# HSA Plus 4000/90

Blue Cross® Blue Shield® of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

Coverage Period: On and after 09/04/13

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual & Family | **Plan Type:** HSA-eligible PPO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.azblue.com** or by calling **1-877-475-8440**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network and out-of-network combined: **$4,000**/member and **$8,000**/family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Your **deductible** is based on a calendar year and starts over each January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Unless a copay, fee or different percentage is shown, the coinsurance percentage of the allowed amount that you will pay for most services is 10% in-network and 50% out of network. Balance bills, charges for non-covered services, and pre-certification charges don't count toward deductible. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. In-network: **$5,000/**member and **$10,000/**family<br>Out-of-network: **$10,000/**member and **$20,000/**family | The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses. If you have funds in an HSA, HRA or FSA, you may be able to use those funds to cover your out-of-pocket expense. |
| **What is not included in the out–of–pocket limit?** | Premiums, 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 out-of-pocket limit. You must keep paying them even if you reach your out-of-pocket limit. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network providers. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. See the chart starting on page 2 for how this plan pays different kinds of providers. |

**Questions:** Call **1-877-475-8440** or visit us at **www.azblue.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call 1-877-475-8440 to request a copy.

| | | |
|---|---|---|
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your benefit book for more information about **excluded services**. |

- **Copays** are fixed dollar amounts (for example, $35) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use **in-network providers** by charging you lower cost-share amounts when you use **in-network providers**, who usually accept the plan's allowed amount. Most out-of-network providers may bill you for full billed charges. When you see a non-contracted, out-of-network provider, the plan will reimburse you for covered claims based on the plan allowed amount, minus your cost share.

| Common Medical Event | Services You May Need | Your Cost If You Use a In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 10% coinsurance | 50% coinsurance & balance bill | Plan doesn't cover acupuncture and services by naturopaths and homeopaths. Limited to one in-network routine vision exam per calendar year |
| | Specialist visit | | | |
| | Other practitioner office visit | | | |
| | Preventive care/screening/immunization | No charge | Most services not covered out of network.<br>50% coinsurance & balance bill | Provider's diagnosis and procedure codes determine whether service is preventive. Only mammography and foreign travel immunizations are covered out of network. |

| Common Medical Event | Services You May Need | Your Cost If You Use a In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 50% coinsurance & balance bill | None. |
| | Imaging (CT/PET scans, MRIs) | | | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.azblue.com. | Prescription drugs | Retail & Mail Order: 10% coinsurance | Retail: 50% coinsurance & balance bill | Some drugs require precertification and won't be covered without it.<br>Mail order is not covered out of network. |
| | Specialty self-injectable drugs | Retail & Mail Order: 10% coinsurance | Not covered | No coverage without precertification. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 50% coinsurance & balance bill | Additional $1,000 access fee for all bariatric surgeries. |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room services | 10% coinsurance | 10% coinsurance & balance bill | None |
| | Emergency medical transportation | 10% coinsurance | | None |
| | Urgent care | 10% coinsurance | 50% coinsurance & balance bill | None |

| Common Medical Event | Services You May Need | Your Cost If You Use a In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 50% coinsurance & balance bill | Precertification required & $300 charge applies if not obtained. Additional $1,000 access fee for all bariatric surgeries. |
| | Physician/surgeon fee | | | |
| | Long-term acute care | 10% coinsurance | 50% coinsurance & balance bill | Precertification required. Services not covered without precertification.<br><br>Benefit limit of 365 total days of long term acute care per member. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 10% coinsurance | 50% coinsurance & balance bill | None. |
| | Mental/Behavioral health inpatient services | | | Precertification required for non-emergency admissions; $300 charge applies if not obtained. |
| | Substance use disorder outpatient services | | | None. |
| | Substance use disorder inpatient services | | | Precertification required for non-emergency admissions; $300 charge applies if not obtained. |
| **If you are pregnant** | Prenatal and postnatal care | 10% coinsurance | 50% coinsurance & balance bill | None |
| | Delivery and all inpatient services | | | |

| Common Medical Event | Services You May Need | Your Cost If You Use a In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care/Home infusion therapy | 10% coinsurance | 50% coinsurance & balance bill | Limited to 6 hours of care per member per day. Custodial care excluded. Certain drugs not covered without precertification. |
| | Rehabilitation services<br>EAR = Extended Active Rehabilitation Facility<br>PT/OT/ST = Physical therapy, occupational therapy, speech therapy | 10% coinsurance | 50% coinsurance & balance bill | Precertification required for inpatient stay in EAR facility or services won't be covered. Benefit limit of 120 days/member/calendar year for EAR inpatient stay.<br>Plan doesn't cover group physical and occupational therapy. |
| | Habilitation services | Not covered | Not covered | Excluded |
| | Skilled nursing care<br>In skilled nursing facility (SNF) | 10% coinsurance | 50% coinsurance & balance bill | No coverage without precertification. Benefit limit of 180 days per member per calendar year. Private duty nursing not covered. |
| | Durable medical equipment | 10% coinsurance | 50% coinsurance & balance bill | No coverage for rental or repair charges that exceed purchase price or for deluxe models that aren't medically necessary. |
| | Hospice service | 10% coinsurance | 50% coinsurance & balance bill | None |
| **If your child needs dental or eye care** | Eye exam | 10% coinsurance. No charge for members under age 5. | 50% coinsurance and balance bill | Limited to one routine vision exam per member per calendar year. |
| | Glasses | Not covered | Not covered | Excluded |
| | Dental check-up | Not covered | Not covered | Excluded |

## Excluded Services & Other Covered Services:

| **Services Your Plan Does NOT Cover** (This isn't a complete list. Check your benefit book for other excluded services.) | | |
|---|---|---|
| • Acupuncture<br>• Care that is not medically necessary<br>• Cosmetic surgery<br>• Dental care except dental accidents<br>• Experimental and investigational treatments<br>• Eye wear except after cataract surgery<br>• Habilitation care<br>• Hearing aids<br>• Infertility Treatment | • Inpatient extended active rehabilitation treatment over 120 days per calendar year<br>• Long-term care (except 365 days of long-term acute care)<br>• Massage therapy other than allowed under medical coverage guidelines<br>• Out-of-network mail order prescriptions and specialty self-injectable medications<br>• Out-of-network preventive care except mammography and foreign travel immunizations | • Private-duty nursing<br>• Routine eye care, except one exam per calendar year<br>• Routine foot care<br>• Services from naturopathic and homeopathic physicians<br>• Sexual dysfunction<br>• Skilled nursing facility treatment over 180 days per calendar year<br>• Weight loss programs |

| **Other Covered Services** (This isn't a complete list. Check your benefit book for other covered services and your costs for these services.) | | |
|---|---|---|
| • Bariatric surgery | • Chiropractic services | • Non-emergency care when travelling outside the U.S. |

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-475-8440. You may also contact your state insurance department at (602) 364-2499 or (800) 325-2548, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-877-475-8440.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 602-864-4884.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 602-864-4884.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 602-864-4884.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-864-4884.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,060
- **Patient pays** $4,480

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $4,000 |
| Copays | $0 |
| Coinsurance | $330 |
| Limits or exclusions | $150 |
| **Total** | **$4,480** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,190
- **Patient pays** $4,210

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $4,000 |
| Copays | $0 |
| Coinsurance | $130 |
| Limits or exclusions | $80 |
| **Total** | **$4,210** |

**This example shows the cost share for a policy covering only one person. If the policy covers a spouse and/or children, a member's cost share may be less than the amount shown if other members contribute to or satisfy the family deductible before the Plan receives claims for that one member.**

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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