Arizona Technology Council AHP
PPO 80 6000 Plan Attachment

Your Cost-Sharing Information

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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. 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.

COST-SHARE TABLE

Type of Cost Share	In-Network	Out-of-Network
Plan-Year Deductible	**$6,000** per member **$12,000** per family	
Out-of-Pocket Maximum	**$7,250** per member **$14,500** per family	**$14,500** per member **$29,000** 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). For services that require a copay, the deductible is waived. 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	**20% coinsurance** (after deductible)	
Behavioral Health Services Inpatient facility & professional services	**20% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Behavioral Health Services Outpatient facility & professional services	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for services you receive at other locations	**50% coinsurance** (after deductible) **+ balance bill**
Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Cardiac & Pulmonary Rehabilitation Outpatient services	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for professional services you receive at an outpatient facility, and any related outpatient facility charges	**50% coinsurance** (after deductible) **+ balance bill**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Cataract Surgery & Keratoconus	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Chiropractic Services	**$60 specialist copay** per member, per provider, per day for services you receive during an office, home, or walk-in clinic visit **20% coinsurance** (after deductible) for: • Visits in which you receive only physical medicine and rehabilitation services and no other covered service • Chiropractic services delivered at other locations	**50% coinsurance** (after deductible) **+ balance bill**
Clinical Trials	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Dental Services—Medical	**20% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Durable Medical Equipment (DME), Medical Supplies, & Prosthetic Appliances & Orthotics	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for: • DME picked up at the doctor's office but billed through a DME supplier. If you have a doctor's office visit at the time you pick up your DME, medical supplies, prosthetic appliance, or orthotics, you also pay the PCP or specialist copay. • Services you receive at locations other than a doctor's office **$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**
Emergency Services	You pay your in-network cost share for emergency services, even for services from out-of-network providers. **Emergency Room (ER)** **$400 ER copay per member, per facility, per day** **Admission to the Hospital From the ER** *If you are admitted as an inpatient:* • **$0 ER copay** • **20% coinsurance** (after in-network deductible) for facility and ancillary services related to the emergency, including facility and ancillary services you receive while you are in the ER, and for emergency professional services you receive after admission	

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	If you are admitted for observation or as an outpatient: • **$400 ER copay** • **20% coinsurance** (after in-network deductible) for professional, facility, and ancillary services you receive that are related to the emergency, and for any related services you receive after you are admitted 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 following three amounts, not to exceed the applicable provider's billed charges: • 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. For all non-emergency services following the emergency treatment and stabilization: • 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	
Eosinophilic Gastrointestinal Disorder (EGID)	**20%** of the cost of formula **Deductible is waived**	**25%** of the cost of formula **Deductible is waived**
Cost is defined here as 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.		
Family Planning Contraceptives & sterilization	**$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 **$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 **$0** for female oral contraceptives, patches, rings, and contraceptive injections **$0** for FDA-approved over-the-counter emergency contraception that is prescribed by a doctor or other healthcare provider **$0** for diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides **20% coinsurance** (after deductible) for FDA-approved male sterilization procedures	**50% coinsurance** (after deductible) **+ balance bill**
Home Health Services	**20% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Hospice Services	**$0**	**$0 + balance bill**
Inpatient & Outpatient Detoxification Services	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for services you receive at other locations	**50% coinsurance** (after deductible) **+ balance bill**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Inpatient Hospital	**20% coinsurance** (after deductible) **$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	**50% coinsurance** (after deductible) **+ balance bill**
	$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.	
Inpatient Rehabilitation Services—Extended Active Rehabilitation (EAR) Services	**20% coinsurance** (after deductible) for the first 60 days of services in a plan year **50% coinsurance** (after deductible) for the second 60 days of services in a plan year. If your claim is submitted with a primary mental health and/or substance use disorder diagnosis, you will pay the cost share applicable to the first 60 days of services in a plan year.	**50% coinsurance** (after deductible) **+ balance bill**
Long-Term Acute Care Inpatient	**20% coinsurance** (after deductible) for the first 100 days of services **50% coinsurance** (after deductible) for days 101-365 of services. If your claim is submitted with a primary mental health and/or substance use disorder diagnosis, you will pay the cost share applicable to the first 100 days of services.	**50% coinsurance** (after deductible) **+ balance bill**
Maternity *Global charge* is a fee charged by the delivering provider that includes certain prenatal, delivery, and postnatal services.	**$30 PCP copay** or **$60 specialist copay** for your first prenatal office or home visit, which covers all services included in the provider's *global charge.* **One copay, per member, per provider, per day** for other doctor's office or home visits not included in the global charge. **20% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Your cost-share obligations may be affected by the addition of a newborn or adopted child, as described in the "Plan Administration" 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.		
Medical Foods for Inherited Metabolic Disorders	**20%** of the cost of medical foods **Deductible is waived**	**50%** of the cost of medical foods **Deductible is waived**
Cost is defined here as 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.		
Neuropsychological & Cognitive Testing	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**

<table>
<tr><th>Benefit</th><th>In-Network Cost Share</th><th>Out-of-Network Cost Share</th></tr>
<tr><td rowspan="2">Outpatient Services</td><td>Diagnostic Laboratory Services:
$30 PCP copay or $60 specialist copay for in-office doctor visits (waived if you receive only covered lab services during your visit)
20% coinsurance (after deductible) for professional services you receive from a pathologist or dermapathologist, and for services provided at locations other than a doctor’s office
Radiology Services:
$30 PCP copay or $60 specialist copay for in-office doctor visits
20% coinsurance (after deductible) for professional services you receive from a radiologist, and for services provided at locations other than a doctor’s office
Outpatient Facility Services (including outpatient surgery):
20% coinsurance (after deductible)
$0 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
Sleep Studies: 20% coinsurance (after deductible)
Medications Given to You at an Outpatient Facility: 20% coinsurance (after deductible)</td><td>50% coinsurance (after deductible) + balance bill</td></tr>
<tr><td colspan="2">$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.</td></tr>
<tr><td colspan="3">Pharmacy & Medications Benefits (next two rows)
Note: Your cost share for any medication is based on the level to which BCBSAZ has assigned it at the time the prescription is filled. No exceptions will be made regarding the assigned level of a medication. BCBSAZ may change the level of a medication at any time without notice. To confirm the status and level of a particular medication, visit MyBlue, or call Pharmacy Benefit Customer Service at the number on your ID card.</td></tr>
<tr><td>Pharmacy Benefit
See Appendix B in your Base Benefit Book for details about your Pharmacy benefits, including how your cost share is calculated.</td><td>Retail Pharmacy Medications (30-day supply)
Level 1: $15 copay
Level 2: $45 copay
Level 3: $75 copay
Level 4 (including compounded medications): $130 copay
Mail-Order Medications (90-day supply)
Level 1: $30 copay
Level 2: $90 copay
Level 3: $150 copay
Level 4: $260 copay
Specialty Medications
Level A: $60 copay
Level B: $110 copay
Level C: $160 copay
Level D: $210 copay</td><td>The following are not covered when obtained from out-of-network pharmacies:
90-day supply at retail
Mail-order medications
Specialty medications
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.

To find cost information for a medication:</td></tr>
</table>

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	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). If you receive a 31- to 60-day supply of medication, you will pay two times the applicable cost share for a 30-day supply. If you receive a 61- to 90-day supply of medication from a network retail pharmacy, you will pay three times the 30-day cost share. 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. 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 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 *step therapy* 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. **$0** for preventive medications and for covered vaccines. BCBSAZ determines: • Which medications are considered preventive, • Which vaccines are covered, and • For which there is a $0 cost share **$0** for the generic version of certain covered preventive medications or items; **applicable cost share** for the brand-name version. You may request an *exception for waiver of cost share* (see "Preventive Services" in section 2 of your Base Benefit Book) for the brand-name version of a preventive medication or item. **$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: • 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 • Female condoms • Sponges and spermicides	• 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
Medications for the Treatment of Cancer	**20% coinsurance** (after deductible) for medications you receive through your medical benefits	**50% coinsurance** (after deductible) **+ balance bill**
For certain cancer treatment medications, as determined by BCBSAZ, you will receive a **15-day supply,** and pay **one-half of the level 1** retail pharmacy copay the first time you receive the medication. You will be able to refill the medication every 15 days, and you will continue to pay one-half of the level 1 retail pharmacy copay 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.		
Physical Therapy (PT), Occupational Therapy (OT), & Speech Therapy (ST) Services	**20% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Physician Services If you receive preventive services from an in-network doctor, your cost share may be waived.	**One $30 PCP copay** or **one $60 specialist copay** per member, per provider, per day for services you receive during an office, home, or walk-in clinic visit **$0** 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 **$0** for the following when the purpose is female contraception (birth control), as documented by your provider on the claim submitted to BCBSAZ: • 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 **20% coinsurance** (after deductible) for: • Covered PT, OT, and ST • PCP and specialist services provided at locations other than a doctor's office, home, or walk-in clinic • Professional services you receive from a radiologist or pathologist, including a dermapathologist, and for professional services you receive that are related to a sleep study, even when the services are provided at a doctor's office • Medications given to you at a doctor's office	**50% coinsurance** (after deductible) **+ balance bill**
See the "Outpatient Services" row above for more information on cost-share amounts for covered services.		

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Post-Mastectomy Services	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Pregnancy, Termination	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Preventive Services You pay applicable cost share for any tests, procedures, or services not covered in the "Preventive Services" section of your Base Benefit Book.	**$0** regardless of the location where services are provided if: • 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 **$0** for the generic version of certain covered preventive medications or items; **applicable cost share** for the brand-name version. You may request an *exception for waiver of cost share* (see "Preventive Services" in section 2 of your Base Benefit Book) for the brand-name version of a preventive medication or item.	**50% coinsurance** (after deductible) **+ balance bill**
Reconstructive Surgery & Services	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Skilled Nursing Facility (SNF)	**20% coinsurance** (after deductible) for the first 90 days of services in a plan year **50% coinsurance** (after deductible) for the second 90 days of services in a plan year. If your claim is submitted with a primary mental health and/or substance use disorder diagnosis, you will pay the cost share applicable to the first 90 days of services in a plan year.	**50% coinsurance** (after deductible) **+ balance bill**
Telehealth Services *Telehealth services* are video consultations you have with a provider using BCBSAZ's BlueCare Anywhere℠ service.	**$0 copay** for telehealth medical consultations **$20 copay** for telehealth counseling sessions provided by a counselor **$45 copay** for telehealth psychiatric consultations provided by a psychiatrist	**Not covered**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Telemedicine Services	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. **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.	**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.
Transplant & Gene Therapy Travel & Lodging	**$0** Maximum reimbursement of $10,000 per member, per transplant or gene therapy treatment	
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.	**$30 copay** for PCP office visits **$60 copay** for specialist office visits **20% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Urgent Care	**$50 copay** per member, per provider, per day for services you receive from a provider that is contracted with the plan network to offer urgent-care services **$30 PCP copay** or **$60 specialist copay** for office visits or walk-in clinic visits for urgent-care services you receive from an in-network provider that is *not* specifically contracted for urgent-care services **20% coinsurance** (after deductible) for urgent-care services you receive from any other type of provider	**50% coinsurance** (after deductible) **+ balance bill**
See the "Emergency Services" row for information about services you receive from certain providers, such as hospitals, that are not specifically contracted with the plan network as urgent-care providers.		

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