

Arizona Technology Council AHP HSA PPO 100 6900 Plan Attachment

Your Cost-Sharing Information

azblue.com/MyBlue



An Independent Licensee of the Blue Cross Blue Shield Association

YOUR PLAN NETWORK

Your Summary of Benefits and Coverage (SBC) and ID card show the name of the plan network that applies to your benefit plan. You'll find the complete directory of providers in your plan's network at [azblue.com/MyBlue](https://www.azblue.com/MyBlue). If you do not have Internet access, would like to request a paper copy of the directory, or have questions about whether or not a certain provider is in the network, please call Blue Cross® Blue Shield® of Arizona (BCBSAZ) Customer Service at the number on your ID card. It's important to make sure your provider is in your plan network before you receive services.

MEMBER COST SHARING & OTHER PAYMENTS

As explained in your Base Benefit Book, your cost share is the cost you pay for the covered healthcare services you use. Depending on your particular benefit plan, the service you receive, and the provider you choose, your cost share can include an access fee, balance bill, coinsurance, copay, deductible, precertification charge, or a combination of these types of payments (we explain these terms in the Base Benefit Book as well). The following table and your SBC explain which cost-share and other payment types apply to each benefit.

BCBSAZ uses your claims to track your progress toward meeting your cost-share obligations. We track the claims based on the order in which we process them, and not based on when you received the service.

ABOUT YOUR PLAN

Your plan is a **high-deductible health plan** designed for use with a Health Savings Account (HSA). An HSA is a tax-exempt trust or custodial account established with a qualified financial institution. You use the funds in the HSA to pay for qualified (approved) medical expenses, as well as to save for the future.

You must meet certain criteria to open an HSA. Enrolling in this plan does not automatically qualify you to open an HSA. If you're not sure whether you meet the criteria for opening an HSA, check with your tax or legal advisor.

Utilizing coupons or other discount programs to obtain covered medications may disqualify the federal tax-preferred status of your HSA. We recommend you consult an attorney or tax advisor if you plan to use coupons or discount programs for prescription medications.

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 or through BCBSAZ. BCBSAZ does not make any contributions to an HSA. Federal and state regulations governing HSAs are subject to change.

Your Responsibilities

Members with HSAs are responsible for telling BCBSAZ about any changes that apply to their health plan *accruals* (your deductibles and out-of-pocket maximums). Sometimes, you may pay less than your normal cost share for a service or medication, and BCBSAZ will be unaware of the discount. For example, a doctor might offer you a discount for paying with cash on the day of your appointment. Or, you might use a coupon that offers a discount on your share of the cost of a drug. If you pay less than your normal cost share and your provider submits a claim, you must tell BCBSAZ about the reduction so BCBSAZ can make sure your deductible and out-of-pocket maximum are corrected. If you do not tell us about these adjustments as they happen, it could result in inaccurate tracking of your deductible(s) and/or your out-of-pocket maximum(s), and jeopardize your status as an HSA-eligible individual.

Federal laws allow you to pay your coinsurance only—without having to meet your deductible—for services, medications, and items that are given to you for a preventive purpose. If your deductible is waived for a service or item that is not provided for a preventive purpose, you may not be able to contribute or withdraw funds from your HSA, and you may be subject to a tax penalty on funds withdrawn from your HSA. If your deductible is being waived for a service or item you are receiving for a non-preventive purpose, contact BCBSAZ Customer Service right away to let us know.

COST-SHARE TABLE

| Type of Cost Share | In-Network | Out-of-Network |
|-----------------------|---|--|
| Plan-Year Deductible | \$6,900 per member \$13,800 per family | |
| Out-of-Pocket Maximum | \$6,900 per member \$13,800 per family | \$13,800 per member \$27,600 per family |

Until you meet your deductible, you will pay the *allowed amount* for most services, plus the *balance bill* for out-of-network services (see the “Know the Lingo” section and Appendix A of your Base Benefit Book for definitions of any *italicized* terms that are not defined here). Note that any access fees you see listed here do not count toward your deductible.

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|--|--|---|
| Ambulance Services | \$0 (after deductible) | |
| Behavioral Health Services Inpatient facility & professional services | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| Behavioral Health Services Outpatient facility & professional services | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| Cardiac & Pulmonary Rehabilitation Outpatient services | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| Cataract Surgery & Keratoconus | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| Chiropractic Services | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| Clinical Trials | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| Dental Services—Medical | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| Durable Medical Equipment (DME), Medical Supplies, & Prosthetic Appliances & Orthotics | \$0 (after deductible) \$0 for one FDA-approved manual or electric breast pump and breast pump supplies per member, per plan year | 50% coinsurance (after deductible) + balance bill |
| Education & Training Diabetes & asthma education & training; nutritional counseling & training | \$0 | 50% coinsurance (after deductible) + balance bill |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|--|--|--|
| <p align="center">Emergency Services</p> | <p>You pay your in-network cost share for emergency services, even for services from out-of-network providers.</p> <p>\$0 (after deductible)</p> <p>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 following three amounts, not to exceed the applicable provider's billed charges:</p> <ul style="list-style-type: none"> • The median in-network provider negotiated rate for the emergency services furnished, • The cost of the emergency services as calculated using the same method BCBSAZ generally uses to determine reimbursement for out-of-network services, or • The amount that would be paid by Medicare Part A or B. <p>For all non-emergency services following the emergency treatment and stabilization:</p> <ul style="list-style-type: none"> • The cost-share amount will depend on the provider's network status and the place you receive services • If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which may be substantial | |
| <p align="center">Eosinophilic Gastrointestinal Disorder (EGID)</p> | <p>\$0 (after deductible)</p> | <p>\$0 (after deductible)</p> |
| <p>Your deductible is based on cost. <i>Cost</i> is either the allowed amount, if the formula is purchased from an in-network provider, or billed charges, if purchased from an out-of-network provider.</p> | | |
| <p align="center">Family Planning</p> <p>Contraceptives & sterilization</p> | <p>\$0 for professional charges for implantation and/or removal (including follow-up care) of FDA-approved female implanted contraceptive (birth control) devices when the purpose of the procedure is contraception, as documented by your doctor on the claim submitted to BCBSAZ</p> <p>\$0 for professional and facility charges for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your doctor on the claim submitted to BCBSAZ</p> <p>\$0 for female oral contraceptives, patches, rings, and contraceptive injections</p> <p>\$0 for FDA-approved over-the-counter emergency contraception that is prescribed by a doctor or other healthcare provider</p> <p>\$0 for diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides</p> <p>\$0 (after deductible) for FDA-approved male sterilization procedures</p> | |
| <p align="center">Home Health Services</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| <p align="center">Hospice Services</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| <p align="center">Inpatient & Outpatient Detoxification Services</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|--|
| <p align="center">Inpatient Hospital</p> | <p>\$0 (after deductible)</p> <p>\$0 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 submitted to BCBSAZ</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| | <p>\$1,000 bariatric surgery access fee plus applicable deductible and coinsurance for all bariatric surgeries. The access fee applies toward the professional charges for bariatric surgery.</p> | |
| <p align="center">Inpatient Rehabilitation Services—Extended Active Rehabilitation (EAR) Services</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| <p align="center">Long-Term Acute Care Inpatient</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| <p align="center">Maternity</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| <p>Your cost-share obligations may be affected by the addition of a newborn or adopted child, as described in the “<i>Plan Administration</i>” section of your Base Benefit Book. If you have coverage only for yourself and no dependents, the 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 have a Family deductible.</p> | | |
| <p align="center">Medical Foods for Inherited Metabolic Disorders</p> | <p>\$0 (after deductible)</p> | <p>\$0 (after deductible)</p> |
| <p>Your deductible is based on cost. <i>Cost</i> is either the allowed amount, if the member buys the medical foods from an in-network provider, or billed charges, if the member buys the medical foods from an out-of-network provider.</p> | | |
| <p align="center">Neuropsychological & Cognitive Testing</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| <p align="center">Outpatient Services</p> | <p>\$0 (after deductible) for:</p> <ul style="list-style-type: none"> • Diagnostic lab services • Radiology services • Sleep studies • Medications administered in an outpatient facility • Outpatient facility services, including outpatient surgery <p>\$0 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 submitted to BCBSAZ</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| | <p>\$1,000 bariatric surgery access fee plus applicable deductible and coinsurance for all bariatric surgeries. The access fee applies toward the professional charges for bariatric surgery.</p> | |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|--|--|--|
| Pharmacy & Medications Benefits (next two rows) | | |
| <p style="text-align: center;">Pharmacy Benefit</p> <p>See Appendix B in your Base Benefit Book for details about your Pharmacy benefits, including how your cost share is calculated.</p> | <p>Retail, Mail Order, and Specialty Pharmacy Medications \$0 (after deductible)</p> <p>You may obtain up to a 90-day supply of covered maintenance medications at a network retail pharmacy (keep in mind that not all medications are available for more than a 30- or 60-day supply). Your cost share will be different depending on the type of pharmacy, how much of the medication you're getting, and the level of the medication.</p> <p>If you purchase a brand-name medication when a generic equivalent is available, you will pay the generic medication cost share plus the difference between the allowed amounts for the generic and brand-name medications, even if the prescribing provider indicates on the prescription that the brand-name medication is what you should have. If you have completed <i>step therapy</i> and are taking a brand-name drug with a generic equivalent as a result of the step-therapy process, you pay the cost share that applies to the brand-name medication.</p> <p>\$0 for preventive medications and for covered vaccines. BCBSAZ determines:</p> <ul style="list-style-type: none"> • Which medications are considered preventive, • Which vaccines are covered, and • For which there is a \$0 cost share <p>• \$0 for the generic version of certain covered preventive medications or items; applicable cost share for the brand-name version. You may request an <i>exception for waiver of cost share</i> (see "Preventive Services" in section 2 of your Base Benefit Book) for the brand-name version of a preventive medication or item.</p> <p>\$0 for the following female contraceptive (birth control) methods when prescribed by your provider for the purpose of contraception and obtained from an in-network pharmacy:</p> <ul style="list-style-type: none"> • FDA-approved brand oral, patch, vaginal ring, and injectable contraceptives with no generic equivalent components • FDA-approved diaphragms, cervical caps, and cervical shields • FDA-approved emergency contraception for members of any age • FDA-approved generic oral, patch, vaginal ring, and injectable contraceptives | <p>The following are not covered when obtained from out-of-network pharmacies:</p> <ul style="list-style-type: none"> • 90-day supply at retail • Mail-order medications • Specialty medications <p>You must pay the full cost for retail prescriptions purchased from an out-of-network pharmacy and submit a claim to BCBSAZ. You will be reimbursed at the in-network level of benefits, up to the allowed amount. You will be responsible for any balance bill, including the difference between the allowed amounts for the generic and brand name medications.</p> <p>To find cost information for a medication:</p> <ul style="list-style-type: none"> • Log in to MyBlue • Under "Pharmacy," click Prescription Benefits & Tools to go to the "My Medicine Cabinet" page • At the top of the page, select "Member Tools > Drug Pricing" |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|--|---|--|
| | <ul style="list-style-type: none"> Female condoms Sponges and spermicides | |
| Medications for the Treatment of Cancer | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| <p>For certain cancer treatment medications, as determined by BCBSAZ, you will receive a 15-day supply, and pay \$0 (after deductible) the first time you receive the medication. You will be able to refill the medication every 15 days, and you will continue to pay your coinsurance (after deductible) for each refill during your first three months of treatment with the medication. If you have side effects from the medication during the three-month period, your prescribing doctor may change your medication. If you tolerate the medication, you will be able to refill the cancer treatment medication for up to 30 days after three months of treatment.</p> | | |
| Physical Therapy (PT), Occupational Therapy (OT), & Speech Therapy (ST) Services | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| <p>Physician Services</p> <p>If you receive preventive services from an in-network doctor, your cost share may be waived.</p> | <p>\$0 (after deductible) for doctor's office visits and for medications administered in a doctor's office</p> <p>\$0 for the following when the purpose is female contraception (birth control) as documented by your provider on the claim submitted to BCBSAZ:</p> <ul style="list-style-type: none"> Professional services for FDA-approved female sterilization procedures, regardless of the location of service Professional services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved 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 | <p>50% coinsurance (after deductible) + balance bill</p> |
| Post-Mastectomy Services | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| Pregnancy, Termination | \$0 (after deductible) | 50% coinsurance (after deductible) + balance bill |
| <p>Preventive Services</p> <p>You pay applicable cost share for any tests, procedures, or services not covered in the "Preventive Services" section of your Base Benefit Book.</p> | <p>\$0 regardless of the location where services are provided if:</p> <ul style="list-style-type: none"> You receive one of the services covered as explained in the "Preventive Services" section of the Base Benefit Book; The procedure code, the diagnosis code, or the combination of procedure and diagnosis codes billed by your provider on the claim indicates the service is preventive; and The primary purpose of the visit at which you received the services was preventive care | <p>50% coinsurance (after deductible) + balance bill</p> |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|---|
| | <p>\$0 for the generic version of certain covered preventive medications or items; applicable cost share for the brand-name version. You may request an <i>exception for waiver of cost share</i> (see "Preventive Services" in section 2 of your Base Benefit Book) for the brand-name version of a preventive medication or item.</p> | |
| <p>Reconstructive Surgery & Services</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| <p>Skilled Nursing Facility (SNF)</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| <p>Telehealth Services <i>Telehealth services</i> are video consultations you have with a provider using BCBSAZ's BlueCare AnywhereSM service.</p> | <p>\$0 (after deductible)</p> | <p>Not covered</p> |
| <p>Telemedicine Services</p> | <p>For any telemedicine service, you pay the same cost-share amount as if the service were provided in person. Cost-share applies for the service provided at your physical location, and also for the service rendered remotely by the telemedicine provider.</p> <p>Example: if you are at a PCP's office and receiving a consultation from a remote specialist, you will pay the cost share for the PCP office visit and the cost share for the specialist office visit or consultation. If you are at home and receiving a consultation from a remote specialist, you would pay only the cost share for the specialist because no other provider is involved at your location.</p> | <p>Not covered, except for emergency and urgent services. In those cases, 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.</p> |
| <p>Transplant & Gene Therapy Travel & Lodging</p> | <p>\$0 (after deductible)</p> <hr/> <p>Maximum reimbursement of \$10,000 per member, per transplant or gene therapy treatment</p> | |
| <p>Transplants Organ, tissue, & bone marrow & 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.</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |
| <p>Urgent Care</p> | <p>\$0 (after deductible)</p> | <p>50% coinsurance (after deductible) + balance bill</p> |

Blue Cross, Blue Shield, the Cross and Shield Symbols, and Blue Distinction are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

©2020 Blue Cross Blue Shield of Arizona, Inc. All rights reserved.