Inpatient Services: You pay deductible up to $5,000. Outpatient Services: You pay 1 PCP Copay ($30) or 1 Specialist Copay ($60) for your first prenatal office or home visit, which covers all Physician Services included in the physician's Global Charge. You pay 1 Copay, per Member, per Provider, per day for other Physician office or home visits not included in the Global Charge. You pay deductible up to $5,000 for professional services in an outpatient facility that are not included in the Global Charge, and for outpatient facility charges.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
	Your Cost-share obligations may be affected by the addition of a newborn or adopted child, as described in the *"Plan Administration"* section of the Base Benefit Book. If you have coverage only for yourself and no Dependents, addition of a child will result in a change from individual coverage to family coverage, and you may be required to pay additional premium. If you currently have individual coverage, when a child is added to your Plan, you will also be required to meet a family deductible and Out-of-pocket Maximum.	
MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS	Deductible is waived.	Deductible is waived. You pay 50% for the Cost of Medical Foods.
	"Cost" is defined as either billed charges, if the Member buys the Medical Foods from an out-of-network Provider or the Allowed Amount, if the member buys the Medical Foods from an in-network Provider.	
NEUROPSYCHOLOGICAL AND COGNITIVE TESTING	You pay deductible up to $5,000 for professional services provided in a facility and for inpatient and outpatient facility charges. For Physician office visits, you pay a PCP Copay ($30) or a Specialist Copay ($60).	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
OUTPATIENT SERVICES	Diagnostic Laboratory Services: You pay a PCP Copay ($30) or a Specialist Copay ($60) for services in a physician's office (Copay is waived if you receive only covered laboratory services during your visit), except professional services provided by a pathologist or dermapathologist will be subject to deductible up to $5,000. You pay deductible up to $5,000 for services in other locations. Radiology Services: You pay a PCP Copay ($30) or a Specialist Copay ($60) for services in a physician's office, except professional services provided by a radiologist will be subject to deductible up to $5,000. You pay deductible up to $5,000 for services in other locations. Outpatient Facility Services (Including Outpatient Surgery): You pay deductible up to $5,000. Your Cost Share is waived for facility charges for FDA-approved female	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	sterilization procedures when the purpose of the procedure is contraception as documented by your Provider on the claim. Sleep Studies: You pay deductible up to $5,000. Medications Administered in an Outpatient Facility: You pay deductible up to $5,000.	
	You pay a $1,000 Bariatric Surgery Access Fee for all bariatric surgeries, in addition to deductible and Coinsurance. The Bariatric Surgery Access Fee applies toward the professional charges for Bariatric Surgery.	
PHARMACY BENEFIT	Retail Pharmacy Medications: You pay the following Cost Share for a 30-day supply: • Level 1: $15 Copay. • Level 2: $45 Copay. • Level 3: $75 Copay. • Level 4: $130 Copay(including Compounded Medications) You pay the following Cost Share for a 90-day supply: • Level 1: $45 • Level 2: $135 • Level 3: $225 • Level 4: $390 Mail Order Pharmacy Medications: You pay the following Cost Share for a 90-day supply: • Level 1: $30 • Level 2: $90 • Level 3: $150 • Level 4: $260 Specialty Medications: You pay the following copays for most medications for a 30-day supply: • Level A: $60 Copay • Level B: $110 Copay • Level C: $160 Copay • Level D: $210 Copay You may obtain up to a 90-day supply of covered medications. Not all medications are available for more than a 30- or 60-day supply. If you purchase a brand-name medication when a generic equivalent is available, you will pay the level 1 Copay plus the difference between the Allowed Amount for the generic and the brand-name medication, even if the prescribing Provider indicates on the prescription that the brand-name medication should be dispensed. If you have completed Step Therapy and are taking a brand-name medication with a generic equivalent as a result of the Step Therapy process, you pay the Cost Share applicable to the brand-name medication.	Retail Pharmacy Medications: You pay your in-network Cost-share amount plus the Balance Bill. The following are not covered when obtained from out-of-network pharmacies: • 90-day supply at retail • Mail order medications • Specialty medications
PHYSICAL THERAPY (PT) – OCCUPATIONAL THERAPY (OT) – SPEECH THERAPY (ST) SERVICES	You pay deductible up to $5,000.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.

Benefit	In-Network Cost Share	Out-of-Network Cost Share
PHYSICIAN SERVICES If you receive Preventive Services from an in-network Physician, your Cost Share may be waived.	You pay 1 Copay per Member, per Provider, per day for services provided during an office, home, or walk-in clinic visit. Your Copay will vary depending on whether you see a PCP ($30) or Specialist ($60). Your Copay is waived if you only receive the following services and no other covered Service during your home or office visit: • Covered allergy injections • Covered immunizations • Covered laboratory services • Covered PT, OT, ST; these services are subject to deductible You pay deductible up to $5,000 for services in other locations. Your Cost Share will be waived for the following services when the purpose of the procedure is contraception as documented by your Provider on the claim: • Professional Physician Services for FDA-approved female sterilization procedures, regardless of the location of Service. • Professional Physician Services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices. • FDA-approved implanted contraceptive devices. • The following FDA-approved generic and brand with no generic equivalent prescription hormonal and barrier contraceptive methods and devices: patches, rings, contraceptive injections, diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides. See the "Guidance Regarding Preventive Medications" section on www.azblue.com for a list of contraceptive methods covered as Preventive Services under the *"Pharmacy Benefit."* You pay deductible up to $5,000 for professional services provided by a radiologist or pathologist, including a dermapathologist and for professional services related to a sleep study even when the services are provided in a physician's office. You pay deductible up to $5,000 for medications administered in a physician's office.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
POST-MASTECTOMY SERVICES	You pay deductible up to $5,000 for professional services provided in a facility and for inpatient and outpatient facility charges. For Physician office visits, you pay a PCP Copay ($30) or a Specialist Copay ($60).	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
PREGNANCY, TERMINATION	You pay deductible up to $5,000 for professional services provided in a facility, and for inpatient and outpatient facility charges. For Physician office visits, you	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	pay a PCP Copay ($30) or a Specialist Copay ($60).	
PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER	See the *"Pharmacy Benefit*" Cost-share row to determine your Cost Share for services received through the *"Pharmacy Benefit."* You pay deductible up to $5,000 for medications received through your medical benefits.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
PREVENTIVE SERVICES You pay applicable Cost Share for any tests, procedures, or services not covered in the *"Preventive Services"* section of the Base Benefit Book.	Your Cost Share is waived, regardless of the location where services are provided, if: • You receive one of the services covered in the *"Preventive Services"* section in the Base Benefit Book; • The procedure code, the diagnosis code, or the combination of procedure codes, and diagnosis codes billed by your Provider on the line of the claim indicates the Service is preventive; and • The primary purpose of the visit at which services were rendered was for preventive care. For certain covered preventive medications and items, your Cost Share is waived for the generic version of the medication or item and you pay applicable Cost Share for the brand-name version of the medication or item. You may request an exception for waiver of Cost Share for the brand-name version of a preventive medication or item. See *"Preventive Services"* in the Base Benefit Book.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
RECONSTRUCTIVE SURGERY AND SERVICES	You pay deductible up to $5,000 for professional services provided in a facility, and for inpatient and outpatient facility charges. For Physician office visits, you pay a PCP Copay ($30) or a Specialist Copay ($60).	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
SKILLED NURSING FACILITY (SNF) SERVICES	First 90 Days of Services in a Calendar Year: You pay deductible up to $5,000. Second 90 Days of Services in a Calendar Year: You pay deductible up to $5,000 and 50% Coinsurance. However, if your claim is submitted with a primary mental health and/or substance abuse diagnosis, you will pay the Cost Share applicable to the first 90 days of services in a calendar year.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
TELEHEALTH SERVICES	Your Cost Share is waived for telehealth medical. You pay a telehealth counseling Copay ($20) for services provided by a counselor, or a telehealth psychiatry Copay ($45) for services provided by a psychiatrist.	Not covered.
TELEMEDICINE SERVICES	You pay the Cost-share amounts applicable to the services provided via telemedicine. Cost Share applies for the Service provided at your physical location, and also for the Service rendered remotely by the telemedicine Provider. To illustrate: if you are in a PCP's office and receive a consultation from a remote Specialist, you pay the Cost Share applicable for a PCP office visit and the Cost Share applicable for a Specialist office visit or consultation. If you are at home and	Not covered, except for Emergency Services and Urgent Care. You pay the Cost-share amounts applicable to all services provided via telemedicine. You will always pay in-network Cost Share for Emergency Services provided via telemedicine.

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	receive a consultation from a remote Specialist, you pay only the Specialist Cost Share because no other Provider is involved at your location.	
TRANSPLANTS – ORGAN – TISSUE – BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES If both a donor and a transplant recipient are covered by a BCBSAZ plan or a plan administered by BCBSAZ, the transplant recipient pays the Cost Share related to the transplant.	You pay deductible up to $5,000 for professional services provided in a facility and for inpatient and outpatient facility charges. For Physician office visits, you pay a PCP Copay ($30) or a Specialist Copay ($60).	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers. Certain facilities are contracted with the Plan Network to provide covered transplants to BCBSAZ members. Not all such facilities are contracted to provide services related to a covered transplant, such as pre-transplant testing, certain types of chemotherapy and radiation therapy and other services covered under this plan. If you receive pre-transplant testing or other services associated with the transplant from a facility that is not contracted with the Plan Network or a Host Blue plan, or is not a Blue Distinction® Center for Transplants, to provide those services, you will pay the Balance Bill plus out-of-network Cost Share.
TRANSPLANT AND GENE THERAPY TRAVEL AND LODGING	Your Cost Share is waived. Maximum of $10,000 reimbursement per Member, per transplant or gene therapy treatment.	
URGENT CARE	You pay an Urgent Care Copay ($50) per Member, per Provider, per day for services received from a freestanding Urgent Care Provider who is contracted with the Plan Network to render Urgent Care services. If you receive services from a Plan Network Provider who is not specifically contracted for Urgent Care services, you pay a PCP Copay ($30) or Specialist Copay ($60) for services in a physician's office, home visit, or walk-in clinic. You pay deductible up to $5,000. If you receive services from certain Providers, such as hospitals, that are not specifically contracted with the Plan Network as Urgent Care Providers, see the *"Emergency Services"* row.	You pay deductible up to $5,000 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.