Arizona Technology Council AHP
PPO HSA 80 1500 Plan Attachment

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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, deductible, or some combination of these payments. Each Cost Share and other payment type is explained below. This section, the *"Cost-Share Table"* 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 the Member or family 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 access fees do not count toward the deductible.

For a plan issued to a Contract Holder with no Dependents, the Contract Holder must meet his or her individual deductible before the Benefit Plan begins to pay for Covered Services. If you have other family members on the plan, the family Calendar-year Deductible must be met before the Benefit Plan begins to pay for Covered Services.

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.

Health Savings Account (HSA)

This Benefit Plan is a high-deductible health plan designed for use with an HSA, which is a tax-exempt trust or custodial account established with a qualified financial institution. A Member uses the funds in the HSA to pay for qualified medical expenses and provide savings for the future. You must satisfy certain criteria to be eligible to open an HSA and contribute to and/or withdraw funds from an HSA. Enrolling in this Plan does not automatically qualify you to open an HSA and contribute to and/or withdraw funds from an HSA. Check with your tax or legal advisor regarding whether you satisfy these criteria. BCBSAZ is not an HSA trustee or custodian and does not provide tax, legal, or investment advice about HSAs. You cannot set up an HSA with BCBSAZ. BCBSAZ does not make any contributions to the HSA. Federal and state regulations governing HSAs are subject to change.

Members with HSAs are responsible to tell BCBSAZ about any changes that apply to their health plan accruals. Sometimes members may have adjustments in their actual incurred expenses for services, of which BCBSAZ is unaware. (For example, a Provider may choose to discount all patients' Cost Share by 2 percent if the patient pays cash on the day of Service. Or, a Member may have a discount coupon for the member's share of the cost of a drug.) If your out-of-pocket costs are reduced after your Provider submits a claim, you must tell BCBSAZ about the reduction so BCBSAZ can properly credit amounts to your deductible and Out-of-pocket Maximum. If you do not tell us about these adjustments, it could result in inaccurate accumulations and jeopardize your status as an HSA-eligible individual.

Federal laws allow waiver of minimum deductible requirements applicable to qualified high-deductible health plans for services and medications provided for a preventive purpose. If your deductible is waived for a Service or item that is not provided for a preventive purpose, you may be ineligible to contribute or withdraw funds from your HSA, and you may be subject to a tax penalty on funds withdrawn from your HSA. Contact BCBSAZ if your deductible is being waived for a Service or item you are receiving for a non-preventive purpose.

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. 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.

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

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	Individual only: $1,500 Family: $3,000	
OUT-OF-POCKET MAXIMUM	$4,500 per Member Family: $9,000	$9,000 per Member Family: $18,000

Benefit	In-Network Cost Share	Out-of-Network Cost Share
AMBULANCE SERVICES	You pay deductible up to $1,500 and 20% Coinsurance.	
BEHAVIORAL AND MENTAL HEALTH SERVICES (Inpatient Facility and Professional Services)	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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 deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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 deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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 $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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 $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
CHIROPRACTIC SERVICES	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
CLINICAL TRIALS	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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 $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES, AND PROSTHETIC APPLIANCES AND ORTHOTICS	You pay deductible up to $1,500 and 20% in-network Coinsurance. 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 $1,500 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 $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.

<table>
<tr><th>Benefit</th><th>In-Network Cost Share</th><th>Out-of-Network Cost Share</th></tr>
<tr><td>EMERGENCY SERVICES</td><td colspan="2">You pay deductible up to $1,500 and 20% in-network Coinsurance. You pay your in-network Cost Share for Emergency Services, even for services from out-of-network Providers. 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.</td></tr>
<tr><td rowspan="2">EOSINOPHILIC GASTROINTESTINAL DISORDER</td><td>You pay deductible up to $1,500 for the Cost of Formula.</td><td>You pay deductible up to $1,500 for the Cost of Formula.</td></tr>
<tr><td colspan="2">"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.</td></tr>
<tr><td>FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)</td><td><u>Implanted Devices</u>: Your Cost Share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved implanted contraceptive devices when the purpose of the procedure is contraception, as documented by your Provider on the claim.

<u>Sterilization Procedures</u>: 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 $1,500 and 20% in-network Coinsurance for FDA-approved male sterilization procedures.

<u>Hormonal Contraceptive Methods</u>: Your Cost Share is waived for oral contraceptives, patches, rings, and contraceptive injections.

<u>Emergency Contraception</u>: Your Cost Share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a Physician or other Provider.

<u>Barrier Contraceptive Methods</u>: Your Cost Share is waived for diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides.</td><td>You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.</td></tr>
<tr><td>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.</td><td>You pay deductible up to $1,500 and 20% in-network Coinsurance.</td><td>You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.</td></tr>
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Benefit	In-Network Cost Share	Out-of-Network Cost Share
HOSPICE SERVICES	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
INPATIENT HOSPITAL	You pay deductible up to $1,500 and 20% in-network Coinsurance. 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 $1,500 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	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
LONG-TERM ACUTE CARE (INPATIENT)	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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.	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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 be required to meet a family deductible and Out-of-pocket Maximum.	
MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS“	You pay deductible up to $1,500 for the Cost of Medical Foods.	You pay deductible up to $1,500 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 $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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
OUTPATIENT SERVICES	Diagnostic Laboratory Services: You pay deductible up to $1,500 and 20% in-network Coinsurance. Radiology Services: You pay deductible up to $1,500 and 20% in-network Coinsurance. Outpatient Facility Services (Including Outpatient Surgery): You pay deductible up to $1,500 and 20% in-network Coinsurance. 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. Sleep Studies: You pay deductible up to $1,500 and 20% in-network Coinsurance. Medications Administered in an Outpatient Facility: You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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.	
PHARMACY BENEFIT	Retail/Mail Order Pharmacy Medications/Specialty Medications: You pay deductible up to $1,500 and 20% in-network Coinsurance 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 be responsible for the generic medication Cost Share 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 $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
PHYSICIAN SERVICES If you receive Preventive Services from an in-network Physician, your Cost Share may be waived.	You pay deductible up to $1,500 and 20% in-network Coinsurance. 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-	You pay deductible up to $1,500 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
	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 $1,500 and 20% in-network Coinsurance for medications administered in a physician's office.	
POST-MASTECTOMY SERVICES	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
PREGNANCY, TERMINATION	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
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 $1,500 and 20% in-network Coinsurance for medications received through your medical benefits.	You pay deductible up to $1,500 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 in 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 $1,500 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 $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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
SKILLED NURSING FACILITY (SNF) SERVICES	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
TELEHEALTH SERVICES	You pay deductible up to $1,500 and 20% in-network Coinsurance.	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 receive a consultation from a remote Specialist, you pay only the Specialist Cost Share because no other Provider is involved at your location.	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.
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 $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 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	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.
	Maximum of $10,000 reimbursement per Member, per transplant.	
URGENT CARE	You pay deductible up to $1,500 and 20% in-network Coinsurance.	You pay deductible up to $1,500 and 50% out-of-network Coinsurance. You also pay the Balance Bill for services from noncontracted Providers.