

**Individual HMO EverydayHealth Silver 5  
Plan Attachment  
On Marketplace**

**Your Cost-Sharing Information**

[azblue.com/MyBlue](https://azblue.com/MyBlue)



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## 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<sup>SM</sup>](#). 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, coinsurance, copay, deductible, 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

PLEASE NOTE: The member cost share noted in the following grid is waived for items or services furnished to an American Indian or Native Alaskan by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

Type of Cost Share	Amount of Cost Share
<b>Calendar-Year Deductible</b>	<b>\$0</b> per member
	<b>\$0</b> per family
<b>Out-of-Pocket Maximum</b>	<b>\$3,000</b> per member
	<b>\$6,000</b> per family

Cost share for ancillary services provided by an out-of-network provider at a 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 cost-share limits.

Benefit	Your Cost Share
<b>Ambulance Services</b>	<b>40% coinsurance</b>
<b>Behavioral Health Services</b> Inpatient facility and professional services	<b>40% coinsurance</b>
<b>Behavioral Health Services</b> Outpatient facility and professional services	<b>Primary care provider (PCP) or specialist visit copay</b> —see the Physician Services row <b>40% coinsurance</b> for services you receive at other locations
<b>Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder</b>	<b>PCP or specialist visit copay</b> —see the Physician Services row <b>40% coinsurance</b> for services you receive at other locations
<b>Cataract Surgery and Keratoconus</b>	<b>PCP or specialist visit copay</b> —see the Physician Services row <b>40% coinsurance</b> for professional services you receive at an inpatient or outpatient facility, and any related facility charges
<b>Chiropractic Services</b>	<b>Specialist visit copay</b> —see the Physician Services row. The copay does not apply if you receive only physical medicine and rehabilitation services and no other covered service during your visit. <b>40% coinsurance</b> for: <ul style="list-style-type: none"> <li>• Visits in which you only receive physical medicine and rehabilitation services and no other covered service</li> <li>• Chiropractic services provided at other locations</li> </ul>
<b>Chronic Disease Education and Training</b>	<b>\$0</b>

Benefit	Your Cost Share
<b>Clinical Trials</b>	<b>PCP or specialist visit copay</b> —see the Physician Services row <b>40% coinsurance</b> for professional services you receive at an inpatient or outpatient facility, and any related facility charges
<b>Dental Services—Medical</b>	<b>40% coinsurance</b>
<b>Durable Medical Equipment, Medical Supplies, and Prosthetic Appliances and Orthotics</b>	<b>\$0</b> for one FDA-approved manual or electric breast pump and breast pump supplies <b>per member, per calendar year</b> <b>PCP or specialist visit copay</b> —see the Physician Services row <b>40% coinsurance</b> for: <ul style="list-style-type: none"> <li>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.</li> <li>Services you receive at locations other than a doctor's office</li> </ul>
<b>Emergency Services</b>	<b>40% coinsurance</b>
<b>Eosinophilic Gastrointestinal Disorder</b>	<b>25%</b> of the cost of formula Cost is defined here as either the allowed amount if the formula is purchased from a network provider, or billed charges if purchased from an out-of-network provider.
<b>Family Planning—Contraceptives and Sterilization</b>	<b>\$0</b> 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 <b>\$0</b> 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 <b>\$0</b> for female oral contraceptives, patches, rings, and contraceptive injections <b>\$0</b> for FDA-approved over-the-counter emergency contraception that is prescribed by a doctor or other healthcare provider <b>\$0</b> for diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides For FDA-approved male sterilization procedures: <ul style="list-style-type: none"> <li><b>PCP or specialist visit copay</b>—see the Physician Services row</li> <li><b>40% coinsurance</b> for services you receive at locations other than a doctor's office</li> </ul>
<b>Hearing Aids and Services</b>	<b>PCP or specialist visit copay</b> —see the Physician Services row <b>40% coinsurance</b> for professional services you receive at an inpatient or outpatient facility, any related facility charges, and hearing devices obtained in any location
<b>Home Health Services</b>	<b>40% coinsurance</b>
<b>Hospice Services</b>	<b>\$0</b>
<b>Inpatient and Outpatient Detoxification Services</b>	<b>PCP or specialist visit copay</b> —see the Physician Services row <b>40% coinsurance</b> for services you receive at other locations
<b>Inpatient Hospital</b>	<b>40% coinsurance</b> <b>\$0</b> 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 <b>\$500 bariatric surgery access fee</b> (in addition to coinsurance) for all bariatric surgeries. This access fee applies toward the professional charges for bariatric surgery.
<b>Inpatient Rehabilitation—Extended Active Rehabilitation and Skilled Nursing Facility Services</b>	<b>40% coinsurance</b>
<b>Long-Term Acute Care—Inpatient</b>	<b>40% coinsurance</b>

Benefit	Your Cost Share
<b>Maternity</b>  Global charge is a fee charged by the delivering provider that includes certain prenatal, delivery, and postnatal services.	<b>PCP or specialist visit copay</b> (see the Physician Services row) for your first prenatal office or home visit, which covers all services included in the provider's global charge  <b>One PCP or specialist copay, per member, per provider, per day</b> for other office or home visits not included in the global charge  <b>40% coinsurance</b> for professional services you receive at an inpatient or outpatient facility, and any related facility charges  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.
<b>Medical Foods for Inherited Metabolic Disorders</b>	<b>40%</b> of the cost of medical foods  Cost is defined here as either the allowed amount if the medical foods are purchased from a network provider, or billed charges if purchased from an out-of-network provider.
<b>Neuropsychological and Cognitive Testing</b>	<b>PCP or specialist visit copay</b> —see the Physician Services row  <b>40% coinsurance</b> for professional services you receive at an inpatient or outpatient facility, and any related facility charges
<b>Outpatient Services</b>	<b>Diagnostic Laboratory Services:</b> <ul style="list-style-type: none"> <li>• <b>\$0</b> if you only receive covered laboratory services at a doctor's office</li> <li>• <b>PCP or specialist visit copay</b>—see the Physician Services row for services you receive at a doctor's office</li> <li>• <b>40% coinsurance</b> for professional services you receive from a pathologist or dermapathologist, and services you receive at locations other than a doctor's office</li> </ul> <b>Radiology Services:</b> <ul style="list-style-type: none"> <li>• <b>PCP or specialist visit copay</b>—see the Physician Services row for services you receive at a doctor's office</li> <li>• <b>40% coinsurance</b> for professional services you receive from a radiologist, and services you receive at locations other than a doctor's office</li> </ul> <b>Outpatient Facility Services</b> (including outpatient surgery): <ul style="list-style-type: none"> <li>• <b>\$0</b> for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim</li> <li>• <b>40% coinsurance</b> for professional services you receive at an inpatient or outpatient facility, and any related facility charges</li> <li>• <b>\$500 bariatric surgery access fee</b> (in addition to coinsurance) for all bariatric surgeries. This access fee applies toward the professional charges for bariatric surgery.</li> </ul> <b>Sleep Studies: 40% coinsurance</b>  <b>Medications Given to You at an Outpatient Facility: 40% coinsurance</b>
<b>Pharmacy and Medications Benefits (next two rows)</b>  <b>Note:</b> 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 <a href="#">MyBlue</a> , or call Pharmacy Benefit Customer Service at the number on your ID card.	
<b>Pharmacy Benefit</b>  A pharmacy deductible is the amount each member must pay for tier 2 and tier 3 medications covered under the Pharmacy benefit each calendar year before the benefit plan begins to pay for those medications. After meeting the pharmacy deductible, you pay copays for tier 2 and tier 3 medications. The pharmacy deductible is	<b>Retail Medications</b> (30-day supply) <ul style="list-style-type: none"> <li>• Tier 1a: <b>\$0</b></li> <li>• Tier 1b: <b>\$6 copay</b></li> <li>• Tier 2: pharmacy deductible up to <b>\$300</b>, then <b>\$75 copay</b></li> <li>• Tier 3 (including compounded medications and formulary exceptions): pharmacy deductible up to <b>\$300</b>, then <b>50% coinsurance</b></li> </ul> <b>Mail Order Medications</b> (90-day supply) <ul style="list-style-type: none"> <li>• Tier 1a: <b>\$0</b></li> <li>• Tier 1b: <b>\$12 copay</b></li> <li>• Tier 2: pharmacy deductible up to <b>\$300</b>, then <b>\$150 copay</b></li> </ul>

Benefit	Your Cost Share
<p>calculated on the medication allowed amount.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Tier 3 (including formulary exceptions): pharmacy deductible up to <b>\$300</b>, then <b>50% coinsurance</b></li> </ul> <p><b>Specialty Medications</b> (30-day supply of most medications)</p> <ul style="list-style-type: none"> <li>• <b>50% coinsurance</b></li> <li>• <b>Pharmacy deductible is waived</b></li> </ul> <p>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.</p> <p>If you purchase a brand-name medication when a generic equivalent is available, you will pay the applicable <b>tier 1 copay plus the difference between the allowed amounts for the generic and brand-name medications</b>, 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 (after meeting the pharmacy deductible for tiers 2 and 3 medications).</p> <p><b>\$0</b> for preventive medications and covered vaccines. BCBSAZ determines under 45 CFR § 147.130:</p> <ul style="list-style-type: none"> <li>• Which medications are considered preventive,</li> <li>• Which vaccines are covered, <b>and</b></li> <li>• For which there is a \$0 cost share</li> </ul> <p><b>\$0</b> for the generic version of certain covered preventive medications or items; <b>applicable cost share</b> 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.</p> <p><b>\$0</b> for the following female contraceptive (birth control) methods when your provider prescribes them for the purpose of contraception:</p> <ul style="list-style-type: none"> <li>• FDA-approved brand oral, patch, vaginal ring, and injectable contraceptives with no generic equivalent components</li> <li>• FDA-approved diaphragms, cervical caps, and cervical shields</li> <li>• FDA-approved emergency contraception for members of any age</li> <li>• FDA-approved generic oral, patch, vaginal ring, and injectable contraceptives</li> <li>• Female condoms</li> <li>• Sponges and spermicides</li> </ul>
<p><b>Medications for the Treatment of Cancer</b></p>	<p><b>40% coinsurance</b> for medications you purchase through your medical benefit</p> <p>See the Pharmacy Benefit cost-share row to determine your cost share for services you receive through the Pharmacy benefit.</p> <p>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 <b>15-day supply</b>, and pay <b>one-half of the tier 1b</b> 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.</p>
<p><b>Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy, Cardiac, and Pulmonary Services</b></p>	<p><b>40% coinsurance</b></p>

Benefit	Your Cost Share
<p><b>Physician Services</b></p> <p>Your cost share will be waived if you receive covered preventive services only during your visit.</p>	<p><b>\$0 for first 2 visits, then \$15 copay</b> when you see your designated PCP or have a referral from your designated PCP to a network non-designated PCP</p> <p><b>\$40 copay</b> when you see a specialist</p> <p><b>One copay per member, per provider, per day</b> for services you receive during an office, home, or walk-in clinic visit</p> <p><b>\$0</b> if you only receive the following services and no other covered service during your office, home, or walk-in clinic visit:</p> <ul style="list-style-type: none"> <li>• Covered allergy injections</li> <li>• Covered immunizations</li> <li>• Covered laboratory services</li> </ul> <p><b>\$0</b> for the following when the purpose is female contraception (birth control), as documented by your provider on the claim:</p> <ul style="list-style-type: none"> <li>• Professional services for FDA-approved female sterilization procedures, regardless of the location of service</li> <li>• Professional services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices</li> <li>• FDA-approved implanted female contraceptive devices</li> <li>• 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</li> </ul> <p><b>40% coinsurance</b> for:</p> <ul style="list-style-type: none"> <li>• Covered physical therapy, occupational therapy, and speech therapy</li> <li>• PCP and specialist services provided at locations other than a doctor's office, home, or walk-in clinic</li> <li>• 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</li> <li>• Medications given to you at a doctor's office</li> </ul>
<p><b>Post-Mastectomy Services</b></p>	<p><b>PCP or specialist visit copay</b>—see the Physician Services row</p> <p><b>40% coinsurance</b> for professional services you receive at an inpatient or outpatient facility, and any related facility charges</p>
<p><b>Preventive Services</b></p> <p>You pay applicable cost share for any tests, procedures, or services not covered in the Preventive Services section in your Base Benefit Book.</p>	<p><b>\$0</b> regardless of the location where services are provided if:</p> <ul style="list-style-type: none"> <li>• You receive one of the services covered as explained in the Preventive Services section in your Base Benefit Book;</li> <li>• 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; <b>and</b></li> <li>• The primary purpose of the visit at which you received the services was preventive care.</li> </ul> <p><b>\$0</b> for the generic version of certain covered preventive medications or items; <b>applicable cost share</b> 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.</p>
<p><b>Reconstructive Surgery and Services</b></p>	<p><b>PCP or specialist visit copay</b>—see the Physician Services row</p> <p><b>40% coinsurance</b> for professional services you receive at an inpatient or outpatient facility, and any related facility charges</p>
<p><b>Services to Diagnose Infertility</b></p>	<p><b>PCP or specialist visit copay</b>—see the Physician Services row</p> <p><b>40% coinsurance</b> for professional services you receive at an inpatient or outpatient facility, and any related facility charges</p>

Benefit	Your Cost Share
<b>Telehealth Services—BlueCare Anywhere<sup>SM</sup></b> Telehealth services are video consultations you have with a provider using BCBSAZ's BlueCare Anywhere service.	<b>\$5 copay</b> for telehealth: <ul style="list-style-type: none"> <li>• Medical consultations</li> <li>• Counseling sessions provided by a counselor</li> <li>• Psychiatric consultations provided by a psychiatrist</li> </ul>
<b>Telehealth Services—Network Providers</b>	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.  <b>Example:</b> 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.
<b>Transplant Travel and Lodging</b>	<b>\$0</b> Maximum reimbursement of <b>\$10,000 per member, per transplant</b>
<b>Transplants—Organ, Tissue, and Bone Marrow and Stem Cell Procedures</b> 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.	<b>PCP or specialist visit copay</b> —see the Physician Services row  <b>40% coinsurance</b> for professional services you receive at an inpatient or outpatient facility, and any related facility charges
<b>Travel Reimbursement—Outside Service Area</b>	<b>\$0</b>
<b>Urgent Care</b>	<b>\$40 copay per member, per provider, per day</b> for services you receive from a provider that is contracted with the plan network to offer urgent care services  <b>PCP or specialist visit copay</b> (see the Physician Services row) for services you receive during an office, home, or walk-in clinic visit from a plan network provider that is not specifically contracted for urgent care services  <b>40% coinsurance</b> for urgent care services you receive from any other type of provider  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
<b>Pediatric Dental Type I Services</b>	<b>\$0</b>
<b>Pediatric Dental Type II Services</b>	<b>50% coinsurance</b>
<b>Pediatric Dental Type III Services</b>	<b>50% coinsurance</b>
<b>Pediatric Dental Type IV Services</b>	<b>50% coinsurance</b>
<b>Pediatric Vision Exams (Routine)</b>	Members under age 5: <b>\$0</b> Members ages 5-19: <b>\$15 copay</b> If a medical condition is identified during your routine vision exam, you will be responsible for additional cost share.
<b>Pediatric Contact Lens Fit and Follow Up</b>	<b>\$0</b>
<b>Pediatric Eyewear (Eyeglasses or Contact Lenses)</b>	<b>\$0</b>

Benefit	Your Cost Share
<b>Pediatric Low Vision Evaluation and Follow Up</b>	\$0
<b>Pediatric Low Vision Hardware</b>	\$0