Individual HMO Prosano® Protect Bronze 11000
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 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	Prosano Health: Deductible waived **$11,000** per member **$22,000** per family
Out-of-Pocket Maximum	**$11,000** per member **$22,000** per family

You can receive covered services from network providers. Your cost share is waived for covered services provided at or by Prosano Health Advanced Primary Care Centers (Prosano Health). You will pay network cost share for covered services provided by network providers other than Prosano Health.

The following services are available at Prosano Health for **zero cost share**:

- **Primary Care (In-Person and Virtual):** Primary care services, as well as high-quality chronic condition management, and well visits for children over 5 years of age
- **Integrated Behavioral Health (In-Person and Virtual):** A behavioral health assessment and short-term counseling
- **Urgent Services (In-Person and Virtual):** Appointments for all ages, available during normal clinic hours, to treat illnesses such as cough, cold, flu, stomach pain, and rashes
- **Lab Services:** For labs ordered, drawn, and processed at Prosano Health locations
- **Care Guide:** A clinical resource for questions regarding follow-up care, referrals to non-primary care services, appointment support, and any other care concerns
- **Benefit Liaison:** Dedicated support for any questions regarding your benefits, cost share, or claims

For services performed outside of Prosano Health, 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	**$0** (after deductible)
Behavioral Health Services Inpatient facility and professional services	**$0** (after deductible)
Behavioral Health Services Outpatient facility and professional services	**$0** (after deductible) *Prosano Health Services–see description above this table for the integrated behavioral health services available at no cost share
Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder	**$0** (after deductible)
Cataract Surgery and Keratoconus	**$0** (after deductible)
Chiropractic Services	**$0** (after deductible)
Chronic Disease Education and Training	**$0** **Deductible is waived**
Clinical Trials	**$0** (after deductible)
Dental Services—Medical	**$0** (after deductible)
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** **$0** (after deductible)
Emergency Services	**$0** (after deductible)
Eosinophilic Gastrointestinal Disorder	**$0** **Deductible is waived**
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 **$0** for diaphragms, cervical caps, cervical shields, condoms, sponges, and spermicides **$0** (after deductible) for FDA-approved male sterilization procedures
Hearing Aids and Services	**$0** (after deductible)
Home Health Services	**$0** (after deductible)
Hospice Services	**$0** (after deductible)
Inpatient and Outpatient Detoxification Services	**$0** (after deductible)
Inpatient Hospital	**$0** (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
Inpatient Rehabilitation—Extended Active Rehabilitation and Skilled Nursing Facility Services	**$0** (after deductible)

Benefit	Your Cost Share
Long-Term Acute Care—Inpatient	**$0** (after deductible)
Maternity	**$0** (after deductible) 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	**$0** **Deductible is waived**
Neuropsychological and Cognitive Testing	**$0** (after deductible)
Outpatient Services	**$0** for lab services ordered, drawn, and processed at Prosano Health locations **$0** (after deductible) for: • Diagnostic lab services • Radiology services • Sleep studies • Medications administered at an outpatient facility • Outpatient facility services, including outpatient surgery **$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
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: **$15 copay** • Tier 1b: **$25 copay** • Tier 2: **$0** (after deductible) • Tier 3 (including compounded medications and formulary exceptions): **$0** (after deductible) **Mail Order Medications** (90-day supply) • Tier 1a: **$45 copay** • Tier 1b: **$75 copay** • Tier 2: **$0** (after deductible) • Tier 3 (including formulary exceptions): **$0** (after deductible) **Specialty Medications** (including formulary exceptions, 30-day supply of most medications): **$0** (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

Benefit	Your Cost Share
	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. 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	**$0** (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	**$0** (after deductible)
Physician Services Your cost share will be waived if you receive covered preventive services only during your visit.	**$0** for services you receive from Prosano Health providers **$0** (after deductible) when you see a PCP or specialist outside of Prosano Health **$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 **$0** (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 • 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

Benefit	Your Cost Share
Post-Mastectomy Services	**$0** (after deductible)
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	**$0** (after deductible)
Services to Diagnose Infertility	**$0** (after deductible)
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.	**$0** (after deductible) 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**
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.	**$0** (after deductible)
Travel Reimbursement—Outside Service Area	**$0** **Deductible is waived**
Urgent Care	**$0** (after deductible)
Pediatric Dental Type I Services	**$0** **Deductible is waived**
Pediatric Dental Type II Services	**$0** (after deductible)
Pediatric Dental Type III Services	**$0** (after deductible)

Benefit	Your Cost Share
Pediatric Dental Type IV Services	**$0** (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**