Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2024-12/31/2024

BluePreferred® HSA Plus 3200 80

BlueCross BlueShield Arizona Coverage for: Individual & Family | Plan Type: HSA-qualified PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit azblue.com/GroupPlanDocJan2024N. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-877-475-8440 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$3,200/individual or \$6,400/family Out-of-network: \$6,400/individual or \$12,800/family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . Unless a <u>copay</u> , fee, or other percent is shown, the <u>coinsurance</u> percent of the <u>allowed amount</u> that you pay for most services is 20% <u>in-network</u> and 50% <u>out-of-network</u> .
Are there services covered before you meet your deductible?	Yes. Certain <u>in-network preventive</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network: \$5,500/individual or \$11,000/family Out-of-network: \$11,000/individual or \$22,000/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, out-of-network precertification charges, balance-bills, and costs for health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network providers.	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common Medical		What You Will Pay		Limitations, Exceptions, & Other
Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	20% coinsurance		<u>Precertification</u> may be required. \$500 charge if no <u>precertification</u> for <u>out-of-network</u> services.
If you visit a health	Specialist visit	20% coinsurance		20% <u>coinsurance</u> for medical telehealth consultations through BlueCare Anywhere SM .
care <u>provider's</u> office or clinic	re <u>provider's</u> office 50% <u>coinsurance</u> & halance hill	Preventive services not required to be covered by state or federal law are not covered. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.		
If you have a test	Diagnostic test (x-ray, blood work)		50% coinsurance &	Precertification may be required. \$500 charge if
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	balance bill may apply	no precertification for out-of-network services.

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* For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDocJan2024N.

Common Medical		What You Will Pay		Limitations, Exceptions, & Other
Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.azblue.com	Prescription drugs	20% <u>coinsurance</u> (retail and mail order)	50% <u>coinsurance</u> & <u>balance bill</u>	Some drugs require <u>precertification</u> and won't be covered without it. Mail order not covered <u>out-of-network</u> . If a generic drug is available, pay the generic <u>cost share</u> + the price difference between the <u>allowed amount</u> for the brand and generic drugs.
	Specialty drugs	20% coinsurance	Not covered	Some drugs require <u>precertification</u> and won't be covered without it.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	200/	50% coinsurance & balance bill	Additional \$1,000 access fee for all bariatric surgeries. Precertification may be required. \$500
	Physician/surgeon fees	20% coinsurance	50% coinsurance & balance bill may apply	charge if no <u>precertification</u> for <u>out-of-network</u> services.
	Emergency room care	20% coinsurance		Out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge.
If you need immediate medical attention	Emergency medical transportation	20% coinsurance		None.
	Urgent care	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	None.

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* For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDocJan2024N.

Common Medical		What You Will Pay		Limitations, Exceptions, & Other	
Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance & balance bill	Additional \$1,000 access fee for all bariatric surgeries. Precertification may be required. \$500	
If you have a hospital stay	Physician/surgeon fees	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u> may apply	charge if no <u>precertification</u> for <u>out-of-network</u> services.	
	Long-term acute care (LTAC)	20% coinsurance	50% coinsurance & balance bill	Precertification may be required. \$500 charge if no precertification for out-of-network services. Limit of 365 total LTAC days per member.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance & balance bill may apply	Precertification may be required. \$500 charge if no precertification for out-of-network services. 20% coinsurance for counseling or psychiatric telehealth consultations through BlueCare Anywhere SM .	
abuse services	Inpatient services	20% coinsurance		Precertification may be required. \$500 charge if no precertification for out-of-network services.	
	Office Visits	20% coinsurance	50% coinsurance & balance bill	Maternity care may include tests and services	
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u> may apply	described elsewhere in the <u>SBC</u> (i.e. ultrasound). <u>Cost sharing</u> does not apply for in-network	
	Childbirth/delivery facility services	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	preventive services.	

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Common Medical	Common Medical What You Will Pay:		Limitations, Exceptions, & Other	
Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Home health care/Home infusion therapy	20% coinsurance	50% coinsurance & balance bill	Precertification may be required. \$500 charge if no precertification for out-of-network services. Limit of 42 visits (of up to 4 hours)/calendar year.
If you need help recovering or have other special health needs	Rehabilitation services • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification may be required. \$500 charge if no precertification for out-of-network services. Limit of 120 days/calendar year for Extended Active Rehabilitation Facility (EAR) and 180 days/calendar year for Skilled Nursing Facility (SNF).
	Habilitation services	Not covered*	Not covered*	
	Skilled nursing care	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	*Limited coverage available for <u>habilitation</u> services to treat autism spectrum disorder for groups of 51 or more eligible employees.
	Durable medical equipment	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Precertification</u> may be required. \$500 charge if no <u>precertification</u> for <u>out-of-network</u> services.
<u> </u>	Hospice services	20% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification may be required. \$500 charge if no precertification for out-of-network services.
If your shild woods	Children's eye exam	Not covered	Not covered	Excluded
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Excluded
	Children's dental check-up	Not covered	Not covered	Excluded

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* For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDocJan2024N.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care except as stated in plan
- <u>DME</u> rental/repair charges that exceed <u>DME</u> purchase price
- Experimental and investigational treatments except as stated in <u>plan</u>
- Eyewear except as stated in plan
- Flat feet treatment and services
- Genetic and chromosomal testing, except as stated in plan

- <u>Habilitation</u> services, except certain autism services
- Hearing aids
- Home health care and infusion therapy exceeding
 42 visits (of up to 4 hours)/calendar year
- Homeopathic services
- Infertility medication and treatment
- Inpatient EAR treatment exceeding 120 days per calendar year and inpatient SNF treatment exceeding 180 days per calendar year
- Long-term care, except long-term acute care up to a 365 days benefit <u>plan</u> maximum
- Massage therapy other than allowed under evidence-based criteria

- Naturopathic services
- <u>Out-of-network</u> Mail Order, <u>out-of-network</u>
 <u>Specialty</u>, and <u>out-of-network</u> 90 day supplies of drugs
- Private-duty nursing
- Respite care, except as stated in plan
- Routine foot care
- Routine vision exams
- Sexual dysfunction treatment and services
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Bariatric surgery

Chiropractic care

Non-emergency care when travelling outside the U.S.

^{*} For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDocJan2024N.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Church <u>plans</u> are not covered by the Federal <u>COBRA</u> continuation coverage rules. If the coverage is insured, individuals should contact the Arizona Department of Insurance (602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area) regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.
- For non-federal governmental group health plans and church plans that are group health plans, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area or https://difi.az.gov/consumer/i/health.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

^{*} For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDocJan2024N.

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínígóó. Ata' halne'ígíí kojí' bich'j' hodíilnih 877-475-4799.

Chinese: 如果您,或是您正在協助的對象,有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題,您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員,請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyên với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 877-475-877.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید .4799-475-877 تماس حاصل نمایید.

Assyrian:

يہ ئېمەن، بې ښټ فخپوقد دۈمودوس تمەن، دېمگەمەن، دېمگەمەن، دېمگەمەن، دېمگەمەن، دېمگەمەن، ئېمەن، دېمگەمەن، دېمگەم

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีค่าถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

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About These Coverage Examples

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,200
Copayments	\$0
<u>Coinsurance</u>	\$1,880
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$5,130

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing		
<u>Deductibles</u>	\$3,200	
<u>Copayments</u>	\$0	
Coinsurance	\$440	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$3,660	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to enable people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

LE35706 01/24 C08205-0124