Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
 Coverage Period: On or after 01/01/2024

 Vigilant HSA 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/member. 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 <u>deductible</u> ?	<u>In-network</u> and <u>out-of-network</u> : \$3,200 /individual or \$6,400 /family	Generally, you must pay all of the costs from <u>providers</u> 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 <u>deductible</u> ?	Yes. Certain <u>in-network preventive</u> <u>services</u> 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 <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 <u>https://www.healthcare.gov/coverage/preventive- care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network: \$5,250 /individual or \$10,500 /family <u>Out-of-network</u> : \$10,500 /individual or \$21,000 /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 prior authorization charges, balance bills, and costs for health care this <u>plan</u> 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 <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> '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 <u>provider</u> '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 <u>specialist</u> you choose without a <u>referral</u> .

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.

		What Yo	u Will Pay	Limitations, Exceptions, & Other	
Common Medical 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	50% <u>coinsurance</u> & <u>balance</u> bill	<u>Prior authorization</u> may be required. \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Medical telehealth consultations covered through	
If you visit a health	<u>Specialist</u> visit	20% <u>coinsurance</u>		BlueCare Anywhere SM .	
care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	<u>Preventive services</u> not required to be covered by state or federal law are not covered. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance & balance	Prior authorization may be required. \$500 charge if	
	Imaging (CT/PET scans, MRIs)		<u>bill</u> may apply	no <u>prior authorization</u> for <u>out-of-network</u> services.	
If you need drugs to treat your illness or condition More information about prescription drug	Prescription drugs	20% <u>coinsurance</u> (retail and mail order)	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Some drugs require <u>prior authorization</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 some brand drugs.	
coverage is available at www.azblue.com	Specialty drugs	20% coinsurance	Not covered	Some drugs require <u>prior authorization</u> and won't be covered without it.	

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% <u>coinsurance</u>	50% coinsurance & balancebill50% coinsurance & balancebill may apply	Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services. Additional \$1,000 access fee for all bariatric surgeries.
If you need immediate	Emergency room care			Out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge.
medical attention	Emergency medical transportation	20% <u>coinsurance</u>		None
	Urgent care	20% coinsurance	50% <u>coinsurance</u> & <u>balance</u> bill	None
lf you have a hospital stay	Facility fee (e.g., hospital room)	- 20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services.
	Physician/surgeon fees		50% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply	Additional \$1,000 access fee for all bariatric surgeries.
	Long-term acute care	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	<u>Prior authorization</u> may be required. \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 365 total LTAC days per member.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply	Prior authorization may be required. \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Counseling telehealth consultations and Psychiatric telehealth consultations covered through BlueCare Anywhere SM .
	Inpatient services	20% coinsurance	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply	Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services.

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Office Visits		50% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Maternity care may include tests and services
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply	described elsewhere in the <u>SBC</u> (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>in-network</u>
	Childbirth/delivery facility services	20% coinsurance	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	preventive services.
	Home health care/Home infusion therapy	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance</u> bill	Prior authorization may be required. \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 42 visits (of up to 4 hours)/calendar year. Custodial care excluded.
If you need help recovering or have	Rehabilitation services • EAR = Extended Active Rehabilitation Facility • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. \$500 charges no prior authorization for out-of-network service Limit of 120 days/calendar year for EAR and 18
other special health needs	Habilitation services	Not covered	Not covered	days/calendar year for SNF. <u>Plan</u> does not cover group physical and occupational therapy.
	Skilled nursing care In skilled nursing facility (SNF)	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	
	Durable medical equipment	20% coinsurance	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services.
	Hospice services	20% coinsurance	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. \$500 charge if no prior authorization for out-of-network services.

			What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	If your child needs	Children's eye exam	Not covered	Not covered	Excluded. <u>Screening</u> for members under age 5 covered under " <u>Preventive care</u> / <u>screening</u> / immunization."
	dental or eye care	Children's glasses	Not covered	Not covered	Excluded
		Children's dental check-up	Not covered	Not covered	Excluded

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 Genetic and chromosomal testing except as stated Out-of-network Mail Order drugs, out-of-network Specialty drugs, and out-of-network 90-day retail in plan Alternative medicine • supply of drugs Habilitation services Care that is not medically necessary • Preventive services not required to be covered by Hearing aids Cosmetic surgery, cosmetic services & supplies • state or federal law Home health care and infusion therapy exceeding Custodial care • Private-duty nursing 42 visits (of up to 4 hours)/calendar year • Dental care except dental accidents Respite care except as stated in plan Inpatient EAR treatment exceeding 120 days per DME rental/repair charges that exceed DME Routine foot care calendar year and inpatient SNF treatment purchase price Routine vision exams exceeding 180 days per calendar year Experimental and investigational treatments Services, tests and procedures that are excluded · Long-term care, except long-term acute care up to except as stated in plan under medical coverage guidelines a 365 days benefit plan maximum Eyewear except after cataract surgery Sexual dysfunction treatment and services Massage therapy other than allowed under · Fertility and infertility medication and treatment Weight loss programs • evidence-based criteria Flat feet treatment and services except as stated in plan

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 traveling outside the U.S. 	

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 Health Insurance <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318- 2596.

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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.

Page 6 of 9 * For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

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 yiťéego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí ťáadoo le'é yína'ídíłkidgo beehaz'áanii hóló díí ťáá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínígóó. Ata' halne'ígíí kojį' bich'į' 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 chuyện 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 المتحدث مع مترجم اتصل ب 479-475-877.

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 로 전화하십시오.

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:

ی به همه، به هم فه وفووه وه دومه دیمکومه دومتو دوم Blue Cross Blue Shield of Arizona به مه دومد مه وفده فروه و دوموه به هم دیمه مود همه، به همه دومه وسنه ۲۹۳۹-475-8778.

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) <u>coinsurance</u>	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost\$12,700

In this example, Peg would pay:

Cost Sharing			
<u>Deductibles</u>	\$3,200		
Copayments	\$0		
Coinsurance	\$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
■ <u>Specialist</u> coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (*including disease education*) <u>Diagnostic tests</u> (*blood work*) <u>Prescription drugs</u> <u>Durable medical equipment</u> (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing		
Deductibles	\$3,200	
Copayments	\$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) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like: <u>Emergency room care</u> (including medical supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutches) <u>Rehabilitation services</u> (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.

L20442-0124

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