Individual PPO BluePortfolio℠ Plus 1750 90
Plan Attachment

Your Cost-Sharing Information

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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.

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you may not be able to contribute or withdraw funds from your HSA, and you may be subject to a tax penalty on funds withdrawn from your HSA.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 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, balance bill, coinsurance, deductible, prior authorization charge, 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. 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	In-Network	Out-of-Network
Calendar-Year Deductible	Individual only: **$1,750** Family: **$3,500**	Individual only: **$3,500** Family: **$7,000**
Out-of-Pocket Maximum	**$5,500** per member **$11,000** per family	**$11,000** per member **$22,000** 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. For a plan issued to a contract holder with no dependents, the contract holder must meet his or her individual deductible before the 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 plan begins to pay for covered services.

If your out-of-network provider does not get a prior authorization from BCBSAZ for a service that requires it, you may be required to pay a $300 prior authorization charge, or the claim may be denied. You'll find a list of services that need prior authorization at azblue.com/individualsandfamilies/resources/forms and medications that need prior authorization at azblue.com/pharmacy. If you have to pay a prior authorization charge, it does not count toward your calendar-year deductible or out-of-pocket maximum.

Cost share for ancillary services provided by an out-of-network provider at an in-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	In-Network Cost Share	Out-of-Network Cost Share
Ambulance Services	**10% coinsurance** (after in-network deductible)	
Behavioral Health Services Inpatient facility and professional services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Behavioral Health Services Outpatient facility and professional services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Cancer Clinical Trials	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Cardiac and Pulmonary Rehabilitation—Outpatient Services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Cataract Surgery and Keratoconus	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Chiropractic Services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Dental Services—Medical	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
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)	**50% coinsurance** (after deductible) **+ balance bill**
Education and Training	**$0** **Deductible is waived**	**Not covered out-of-network:** Diabetes and asthma education and training **50% coinsurance** (after deductible) **+ balance bill** for nutritional counseling and training

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Emergency Services	You pay your in-network cost share for emergency services, even for services from out-of-network providers. **Emergency Room (ER)** **$150 ER access fee per member, per facility, per day + 10% in-network coinsurance** (after in-network deductible) **Admission to the hospital From the ER** If you are admitted as an inpatient: • **$0 ER access fee** • **10% in-network coinsurance** (after in-network deductible) for facility and ancillary services related to the emergency, including facility and ancillary services you receive while you are at the ER, and emergency professional services you receive after admission If you are admitted for observation or as an outpatient: • **$150 ER access fee** • **10% in-network coinsurance** (after in-network deductible) for professional, facility, and ancillary services you receive that are related to the emergency, and any related services you receive after you are admitted for observation, or as an outpatient	
Eosinophilic Gastrointestinal Disorder	**$0** (after deductible)	**$0** (after deductible) Your deductible is based on the cost of formula. Cost is defined as billed charges.
Family Planning—Contraceptives and Sterilization For preventive services, see the Preventive Services row.	**$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, condoms, sponges, and spermicides **10% coinsurance** (after deductible) for FDA-approved male sterilization procedures	**50% coinsurance** (after deductible) **+ balance bill** for male sterilization procedures
Home Health Services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Hospice Services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Inpatient and Outpatient Detoxification Services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
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	**50% coinsurance** (after deductible) **+ balance bill**
Inpatient Rehabilitation—Extended Active Rehabilitation Services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Long-Term Acute Care—Inpatient	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Maternity—Complications of Pregnancy Only	**10% coinsurance** (after deductible)	**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 Eligibility for Benefits section in 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	**$0** (after deductible)	**$0** (after deductible) Your deductible is based on the cost of medical foods. Cost is defined as billed charges.
Neuropsychological and Cognitive Testing	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
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	**50% coinsurance** (after deductible) **+ balance bill**
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. 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	**50% coinsurance** (after deductible) **+ balance bill** The following are **not covered** when obtained from out-of-network pharmacies: • 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 responsible for any balance bill, including the difference between the allowed amounts for the generic and brand-name medications.

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	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 under 45 CFR § 147.130: • 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 in 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 and obtained from an in-network pharmacy: • Condoms • 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 • Sponges and spermicides	
Medications for the Treatment of Cancer	**10% coinsurance** (after deductible) for medications you purchase through your medical benefit See the Pharmacy Benefit cost-share row to determine your cost share for services you receive through the Pharmacy benefit.	**50% coinsurance** (after deductible) **+ balance bill**
	For certain cancer treatment medications, as determined by BCBSAZ, you will receive a **15-day supply**, and pay **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 three months of treatment.	**Not covered**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Physical Therapy, Occupational Therapy, and Speech Therapy Services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Physician Services Your cost share will be waived if you receive covered preventive services only from an in-network provider during your visit. For preventive services, see the Preventive Services row.	**10% coinsurance** (after deductible) **$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, condoms, sponges, and spermicides	**50% coinsurance** (after deductible) **+ balance bill**
Post-Mastectomy Services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Pregnancy, Termination	**10% coinsurance** (after deductible)	**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 in your Base Benefit Book. All preventive services, except for mammography and foreign travel immunizations, must be received from in-network providers, or the services will not be covered.	**$0** regardless of the location where services are provided if: • You receive one of the services covered as explained in the Preventive Services section in 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 the Preventive Services section in your Base Benefit Book) for the brand-name version of a preventive medication or item.	**50% coinsurance** (after deductible) **+ balance bill** for mammography services and foreign travel immunizations
Reconstructive Surgery and Services	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Skilled Nursing Facility	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Telehealth Services—BlueCare Anywhere℠ Telehealth services are video consultations you have with a provider using BCBSAZ's BlueCare Anywhere service.	**10% coinsurance** (after deductible)	**Not covered**
Telehealth Services—In-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 primary care provider's (PCP) 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.	**Not covered, except for emergency and urgent services.** In those cases, you pay the cost-share amounts applicable to all services provided via telehealth. You will always pay in-network cost share for emergency services provided via telehealth.
Transplant or Gene Therapy Travel and Lodging	**10% coinsurance** (after in-network deductible) Maximum reimbursement of **$10,000 per member, per transplant or gene therapy treatment**	
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)	**50% coinsurance** (after deductible) **+ balance bill**
Urgent Care	**10% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**