# Individual HMO EverydayHealth Silver 7500 Plan Attachment On Marketplace

**Your Cost-Sharing Information** 

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## 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 <a href="azblue.com">azblue.com</a>. 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 (AZ Blue) 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. AZ Blue 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
Calendar-Year Deductible	<b>\$7,500</b> per member
	<b>\$15,000</b> per family
Out-of-Pocket Maximum	<b>\$9,200</b> per member
	<b>\$18,400</b> per family

Until you meet your deductible, you will pay the allowed amount for most 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.

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 deductible and cost-share limits.

Benefit	Your Cost Share
Ambulance Services	40% coinsurance (after deductible)
Behavioral Health Services	
Inpatient facility and professional services	40% coinsurance (after deductible)
Behavioral Health Services	Primary care provider (PCP) or specialist visit copay—see the Physician Services
Outpatient facility and professional services	row 40% coinsurance (after deductible) for services you receive at other locations
Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder	PCP or specialist visit copay—see the Physician Services row
	40% coinsurance (after deductible) for services you receive at other locations
Cataract Surgery and Keratoconus	PCP or specialist visit copay—see the Physician Services row
	40% coinsurance (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges

Benefit	Your Cost Share
Chiropractic Services	<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.
	40% coinsurance (after deductible) for:
	<ul> <li>Visits in which you receive only physical medicine and rehabilitation services and no other covered service</li> </ul>
	Chiropractic services provided at other locations
Chronic Disease Education and Training	\$0
	Deductible is waived
	PCP or specialist visit copay—see the Physician Services row
Clinical Trials	<b>40% coinsurance</b> (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges
Dental Services—Medical	40% coinsurance (after deductible)
	\$0 for one FDA-approved manual or electric breast pump and breast pump supplies per member, per calendar year
Durable Medical	PCP or specialist visit copay—see the Physician Services row
Equipment, Medical	40% coinsurance (after deductible) for:
Supplies, and Prosthetic Appliances and Orthotics	<ul> <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 any applicable PCP or specialist copay.</li> </ul>
	Services you receive at locations other than a doctor's office
Emergency Services	40% coinsurance (after deductible)
	25% of the cost of formula
Eosinophilic	Deductible is waived
Gastrointestinal Disorder	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.
Family Planning— Contraceptives and Sterilization	<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
	\$0 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
	\$0 for diaphragms, cervical caps, cervical shields, condoms, sponges, and spermicides
	For FDA-approved male sterilization procedures:
	PCP or specialist visit copay—see the Physician Services row
	40% coinsurance (after deductible) for services you receive at locations other than a doctor's office
Hearing Aids and Services	PCP or specialist visit copay—see the Physician Services row
	<b>40% coinsurance</b> (after deductible) for professional services you receive at an inpatient or outpatient facility, any related facility charges, and hearing devices obtained in any location
Home Health Services	40% coinsurance (after deductible)
Hospice Services	\$0
	Deductible is waived
Inpatient and Outpatient Detoxification Services	PCP or specialist visit copay—see the Physician Services row
	40% coinsurance (after deductible) for services you receive at other locations

Benefit	Your Cost Share
Inpatient Hospital	40% coinsurance (after deductible)
	<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
Inpatient Rehabilitation— Extended Active Rehabilitation and Skilled Nursing Facility Services	40% coinsurance (after deductible)
Long-Term Acute Care— Inpatient	40% coinsurance (after deductible)
	PCP or specialist visit copay (see the Physician Services row) for your first prenatal office or home visit, which covers all services included in the provider's global charge
Maternity	See the Physician Services row for cost share if you receive services that are not included in the provider's global charge.
Global charge is a fee charged by the delivering provider that	<b>40% coinsurance</b> (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges
includes certain prenatal, delivery, and postnatal services.	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.
	40% of the cost of medical foods
Medical Foods for Inherited	Deductible is waived
Metabolic Disorders	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.
Neuropsychological and	PCP or specialist visit copay—see the Physician Services row
Neuropsychological and Cognitive Testing	<b>40% coinsurance</b> (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges
	Diagnostic Laboratory Services:
	\$0 if you only receive covered laboratory services at a doctor's office
	PCP or specialist visit copay—see the Physician Services row for services you receive at a doctor's office
	<ul> <li>40% 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</li> </ul>
	Radiology Services:
Outpatient Services	PCP or specialist visit copay—see the Physician Services row for services you receive at a doctor's office
outpatient dervices	40% coinsurance (after deductible) for 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)

Benefit Your Cost Share

## Pharmacy and Medications Benefits (next two rows)

**Note:** Your cost share for any medication is based on the tier to which AZ Blue has assigned it at the time the prescription is filled. No exceptions will be made regarding the assigned tier of a medication. AZ Blue may change the tier of a medication at any time without notice. To confirm the status and tier of a particular medication, visit your AZ Blue portal account, or call Pharmacy Benefit Customer Service at the number on your ID card.

# Retail Medications (30-day supply)

- Tier 1a: \$3 copay
- Tier 1b: \$15 copay
- Tier 2: pharmacy deductible up to \$600, then \$75 copay
- Tier 3 (including compounded medications and formulary exceptions): pharmacy deductible up to \$600, then 50% coinsurance

#### Mail Order Medications (90-day supply)

- Tier 1a: \$6 copay
- Tier 1b: \$30 copay
- Tier 2: pharmacy deductible up to \$600, then \$150 copay
- Tier 3 (including formulary exceptions): pharmacy deductible up to \$600, then 50% coinsurance

# Specialty Medications (30-day supply of most medications)

- 50% coinsurance
- · Calendar-year and pharmacy deductibles are waived

# 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 applicable **tier 1 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 (after meeting the pharmacy deductible for tiers 2 and 3 medications).

**\$0** for preventive medications and covered vaccines. AZ Blue 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 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:

- 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

# **Pharmacy Benefit**

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 calculated on the medication allowed amount.

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.

Benefit	Your Cost Share
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.
	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 AZ Blue, 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.
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac, and Pulmonary Services	40% coinsurance (after deductible)
	\$0 for first visit, then \$20 copay when you see a PCP
	\$75 copay when you see a specialist
	One copay per member, per provider, per day for services you receive during an office, home, or walk-in clinic visit
	<b>\$0</b> if you only receive the following services and no other covered service during your office, home, or walk-in clinic visit:
	Covered allergy injections
	Covered immunizations
	Covered laboratory services
	<b>\$0</b> for the following when the purpose is female contraception (birth control), as documented by your provider on the claim:
Physician Services	<ul> <li>Professional services for FDA-approved female sterilization procedures, regardless of the location of service</li> </ul>
Your cost share will be waived if you receive covered preventive services only during your visit.	<ul> <li>Professional services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices</li> </ul>
Services only during your visit.	FDA-approved implanted female contraceptive devices
	<ul> <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, condoms, sponges, and spermicides</li> </ul>
	40% coinsurance (after deductible) for:
	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
	<ul> <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> </ul>
	Medications given to you at a doctor's office
	PCP or specialist visit copay—see the Physician Services row
Post-Mastectomy Services	40% coinsurance (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges

Benefit	Your Cost Share
	\$0 regardless of the location where services are provided if:
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.	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.
	<b>\$0</b> 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.
December vertice Commons	PCP or specialist visit copay—see the Physician Services row
Reconstructive Surgery and Services	<b>40% coinsurance</b> (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges
Samilana ta Diagnasa	PCP or specialist visit copay—see the Physician Services row
Services to Diagnose Infertility	<b>40% coinsurance</b> (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges
Telehealth Services— BlueCare Anywhere <sup>SM</sup>	\$10 copay for telehealth:
Telehealth services are video	Medical consultations
consultations you have with a	Counseling sessions provided by a counselor
provider using AZ Blue's BlueCare Anywhere service.	Psychiatric consultations provided by a psychiatrist
	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.
Telehealth Services— Network Providers	<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.
	\$0
Transplant Travel and Lodging	Deductible is waived
Loughig	Maximum reimbursement of \$10,000 per member, per transplant
Transplants—Organ, Tissue, and Bone Marrow and Stem Cell Procedures If both a donor and a transplant	PCP or specialist visit copay—see the Physician Services row
recipient are covered by an AZ Blue plan or a plan administered by AZ Blue, the transplant recipient pays the cost share related to the transplant.	40% coinsurance (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges
Travel Reimbursement—	\$0
Outside Service Area	Deductible is waived
	<b>\$60 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
Urgent Care	<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> (after deductible) 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

Benefit	Your Cost Share
Pediatric Dental Type I Services	\$0
	Deductible is waived
Pediatric Dental Type II Services	50% coinsurance (after deductible)
Pediatric Dental Type III Services	50% coinsurance (after deductible)
Pediatric Dental Type IV Services	50% coinsurance (after deductible)
	\$0
Pediatric Vision Exams (Routine)	Deductible is waived
	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
	Deductible is waived
Pediatric Eyewear (Eyeglasses or Contact Lenses)	\$0
	Deductible is waived
Pediatric Low Vision Evaluation and Follow Up	\$0
	Deductible is waived
Pediatric Low Vision Hardware	\$0
	Deductible is waived