Group HMO HSA Portfolio Silver 3750

Plan Attachment

Off Marketplace

Your Cost-Sharing Information

azblue.com/MyBlue

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

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. 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.

YOUR PLAN NETWORK

See your Summary of Benefits and Coverage (SBC) and ID card for 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 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 AND OTHER PAYMENTS

Members pay part of the costs for benefits received under this plan. What you pay depends on your particular benefit plan, the service you receive, and the provider you choose. You may have an access fee, coinsurance, deductible, or some combination of these payments as detailed in the tables that follow. You can refer to Appendix A in your Base Benefit Book for a definition of the terms. Your SBC explains 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.

COST-SHARE TABLE

Type of Cost Share	Amount of Cost Share
Calendar-Year Deductible	**$3,750** per member **$7,500** per family
Out-of-Pocket Maximum	**$6,500** per member **$13,000** per family

Until you meet your deductible, you will pay the allowed amount for most services. 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.

Cost share for ancillary services provided by an out-of-network provider at a network facility will be based on the Qualifying Payment Amount, as defined by federal law. All out-of-network cost share for these ancillary services will be counted toward any in-network deductible and cost-share limits.

Benefit	Your Cost Share
Ambulance Services	**10% coinsurance** (after deductible)
Behavioral Health Services Inpatient facility and professional services	**10% coinsurance** (after deductible)
Behavioral Health Services Outpatient facility and professional services	**10% coinsurance** (after deductible)
Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder	**10% coinsurance** (after deductible)
Cataract Surgery and Keratoconus	**10% coinsurance** (after deductible)
Chiropractic Services	**10% coinsurance** (after deductible)
Chronic Disease Education and Training	**$0** **Deductible is waived**
Clinical Trials	**10% coinsurance** (after deductible)
Dental Services—Medical	**10% coinsurance** (after deductible)
Durable Medical Equipment, Medical Supplies, and Prosthetic Appliances and Orthotics	**$0 for one** FDA-approved manual or electric breast pump and breast pump supplies **per member, per calendar year** **10% coinsurance** (after deductible)
Emergency Services	**10% coinsurance** (after deductible)
Eosinophilic Gastrointestinal Disorder Your deductible is based on cost. Cost is either the allowed amount if the formula is purchased from a network provider, or billed charges if purchased from an out-of-network provider.	**$0** (after deductible)

Benefit	Your Cost Share
Family Planning—Contraceptives and 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 provider on the claim **$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 **$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 **10% coinsurance** (after deductible) for FDA-approved male sterilization procedures
Hearing Aids and Services	**10% coinsurance** (after deductible)
Home Health Services	**10% coinsurance** (after deductible)
Hospice Services	**10% coinsurance** (after deductible)
Inpatient and Outpatient Detoxification Services	**10% coinsurance** (after deductible)
Inpatient Hospital	**10% 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 **$1,000 bariatric surgery access fee** (in addition to deductible and coinsurance) for all bariatric surgeries. This access fee applies toward the professional charges for bariatric surgery.
Inpatient Rehabilitation—Extended Active Rehabilitation and Skilled Nursing Facility Services	**10% coinsurance** (after deductible)
Long-Term Acute Care—Inpatient	**10% coinsurance** (after deductible)
Maternity	**10% coinsurance** (after deductible) Your cost-share obligations may be affected by the addition of a newborn or adopted child as described in the Eligibility for Benefits 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 Your deductible is based on cost. Cost is either the allowed amount if the medical foods are purchased from a network provider, or billed charges if purchased from an out-of-network provider.	**$0** (after deductible)
Neuropsychological and Cognitive Testing	**10% coinsurance** (after deductible)

Benefit	Your Cost Share
Outpatient Services	**10% coinsurance** (after deductible) for: • Diagnostic lab services • Radiology services • Sleep studies • Medications administered at an outpatient facility • Outpatient facility services, including outpatient surgery **$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 **$1,000 bariatric surgery access fee** (in addition to deductible and coinsurance) for all bariatric surgeries. This access fee applies toward the professional charges for bariatric surgery.
Pharmacy and Medications Benefits (next two rows)	
Pharmacy Benefit See the Using Your Pharmacy Benefits section in your Base Benefit Book for details about your Pharmacy benefits, including how your cost share is calculated.	**Retail, Mail Order, and Specialty Medications:** **10% coinsurance** (after deductible) 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 tier of the medication. Compounded medications must be obtained from network retail pharmacies. 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 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 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 the Preventive Services section 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 your provider prescribes them for the purpose of contraception: • 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
Medications for the Treatment of Cancer	**10% coinsurance** (after deductible) See the Pharmacy Benefit cost-share row to determine your cost share for services you receive through the Pharmacy benefit.

Benefit	Your Cost Share
For certain cancer treatment medications, as determined by BCBSAZ, you will receive a **15-day supply,** and pay your **10% coinsurance** (after deductible) the first time you receive it. 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 using 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 your first three months of treatment.	
Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy, Cardiac, and Pulmonary Services	**10% coinsurance** (after deductible)
Physician Services Your cost share will be waived if you receive covered preventive services only during your visit.	**10% coinsurance** (after deductible): • When you see your designated PCP or have a referral from your designated PCP to a network non-designated PCP • When you see a specialist • Medications given to you at a doctor's office **$0** for the following when the purpose is female contraception (birth control), as documented by your provider on the claim: • 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 female contraceptive devices • FDA-approved implanted female 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
Post-Mastectomy Services	**10% coinsurance** (after deductible)
Preventive Services You pay applicable cost share for any tests, procedures, or services not covered in the Preventive Services section in 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 your Base Benefit Book; • The procedure code, the diagnosis code, or the combination of procedure 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 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 section in your Base Benefit Book) for the brand-name version of a preventive medication or item.
Reconstructive Surgery and Services	**10% coinsurance** (after deductible)
Services to Diagnose Infertility	**10% coinsurance** (after deductible)
Telehealth Services— BlueCare Anywhere℠ Telehealth services are video consultations you have with a provider using BCBSAZ's BlueCare Anywhere service.	**10% coinsurance** (after deductible)

Benefit	Your Cost Share
Telehealth Services—Network Providers	You pay the cost-share amounts that apply to the services you receive via telehealth (remote services performed by the provider) along with the cost-share amounts that apply to the services you receive in-person at your physical location. **Example:** If you are at a PCP's office and have a consultation with a remote specialist, you will 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 will pay only the specialist cost share because no other provider is involved at your location.
Transplant Travel and Lodging	**10% coinsurance** (after deductible) Maximum reimbursement of **$10,000 per member, per transplant**
Transplants—Organ, Tissue, and Bone Marrow 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.	**10% coinsurance** (after deductible)
Travel Reimbursement—Outside Service Area	**$0** (after deductible)
Urgent Care	**10% coinsurance** (after deductible)
Pediatric Dental Type I Services	**$0** (after deductible)
Pediatric Dental Type II Services	**50% coinsurance** (after deductible)
Pediatric Dental Type III Services	**50% coinsurance** (after deductible)
Pediatric Dental Type IV Services	**50% coinsurance** (after deductible)
Pediatric Vision Exams (Routine)	Members under age 5: **$0** Members ages 5-19: **10% coinsurance** (after deductible) If a medical condition is identified during your routine vision exam, you will be responsible for additional cost share.
Pediatric Contact Lens Fit and Follow Up	**$0** (after deductible)
Pediatric Eyewear (Eyeglasses or Contact Lenses)	**$0** (after deductible)
Pediatric Low Vision Evaluation and Follow Up	**10% coinsurance** (after deductible)
Pediatric Low Vision Hardware	**$0** (after deductible)