# Group PPO EverydayHealth Gold 1500

# Plan Attachment

# Off Marketplace

## Your Cost-Sharing Information

azblue.com/MyBlue

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

## 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, balance bill, coinsurance, copay, deductible, precertification 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. 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 | In-Network | Out-of-Network |
|---|---|---|
| **Calendar-Year Deductible** | **$1,500** per member<br>**$3,000** per family | **$2,000** per member<br>**$4,000** per family |
| **Out-of-Pocket Maximum** | **$6,375** per member<br>**$12,750** per family | **$12,750** per member<br>**$25,500** 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 services that require a copay, the calendar-year deductible is waived. 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 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**<br>**Deductible is waived** | |
| **Behavioral Health Services**<br>Inpatient facility and professional services | **10% coinsurance** (after deductible) | **50% coinsurance** (after deductible) **+ balance bill** |
| **Behavioral Health Services**<br>Outpatient facility and professional services | **$25 copay** for primary care provider (PCP) visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for services you receive at other locations | **50% coinsurance** (after deductible) **+ balance bill** |
| **Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder** | **$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges | **50% coinsurance** (after deductible) **+ balance bill** |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|---|
| **Cataract Surgery and Keratoconus** | **$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges | **50% coinsurance** (after deductible) **+ balance bill** |
| **Chiropractic Services** | **$60 specialist copay per member, per provider, per day** for services you receive during an office, home, or walk-in clinic visit. The copay does not apply if you receive only physical medicine and rehabilitation services and no other covered service during your visit.<br>**10% coinsurance** (after deductible) for:<br>• Visits in which you only receive physical medicine and rehabilitation services and no other covered service<br>• Chiropractic services provided at other locations | **50% coinsurance** (after deductible) **+ balance bill** |
| **Chronic Disease Education and Training** | **$0**<br>**Deductible is waived** | **50% coinsurance** (after deductible) **+ balance bill** |
| **Clinical Trials** | **$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges | **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**<br>**$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for:<br>• Durable medical equipment (DME) picked up at the doctor's office but billed through a DME supplier. If you have a doctor's office visit at the time you pick up your DME, medical supplies, prosthetic appliance, or orthotics, you also pay the PCP or specialist copay.<br>• Services you receive at locations other than a doctor's office | **50% coinsurance** (after deductible) **+ balance bill** |
| **Emergency Services** | **10% coinsurance** (after in-network deductible)<br>You pay your in-network cost share for emergency services, even for services from out-of-network providers. | |
| **Eosinophilic Gastrointestinal Disorder** | **10%** of the cost of formula<br>**Deductible is waived** | **25%** of the cost of formula<br>**Deductible is waived** |
| Cost is defined here as either the allowed amount if the formula is purchased from an in-network provider, or billed charges if purchased from an out-of-network provider. | | |
| **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 | **50% coinsurance** (after deductible) **+ balance bill** |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|---|
| | **$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<br>**$0** for female oral contraceptives, patches, rings, and contraceptive injections<br>**$0** for FDA-approved over-the-counter emergency contraception that is prescribed by a doctor or other healthcare provider<br>**$0** for diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides<br>**10% coinsurance** (after deductible) for FDA-approved male sterilization procedures | |
| **Hearing Aids and Services** | **$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, any related facility charges, and hearing devices obtained in any location | **50% coinsurance** (after deductible) **+ balance bill** |
| **Home Health Services** | **10% coinsurance** (after deductible) | **50% coinsurance** (after deductible) **+ balance bill** |
| **Hospice Services** | **$0**<br>**Deductible is waived** | **$0 + balance bill**<br>**Deductible is waived** |
| **Inpatient and Outpatient Detoxification Services** | **$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for services you receive at other locations | **50% coinsurance** (after deductible) **+ balance bill** |
| **Inpatient Hospital** | **10% coinsurance** (after deductible)<br>**$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** |
| | **$1,000 bariatric surgery access fee** (in addition to applicable 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) | **50% coinsurance** (after deductible) **+ balance bill** |
| **Long-Term Acute Care—Inpatient** | **10% coinsurance** (after deductible) | **50% coinsurance** (after deductible) **+ balance bill** |
| **Maternity**<br>Global charge is a fee charged by the delivering provider that includes certain prenatal, delivery, and postnatal services. | **$25 PCP copay** or **$60 specialist copay** for your first prenatal office or home visit, which covers all services included in the provider's global charge<br>**One copay, per member, per provider, per day** for other office or home visits not included in the global charge<br>**10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges | **50% coinsurance** (after deductible) **+ balance bill** |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|---|
| 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** | **10%** of the cost of medical foods<br>**Deductible is waived** | **50%** of the cost of medical foods<br>**Deductible is waived** |
| Cost is defined here as either the allowed amount if the medical foods are purchased from an in-network provider, or billed charges if purchased from an out-of-network provider. | | |
| **Neuropsychological and Cognitive Testing** | **$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges | **50% coinsurance** (after deductible) **+ balance bill** |
| **Outpatient Services** | **Diagnostic Laboratory Services:**<br>• **$0** if you only receive covered laboratory services at a doctor's office<br>• **$25 PCP copay** or **$60 specialist copay** for services you receive at a doctor's office<br>• **10% coinsurance** (after deductible) for professional services you receive from a pathologist or dermapathologist, and services you receive at locations other than a doctor's office<br>**Radiology Services**<br>• **$25 PCP copay** or **$60 specialist copay** for services you receive at a doctor's office<br>• **10% coinsurance** (after deductible) for professional services you receive from a radiologist, and services you receive at locations other than a doctor's office<br>**Outpatient Facility Services** (including outpatient surgery):<br>• **10% coinsurance** (after deductible)<br>• **$0** for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim<br>**Sleep Studies: 10% coinsurance** (after deductible)<br>**Medications Given to You at an Outpatient Facility: 10% coinsurance** (after deductible) | **50% coinsurance** (after deductible) **+ balance bill** |
| | **$1,000 bariatric surgery access fee** (in addition to applicable deductible and coinsurance) for all bariatric surgeries. This access fee applies toward the professional charges for bariatric surgery. | |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|---|
| **Pharmacy and Medications Benefits** (next two rows)<br>**Note:** Your cost share for any medication is based on the tier to which BCBSAZ has assigned it at the time the prescription is filled. No exceptions will be made regarding the assigned tier of a medication. BCBSAZ may change the tier of a medication at any time without notice. To confirm the status and tier of a particular medication, visit MyBlue, or call Pharmacy Benefit Customer Service at the number on your ID card. | | |
| **Pharmacy Benefit**<br>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 Medications** (30-day supply)<br>• Tier 1a: **$3 copay**<br>• Tier 1b: **$20 copay**<br>• Tier 2: **$70 copay**<br>• Tier 3 (including compounded medications and formulary exceptions): **$130 copay**<br>**Mail Order Medications** (90-day supply)<br>• Tier 1a: **$6 copay**<br>• Tier 1b: **$40 copay**<br>• Tier 2: **$140 copay**<br>• Tier 3 (including formulary exceptions): **$260 copay**<br>**Specialty Medications** (30-day supply of most medications)<br>• **50% coinsurance**<br>• **Calendar-year deductible is waived**<br>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). If you receive a 31- to 60-day supply of medication, you will pay two times the applicable cost share for a 30-day supply. If you receive a 61- to 90-day supply of medication from a network retail pharmacy, you will pay three times the 30-day cost share. 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.<br>If you purchase a brand-name medication when a generic equivalent is available, you will pay the **tier 1a or 1b copay 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.<br>**$0** for preventive medications and covered vaccines. BCBSAZ determines:<br>• Which medications are considered preventive,<br>• Which vaccines are covered, **and**<br>• For which there is a $0 cost share<br>**$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 | The following are **not covered** when obtained from out-of-network pharmacies:<br>• 90-day supply at retail<br>• Mail order medications<br>• Specialty medications<br>**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 reimbursed at the in-network level of benefits, up to the allowed amount. You will be responsible for any balance bill, including the difference between the allowed amounts for the generic and brand name medications.<br>To find cost information for a medication:<br>• Log in to MyBlue<br>• Under "Pharmacy," click Prescription Benefits & Tools to go to the "My Medicine Cabinet" page<br>• At the top of the page, select "Member Tools > Drug Pricing" |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|---|
| | Book) for the brand-name version of a preventive medication or item.<br>**$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:<br>• FDA-approved brand oral, patch, vaginal ring, and injectable contraceptives with no generic equivalent components<br>• FDA-approved diaphragms, cervical caps, and cervical shields<br>• FDA-approved emergency contraception for members of any age<br>• FDA-approved generic oral, patch, vaginal ring, and injectable contraceptives<br>• Female condoms<br>• Sponges and spermicides | |
| **Medications for the Treatment of Cancer** | **10% coinsurance** (after deductible) for medications you purchase through your medical benefit<br>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 cancer treatment medications that are also classified as specialty medications, you pay the tier 1b pharmacy copay. For certain cancer treatment medications, as determined by BCBSAZ, you will receive a **15-day supply,** and pay **one-half of the tier 1b** pharmacy copay the first time you receive it. You will be able to refill the medication every 15 days, and you will continue to pay one-half of the tier 1b pharmacy copay 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. | **Not covered** |
| **Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy, Cardiac, and Pulmonary Services** | **10% coinsurance** (after deductible) | **50% coinsurance** (after deductible) **+ balance bill** |
| **Physician Services**<br>Your cost share will be waived if you receive covered preventive services only from an in-network provider during your visit. | **One $25 PCP copay** or **one $60 specialist copay per member, per provider, per day** for services you receive during an office, home, or walk-in clinic visit<br>**$0** if you only receive the following services and no other covered service during your office, home, or walk-in clinic visit:<br>• Covered allergy injections<br>• Covered immunizations<br>• Covered laboratory services<br>**$0** for the following when the purpose is female contraception (birth control), as | **50% coinsurance** (after deductible) **+ balance bill** |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|---|
| | documented by your provider on the claim:<br>• Professional services for FDA-approved female sterilization procedures, regardless of the location of service<br>• Professional services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices<br>• FDA-approved implanted female contraceptive devices<br>• 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<br>**10% coinsurance** (after deductible) for:<br>• Covered physical therapy, occupational therapy, and speech therapy<br>• PCP and specialist services provided at locations other than a doctor's office, home, or walk-in clinic<br>• Professional services you receive from a radiologist or pathologist, including a dermapathologist, and professional services you receive that are related to a sleep study, even when the services are provided at a doctor's office<br>• Medications given to you at a doctor's office | |
| See the Outpatient Services row above for more information on cost-share amounts for covered services. | | |
| **Post-Mastectomy Services** | **$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges | **50% coinsurance** (after deductible) **+ balance bill** |
| **Preventive Services**<br>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:<br>• You receive one of the services covered as explained in the Preventive Services section in your Base Benefit Book;<br>• 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**<br>• The primary purpose of the visit at which you received the services was preventive care<br>**$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** |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|---|
| **Reconstructive Surgery and Services** | **$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges | **50% coinsurance** (after deductible) **+ balance bill** |
| **Services to Diagnose Infertility** | **$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges | **50% coinsurance** (after deductible) **+ balance bill** |
| **Telehealth Services—BlueCare Anywhere℠**<br>Telehealth services are video consultations you have with a provider using BCBSAZ's BlueCare Anywhere service. | **$0** for telehealth medical consultations<br>**$20 copay** for telehealth counseling sessions provided by a counselor<br>**$45 copay** for telehealth psychiatric consultations provided by a psychiatrist | **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.<br>**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. | **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** | **$0**<br>**Deductible is waived**<br>Maximum reimbursement of **$10,000 per member, per transplant or gene therapy treatment** | |
| **Transplants—Organ, Tissue, and Bone Marrow and Stem Cell Procedures**<br>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. | **$25 copay** for PCP visit<br>**$60 copay** for specialist visit<br>**10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges | **50% coinsurance** (after deductible) **+ balance bill** |

| Benefit | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|---|
| **Urgent Care** | **$60 copay per member, per provider, per day** for services you receive from a provider that is contracted with the plan network to offer urgent care services<br>**$25 PCP copay** or **$60 specialist copay** for services you receive during an office, home, or walk-in clinic visit from an in-network provider that is not specifically contracted for urgent care services<br>**10% coinsurance** (after deductible) for urgent care services you receive from any other type of provider | **50% coinsurance** (after deductible) **+ balance bill** |
| | See the Emergency Services row for cost share if you receive services from certain providers, such as hospitals, that are not specifically contracted with the plan network as urgent care providers. | |
| **Pediatric Dental Type I Services** | **$0**<br>**Deductible is waived** | **$0 + balance bill**<br>**Deductible is waived** |
| **Pediatric Dental Type II Services** | **50% coinsurance** (after deductible) | **60% coinsurance** (after deductible) **+ balance bill** |
| **Pediatric Dental Type III Services** | **50% coinsurance** (after deductible) | **60% coinsurance** (after deductible) **+ balance bill** |
| **Pediatric Dental Type IV Services** | **50% coinsurance** (after deductible) | **60% coinsurance** (after deductible) **+ balance bill** |
| **Pediatric Vision Exams (Routine)** | Members under age 5: **$0**<br>Members ages 5-19: **$25 copay** | **50% coinsurance** (after deductible) **+ balance bill** |
| | 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**<br>**Deductible is waived** | **Not covered** |
| **Pediatric Eyewear (Eyeglasses or Contact Lenses)** | **$0**<br>**Deductible is waived** | **Not covered** |
| **Pediatric Low Vision Evaluation and Follow Up** | **$0**<br>**Deductible is waived** | **50% coinsurance** (after deductible) **+ balance bill** |
| **Pediatric Low Vision Hardware** | **$0**<br>**Deductible is waived** | **Not covered** |