Individual PPO Portfolio
ZCS Plan Attachment
On Marketplace

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

Member cost share is waived for services covered under this plan.

COST-SHARE TABLE

PLEASE NOTE: Services performed outside of Arizona are not covered. The only exceptions are emergencies, urgent telehealth services, eosinophilic gastrointestinal disorder formula, medical foods, and services from an out-of-network provider that have received prior authorization.

If your out-of-network Arizona provider does not get a prior authorization from BCBSAZ for a service that requires it, you may be required to pay a $500 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 maximum.

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Ambulance Services	**$0**	
Behavioral Health Services Inpatient facility and professional services	**$0**	**$0 + balance bill**
Behavioral Health Services Outpatient facility and professional services	**$0**	**$0 + balance bill**
Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder	**$0**	**$0 + balance bill**
Cataract Surgery and Keratoconus	**$0**	**$0 + balance bill**
Chiropractic Services	**$0**	**$0 + balance bill**
Chronic Disease Education and Training	**$0**	**$0 + balance bill**
Clinical Trials	**$0**	**$0 + balance bill**
Dental Services—Medical	**$0**	**$0 + balance bill**
Durable Medical Equipment, Medical Supplies, and Prosthetic Appliances and Orthotics	**$0**	**$0 + balance bill**
Emergency Services	**$0**	
Eosinophilic Gastrointestinal Disorder	**$0**	**$0**
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 sterilization procedures when the purpose of the procedure is	**$0 + balance bill**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	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** for FDA-approved male sterilization procedures	
Hearing Aids and Services	**$0**	**$0 + balance bill**
Home Health Services	**$0**	**$0 + balance bill**
Hospice Services	**$0**	**$0 + balance bill**
Inpatient and Outpatient Detoxification Services	**$0**	**$0 + balance bill**
Inpatient Hospital	**$0**	**$0 + balance bill**
Inpatient Rehabilitation—Extended Active Rehabilitation and Skilled Nursing Facility Services	**$0**	**$0 + balance bill**
Long-Term Acute Care—Inpatient	**$0**	**$0 + balance bill**
Maternity	**$0**	**$0 + balance bill**
Medical Foods for Inherited Metabolic Disorders	**$0**	**$0**
Neuropsychological and Cognitive Testing	**$0**	**$0 + balance bill**
Outpatient Services	**$0**	**$0 + balance bill**
Pharmacy and Medications Benefits (next two rows)		
Pharmacy Benefit	**Retail, Mail Order, and Specialty Medications: $0** 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).	**$0 + balance bill** The following are **not covered** when obtained from out-of-network pharmacies: • 90-day supply at retail • 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 responsible for any balance bill, including the difference between the allowed amounts for the generic and brand-name medications.
Medications for the Treatment of Cancer	**$0**	**$0 + balance bill**
	For certain cancer treatment medications, as determined by BCBSAZ, you will receive a **15-day supply** the first time you receive it. You will be able to refill the medication every 15 days during your first three months using the medication. If you have side effects from the medication	**Not Covered**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
	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, Cognitive Therapy, Cardiac, and Pulmonary Services	**$0**	**$0 + balance bill**
Physician Services	**$0**	**$0 + balance bill**
Post-Mastectomy Services	**$0**	**$0 + balance bill**
Preventive Services	**$0**	**$0 + balance bill**
Reconstructive Surgery and Services	**$0**	**$0 + balance bill**
Services to Diagnose Infertility	**$0**	**$0 + balance bill**
Telehealth Services—BlueCare Anywhere℠ Telehealth services are video consultations you have with a provider using BCBSAZ's BlueCare Anywhere service.	**$0**	**Not covered**
Telehealth Services—In-Network Providers	**$0**	**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** 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.	**$0**	**$0 + balance bill**
Urgent Care	**$0**	**$0 + balance bill**
Pediatric Dental Type I Services	**$0**	**$0 + balance bill**
Pediatric Dental Type II Services	**$0**	**$0 + balance bill**
Pediatric Dental Type III Services	**$0**	**$0 + balance bill**
Pediatric Dental Type IV Services	**$0**	**$0 + balance bill**
Pediatric Vision Exams (Routine)	**$0**	**$0 + balance bill**

Benefit	In-Network Cost Share	Out-of-Network Cost Share
Pediatric Contact Lens Fit and Follow Up	**$0**	**Not covered**
Pediatric Eyewear (Eyeglasses or Contact Lenses)	**$0**	**Not covered**
Pediatric Low Vision Evaluation and Follow Up	**$0**	**$0 + balance bill**
Pediatric Low Vision Hardware	**$0**	**Not covered**