Individual PPO BlueEssential℠ Plus 500 60
Plan Attachment

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 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, 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	**$500** per member **$1,000** per family	**$1,000** per member **$2,000** per family
Out-of-Pocket Coinsurance Maximum	**$5,500** per member	**$11,000** per member
Limit	**In-Network**	
Annual Physician Visit Copay Limit	You pay either the **$35** primary care provider (PCP) copay or the **$60** specialist copay (as applicable) for your first 3 combined in-network doctor's office, home, or walk-in clinic visits, per member, per calendar year. For any additional visits, you will pay your coinsurance for each visit (after you meet the deductible listed above).	
The annual physician copay limit applies to the benefits below that are marked with an asterisk (*).		

Until you meet your deductible, you will pay the allowed amount for most services, plus the balance bill for out-of-network services. 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. For services that require a copay, the calendar-year deductible is waived.

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 coinsurance 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	**40% coinsurance** **Deductible is waived**	
Behavioral Health Services Inpatient facility and professional services	**40% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Behavioral Health Services Outpatient facility and professional services	**$0** for services you receive during an office, home, or walk-in clinic visit **40% coinsurance** (after deductible) for services you receive at other locations	**50% coinsurance** (after deductible) **+ balance bill**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Cancer Clinical Trials*	First 3 office visits in a calendar year: **PCP or specialist visit copay**—see the Physician Services row **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • Professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Cardiac and Pulmonary Rehabilitation—Outpatient Services*	First 3 office visits in a calendar year: **PCP or specialist visit copay**—see the Physician Services row **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • Professional services you receive at an outpatient facility, and any related outpatient facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Cataract Surgery and Keratoconus*	First 3 office visits in a calendar year: **PCP or specialist visit copay**—see the Physician Services row **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • Professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Chiropractic Services*	**Specialist visit copay**—see the Physician Services row for chiropractic services for your first 3 office, home, or walk-in clinic visits in a calendar year **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • Chiropractic services delivered at other locations • Visits in which you receive only physical medicine and rehabilitation services and no other covered service	**50% coinsurance** (after deductible) **+ balance bill**
Dental Services—Medical	**40% 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** First 3 office visits in a calendar year, including doctor visits that you have when you are also picking up a durable medical equipment (DME) item: **PCP or specialist visit copay**—see the Physician Services row **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • Doctor's office visits in conjunction with pickup of a DME item after your	**50% coinsurance** (after deductible) **+ balance bill**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	first 3 visits in a calendar year • Pickup of a DME item at a doctor's office when the item is billed through a DME supplier, and there is no doctor visit involved • Services you receive at locations other than a doctor's office	
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
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 + 40% 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** • **40% 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** • **40% 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	**25% coinsurance** **Deductible is waived**	**25%** of the cost of formula **Deductible is waived** 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 For FDA-approved male sterilization procedures: First 3 office visits in a calendar year: **PCP or specialist visit copay**—see the Physician Services row	**50% coinsurance** (after deductible) **+ balance bill** for male sterilization procedures

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	40% coinsurance (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • Services you receive at other locations	
Home Health Services	**40% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**
Hospice Services	**$0** **Deductible is waived**	**$0 + balance bill** **Deductible is waived**
Inpatient and Outpatient Detoxification Services	**$0** for services you receive during an office, home, or walk-in clinic visit **40% coinsurance** (after deductible) for services you receive at other locations	**50% coinsurance** (after deductible) **+ balance bill**
Inpatient Hospital	**40% 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	**40% coinsurance** (after deductible) for the first 60 days of services in a calendar year **50% coinsurance** (after deductible) for the second 60 days of services in a calendar year (this amount does not count toward your out-of-pocket coinsurance maximum)	**50% coinsurance** (after deductible) **+ balance bill** for the first 60 days of services in a calendar year **50% coinsurance** (after deductible) **+ balance bill** for the second 60 days of services in a calendar year (this amount does not count toward your out-of-pocket coinsurance maximum)
	If your claim is submitted with a primary behavioral health diagnosis, you will pay the cost share applicable to the first 60 days of services in a calendar year, and your coinsurance will count toward the applicable out-of-pocket coinsurance maximum, regardless of how many days of extended active rehabilitation services you have received in a calendar year.	
Long-Term Acute Care—Inpatient	**40% coinsurance** (after deductible) for the first 100 days of services **50% coinsurance** (after deductible) for days 101-365 of services (this amount does not count toward your out-of-pocket coinsurance maximum)	**50% coinsurance** (after deductible) **+ balance bill** for the first 100 days of services **50% coinsurance** (after deductible) **+ balance bill** for the 101-365 days of services (this amount does not count toward your out-of-pocket coinsurance maximum)
	If your claim is submitted with a primary behavioral health diagnosis, you will pay the cost share applicable to the first 100 days of services, and your coinsurance will count toward the applicable out-of-pocket coinsurance maximum, regardless of how many days of long-term acute care services you have received.	
Maternity—Complications of Pregnancy Only*	First 3 office visits in a calendar year: **PCP or specialist visit copay**—see the Physician Services row **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits and for other covered services received at the doctor's office • Professional services you receive at an inpatient or outpatient facility, and any related facility charges	**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	

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	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	**40% coinsurance** (this amount does not count toward your out-of-pocket coinsurance maximum) **Deductible is waived**	**50%** of the cost of medical foods (this amount does not count toward your out-of-pocket coinsurance maximum) **Deductible is waived** Cost is defined as billed charges.
Neuropsychological and Cognitive Testing	**$0** for services you receive during an office, home, or walk-in clinic visit **40% 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:** **PCP or specialist visit copay**—see Physician Services row for services you receive at a doctor's office (waived if you receive only covered lab services during your visit), up to the annual physician visit copay limit of 3 visits **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • Professional services provided by a pathologist or dermapathologist, and services you receive at locations other than a doctor's office **Radiology Services:** **PCP or specialist visit copay**—see Physician Services row for services you receive at a doctor's office, up to the annual physician visit copay limit of 3 visits **40% coinsurance** (after deductible) for: • Additional office visits after you reach the annual physician visit copay limit of 3 visits • Professional services you receive from a radiologist, and services you receive at locations other than a doctor's office **Outpatient Facility Services** (including outpatient surgery): • **40% coinsurance** (after deductible) • **$0** for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim **Sleep Studies: 40% coinsurance** (after deductible) **Medications Given to You at an Outpatient Facility: 40% coinsurance** (after deductible)	**50% coinsurance** (after deductible) **+ balance bill**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Pharmacy and Medications Benefits (next two rows) **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 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) • Generic: **$15 copay** • Brand name (including compounded medications): **$125 copay** **Mail Order Medications** (90-day supply) • Generic: **$15 copay** • Brand name: **$250 copay** **Specialty Medications** (30-day supply of most medications) • Tier A: **$50 copay** • Tier B: **$100 copay** • Tier C: **$200 copay** • Tier D: **$400 copay** 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. 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 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	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 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.

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	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	**40% 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 cancer treatment medications that are also classified as specialty medications, you pay the generic pharmacy copay. For certain cancer treatment medications, as determined by BCBSAZ, you will receive a **15-day supply**, and pay **one-half of the generic 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 generic 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, and Speech Therapy Services	**40% 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.	**$35 copay** when you see a PCP **$60 copay** when you see a specialist **One copay per member, per provider, per day** for the first 3 office, home, or walk-in clinic visits in a calendar year **$0** if you have not yet reached the annual physician visit copay limit **and** you only receive the following services and no other covered service during your visit: • Covered allergy injections • Covered immunizations • Covered laboratory services **$0** for the following when the purpose is	**50% coinsurance** (after deductible) **+ balance bill**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	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 **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician copay limit of 3 visits • Covered physical therapy, occupational therapy, and speech therapy • PCP and specialist services provided at locations other than a doctor's office, home, or walk-in clinic • 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 • Medications given to you at a doctor's office	
Post-Mastectomy Services*	First 3 office visits in a calendar year: **PCP or specialist visit copay**—see the Physician Services row **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • Professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance (after deductible) + balance bill**
Pregnancy, Termination*	First 3 office visits in a calendar year: **PCP or specialist visit copay**—see the Physician Services row **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • 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
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*	First 3 office visits in a calendar year: **PCP or specialist visit copay**—see the Physician Services row **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • Professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Skilled Nursing Facility	**40% coinsurance** (after deductible) for the first 90 days of services in a calendar year **50% coinsurance** (after deductible) for the second 90 days of services in a calendar year (this amount does not count toward your out-of-pocket coinsurance maximum)	**50% coinsurance** (after deductible) **+ balance bill** for the first 90 days of services in a calendar year **50% coinsurance** (after deductible) **+ balance bill** for the second 90 days of services in a calendar year (this amount does not count toward your out-of-pocket coinsurance maximum)
	If your claim is submitted with a primary behavioral health diagnosis, you will pay the cost share applicable to the first 90 days of services in a calendar year, and your coinsurance *will* count toward your out-of-pocket coinsurance maximum, regardless of how many days of skilled nursing facility services you have received in the calendar year.	
Telehealth Services—BlueCare Anywhere℠ Telehealth services are video consultations you have with a provider using BCBSAZ's BlueCare Anywhere service.	**$10 copay** for telehealth medical consultations **$0** for telehealth: • Counseling sessions provided by a counselor • Psychiatric consultations provided by a psychiatrist	**Not covered**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
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 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** **Deductible is waived** 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.	First 3 office visits in a calendar year: **PCP or specialist visit copay**—see the Physician Services row **40% coinsurance** (after deductible) for: • Additional visits after you reach the annual physician visit copay limit of 3 visits • Professional services you receive at an inpatient or outpatient facility, and any related facility charges	**50% coinsurance** (after deductible) **+ balance bill**
Urgent Care*	**$75 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 **PCP or specialist visit copay** (see the Physician Services row) for the first 3 office, home, or walk-in clinic visits for services you receive from an in-network provider that is not specifically contracted for urgent care services **40% coinsurance** (after deductible) for: • Any additional office visits after you meet the annual physician visit copay limit of 3 visits • 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.	