Individual HMO Everyday Copay Silver 5
ACA Health Choice
Plan Attachment
On Marketplace

Your Cost-Sharing Information

azblue.com/member

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 azblue.com. 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 a 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	**$500** per member **$1,000** per family
Out-of-Pocket Maximum	**$3,000** per member **$6,000** 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	**10% coinsurance** (after deductible)
Behavioral Health Services Inpatient facility and professional services	**Inpatient hospital copay**—see the Inpatient Hospital row
Behavioral Health Services Outpatient facility and professional services	**Primary care provider (PCP) or specialist visit copay**—see the Physician Services row **10% 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 **10% coinsurance** (after deductible) for services you receive at other locations
Cataract Surgery and Keratoconus	**PCP or specialist visit copay**—see the Physician Services row **Inpatient hospital copay**—see the Inpatient Hospital row **Outpatient surgery copays**—see the Outpatient Services row **10% coinsurance** (after deductible) for services you receive at other locations

Benefit	Your Cost Share
Chiropractic Services	**Specialist visit copay**—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. **10% coinsurance** (after deductible) for: • Visits in which you receive only physical medicine and rehabilitation services and no other covered service • Chiropractic services provided at other locations
Chronic Disease Education and Training	**$0** **Deductible is waived**
Clinical Trials	**PCP or specialist visit copay**—see the Physician Services row **Inpatient hospital copay**—see the Inpatient Hospital row **Outpatient surgery copays**—see the Outpatient Services row **10% coinsurance** (after deductible) for services you receive at other locations
Dental Services—Medical	**Inpatient hospital copay**—see the Inpatient Hospital row **Outpatient surgery copays**—see the Outpatient Services row **10% coinsurance** (after deductible) for services you receive at other locations
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** **PCP or specialist visit copay**—see the Physician Services row **10% coinsurance** (after deductible) for: • 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. • Services you receive at locations other than a doctor's office
Emergency Services	**Emergency Room (ER)** **$500 copay per member, per facility, per day** for ER facility and ancillary charges, and **$0** for professional services you receive while you are at the ER **Admission to the Hospital from the ER** If you are admitted as an inpatient: • **$0 ER copay** • **$1,000 copay per member, per day, for a maximum of 3 days,** for professional, facility, and ancillary services you receive while you are at the ER, and for all services you receive after admission If you are admitted for observation or as an outpatient: • **$500 ER copay** • **10% coinsurance** (after 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	**10%** of the cost of formula **Deductible is waived** 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	**$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

Benefit	Your Cost Share
	$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 • **Inpatient hospital copay**—see the Inpatient Hospital row • **Outpatient surgery copays**—see the Outpatient Services row
Hearing Aids and Services	**PCP or specialist visit copay**—see the Physician Services row **Inpatient hospital copay**—see the Inpatient Hospital row **Outpatient surgery copays**—see the Outpatient Services row **10% coinsurance** (after deductible) for services you receive at other locations, and hearing devices obtained in any location
Home Health Services	**10% coinsurance** (after deductible)
Hospice Services	**10% coinsurance** (after deductible)
Inpatient and Outpatient Detoxification Services	**PCP or specialist visit copay**—see the Physician Services row **Inpatient hospital copay**—see the Inpatient Hospital row **10% coinsurance** (after deductible) for services you receive at other locations
Inpatient Hospital	**$1,000 copay per member, per day, for a maximum of 3 days,** for each inpatient admission, including ancillary and professional services you receive during the admission **$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
Inpatient Rehabilitation—Extended Active Rehabilitation and Skilled Nursing Facility Services	**Inpatient hospital copay**—see the Inpatient Hospital row
Long-Term Acute Care—Inpatient	**Inpatient hospital copay**—see the Inpatient Hospital row
Maternity Global charge is a fee charged by the delivering provider that includes certain prenatal, delivery, and postnatal services.	**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 See the Physician Services row for cost share if you receive services that are not included in the provider's global charge. **Inpatient hospital copay**—see the Inpatient Hospital row **Outpatient surgery copays**—see the Outpatient Services row **10% coinsurance** (after deductible) for services you receive at other locations 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 **Deductible is waived** 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 Cognitive Testing	**PCP or specialist visit copay**—see the Physician Services row **Inpatient hospital copay**—see the Inpatient Hospital row **10% coinsurance** (after deductible) for services you receive at other locations

Benefit	Your Cost Share
Outpatient Services	**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 • **10% coinsurance** (after deductible) for professional services you receive from a pathologist or dermatopathologist, and services you receive at locations other than a doctor's office **Radiology Services:** • **PCP or specialist visit copay**—see the Physician Services row for services you receive at a doctor's office • **10% 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): • **$150 copay per visit, per provider,** for professional services you receive for outpatient surgery • **$150 copay per service** for outpatient surgery facility charges • **10% coinsurance** (after deductible) for ancillary services you receive during your outpatient surgery and for services you receive at other locations • **$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: 10% coinsurance** (after deductible) **Medications Given to You at an Outpatient Facility:** **10% coinsurance** (after deductible)
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. 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.	
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) • Tier 1a: **$5 copay** • Tier 1b: **$10 copay** • Tier 2: **$20 copay** • Tier 3 (including compounded medications and formulary exceptions): **10% coinsurance** (after deductible) **Mail Order Medications** (90-day supply) • Tier 1a: **$15 copay** • Tier 1b: **$30 copay** • Tier 2: **$60 copay** • Tier 3 (including formulary exceptions): **10% coinsurance** (after deductible) **Specialty Medications** (including formulary exceptions, 30-day supply of most medications): **10% coinsurance** (after deductible) 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 have a copay and 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 have a copay and 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 **tier 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.

Benefit	Your Cost Share
	$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
Medications for the Treatment of Cancer	**10% 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 **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.
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac, and Pulmonary Services	**10% coinsurance** (after deductible)
Physician Services Your cost share will be waived if you receive covered preventive services only during your visit.	**$10 copay** when you see a PCP **$20 copay** when you see a specialist **One copay per member, per provider, per day** for services you receive during an office or home visit **$0** if you only receive the following services and no other covered service during your office or home visit: • Covered allergy injections • Covered immunizations • Covered laboratory services **$0** for the following when the purpose is 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

Benefit	Your Cost Share
	10% coinsurance (after deductible) for: • Covered physical therapy, occupational therapy, and speech therapy • Professional services you receive from a radiologist or pathologist, including a dermatopathologist, 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	**PCP or specialist visit copay**—see the Physician Services row **Inpatient hospital copay**—see the Inpatient Hospital row **Outpatient surgery copays**—see the Outpatient Services row **10% coinsurance** (after deductible) for services you receive at other locations
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.	**$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.
Reconstructive Surgery and Services	**PCP or specialist visit copay**—see the Physician Services row **Inpatient hospital copay**—see the Inpatient Hospital row **Outpatient surgery copays**—see the Outpatient Services row **10% coinsurance** (after deductible) for services you receive at other locations
Services to Diagnose Infertility	**PCP or specialist visit copay**—see the Physician Services row **10% coinsurance** (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges
Telehealth Services—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.
Telehealth Services—Telehealth from AZ Blue Telehealth services are video consultations you have with a provider using Telehealth from AZ Blue, available through the TSA.	**$10 copay** for telehealth: • Medical consultations • Counseling sessions provided by a counselor • Psychiatric consultations provided by a psychiatrist
Transplant Travel and Lodging	**$0** **Deductible is waived** Maximum reimbursement of **$10,000 per member, per transplant**

Benefit	Your Cost Share
Transplants—Organ, Tissue, and Bone Marrow and Stem Cell Procedures If both a donor and a transplant 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.	**PCP or specialist visit copay**—see the Physician Services row **Inpatient hospital copay**—see the Inpatient Hospital row **Outpatient surgery copays**—see the Outpatient Services row **10% coinsurance** (after deductible) for services you receive at other locations
Travel Reimbursement—Outside Service Area	**$0** **Deductible is waived**
Urgent Care	**$25 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 services you receive during an office or home visit from a plan network provider that is not specifically contracted for urgent care services **10% coinsurance** (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
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)
Pediatric Vision Exams (Routine)	**$0** **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**