




⚠ The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit azblue.com/member. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call **1-877-475-8440** to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| What is the overall deductible? | <u>In-network</u> and <u>out-of-network</u> : \$4,000 /individual or \$8,000 /family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . Unless a <u>copay</u> , fee, or other percent is shown, the <u>coinsurance</u> percent of the <u>allowed amount</u> that you pay for most services is 20% <u>in-network</u> and 50% <u>out-of-network</u> . |
| Are there services covered before you meet your deductible? | Yes. Certain <u>in-network</u> <u>preventive services</u> ; <u>in-network</u> <u>primary care</u> and <u>specialist</u> visits; <u>prescription drugs</u> ; <u>emergency room care</u> ; <u>in-network</u> <u>urgent care</u> visits; <u>hospice services</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | <u>In-network</u> : \$6,350 /individual or \$12,700 /family <u>Out-of-network</u> : \$12,700 /individual or \$25,400 /family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>out-of-network</u> <u>prior authorization</u> charges, <u>balance bills</u> , and costs for health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |

| Important Questions | Answers | Why This Matters: |
|--|--|--|
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.azblue.com or call 1-877-475-8440 for a list of <u>in-network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$35 <u>copay</u> /provider/day, <u>deductible</u> does not apply | 50% <u>coinsurance</u> & <u>balance bill</u> | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. <u>Specialist copay</u> for most chiropractic services. No charge for medical telehealth consultations through BlueCare Anywhere SM . |
| | <u>Specialist</u> visit | \$75 <u>copay</u> /provider/day, <u>deductible</u> does not apply | | |
| | <u>Preventive care/screening/immunization</u> | No charge, <u>deductible</u> does not apply | 50% <u>coinsurance</u> & <u>balance bill</u> | |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | Office visit <u>copay</u> , <u>deductible</u> does not apply or 20% <u>coinsurance</u> | 50% <u>coinsurance</u> & <u>balance bill</u> may apply | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. <u>Cost share</u> varies based on place of service and <u>provider's network</u> status & type. |
| | Imaging (CT/PET scans, MRIs) | | | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.azblue.com | Tier 1 | \$15 <u>copay</u> /30 day supply, <u>deductible</u> does not apply | \$15 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply | Some drugs require <u>prior authorization</u> and won't be covered without it. 90-day supply costs 2.5 <u>copays</u> for retail pharmacy and 2 <u>copays</u> for mail order. Mail order not covered <u>out-of-network</u> . If a generic drug is available, pay the generic <u>cost share</u> + the price difference between the <u>allowed amount</u> for some brand drugs. |
| | Tier 2 | \$45 <u>copay</u> /30 day supply, <u>deductible</u> does not apply | \$45 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply | |
| | Tier 3 | \$85 <u>copay</u> /30 day supply, <u>deductible</u> does not apply | \$85 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply | |
| | Tier 4 | \$150 <u>copay</u> /30 day supply, <u>deductible</u> does not apply | \$150 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply | |
| | <u>Specialty drugs</u> | <u>Copays</u> (<u>deductible</u> does not apply): Tier A: \$70 Tier B: \$120 Tier C: \$200 Tier D: \$250 | Not covered | Specialty <u>copay</u> covers up to a 30-day supply. Some drugs require <u>prior authorization</u> and won't be covered without it. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> & <u>balance bill</u> | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. |
| | Physician/surgeon fees | | 50% <u>coinsurance</u> & <u>balance bill</u> may apply | |
| If you need immediate medical attention | <u>Emergency room care</u> | \$450 <u>copay</u> , <u>deductible</u> does not apply | | <u>Copay</u> is waived if you are admitted as an inpatient to the hospital and you pay inpatient <u>deductible</u> and <u>coinsurance</u> . Admittance for observation is not inpatient. <u>Out-of-network providers</u> can't <u>balance bill</u> for the difference between the <u>allowed amount</u> and the billed charge. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | | None |
| | <u>Urgent care</u> | \$50 <u>copay</u> /provider/day, <u>deductible</u> does not apply | 50% <u>coinsurance</u> & <u>balance bill</u> | <u>Copay</u> applies only to facilities specifically contracted for <u>urgent care</u> . |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> & <u>balance bill</u> | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. |
| | Physician/surgeon fees | | 50% <u>coinsurance</u> & <u>balance bill</u> may apply | |
| | Long-term acute care | 20% <u>coinsurance</u> except 50% <u>coinsurance</u> days 101-365 | 50% <u>coinsurance</u> & <u>balance bill</u> | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 365 total LTAC days per member. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office visit <u>copay</u> , <u>deductible</u> does not apply or 20% <u>coinsurance</u> . <u>Copay</u> amount varies based on <u>PCP/Specialist</u> . | 50% <u>coinsurance</u> & <u>balance bill</u> may apply | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. <u>Copay</u> applies to office, home, walk-in clinic visits. <u>Coinsurance</u> applies to all other locations. \$20 <u>copay</u> for counseling and \$45 <u>copay</u> for Psychiatric telehealth consultations through BlueCare Anywhere SM . |
| | Inpatient services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> & <u>balance bill</u> may apply | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. |
| If you are pregnant | Office Visits | Office visit <u>copay</u> , <u>deductible</u> does not apply or 20% <u>coinsurance</u> | 50% <u>coinsurance</u> & <u>balance bill</u> | Only one <u>copay</u> is collected for services included in delivering physician's global charge. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the <u>SBC</u> (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>in-network</u> <u>preventive</u> services. |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> & <u>balance bill</u> may apply | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> & <u>balance bill</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care/Home infusion therapy</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance & balance bill</u> | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 42 visits (of up to 4 hours)/calendar year. Custodial care excluded. |
| | <u>Rehabilitation services</u> • EAR = Extended Active Rehabilitation Facility • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy | 20% <u>coinsurance</u> except 50% <u>coinsurance</u> for days 61-120 of EAR | 50% <u>coinsurance & balance bill</u> | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 120 days/calendar year for EAR and 180 days/calendar year for SNF. <u>Plan</u> does not cover group physical and occupational therapy. |
| | <u>Habilitation services</u> | Not covered | Not covered | |
| | <u>Skilled nursing care</u> In skilled nursing facility (SNF) | 20% <u>coinsurance</u> except 50% <u>coinsurance</u> for days 91-180 | 50% <u>coinsurance & balance bill</u> | |
| | <u>Durable medical equipment</u> | Office visit <u>copay</u> , <u>deductible</u> does not apply or 20% <u>coinsurance</u> . | 50% <u>coinsurance & balance bill</u> | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. <u>Cost share</u> varies based on place of service and <u>provider's network</u> status. |
| | <u>Hospice services</u> | No charge, <u>deductible</u> does not apply | No charge except <u>balance bill</u> , <u>deductible</u> does not apply | \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. |
| If your child needs dental or eye care | Children's eye exam | [\$ <u>copay</u> , <u>deductible</u> does not apply] [No charge after <u>deductible</u> | [B]% <u>coinsurance & balance bill</u> | [Limit of 1 routine vision exam/[calendar] year.] No charge for member under age 5 <u>in-network</u> [and <u>out-of-network</u>]. [Excluded. <u>Screening</u> for members under age 5 covered under " <u>Preventive care / screening / immunization</u> ."]] |
| | Children's glasses | Not covered | Not covered | Excluded |
| | Children's dental check-up | Not covered | Not covered | Excluded |

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Alternative medicine
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care except dental accidents
- DME rental/repair charges that exceed DME purchase price
- Experimental and investigational treatments except as stated in plan
- Eyewear except after cataract surgery
- Fertility and infertility medication and treatment
- Flat feet treatment and services except as stated in plan
- Genetic and chromosomal testing except as stated in plan
- Habilitation services
- Hearing aids
- Home health care and infusion therapy exceeding 42 visits (of up to 4 hours)/calendar year
- Inpatient EAR treatment exceeding 120 days per calendar year and inpatient SNF treatment exceeding 180 days per calendar year
- Long-term care, except long-term acute care up to a 365 days benefit plan maximum
- Massage therapy other than allowed under evidence-based criteria
- Out-of-network Mail Order drugs and out-of-network Specialty
- Preventive services not required to be covered by state or federal law
- Private-duty nursing
- Respite care except as stated in plan
- Routine foot care
- Routine vision exams
- Services, tests and procedures that are excluded under medical coverage guidelines
- Sexual dysfunction treatment and services
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact the Arizona Department of Insurance (602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area) regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.
- For non-federal governmental group health plans and church plans that are group health plans, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area or <https://difi.az.gov/consumer/i/health>.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

About These Coverage Examples



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$4,000
- Specialist copayment \$75
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$4,000 |
| <u>Copayments</u> | \$90 |
| <u>Coinsurance</u> | \$1,190 |
| What isn't covered | |
| Limits or exclusions | \$50 |
| The total Peg would pay is | \$5,330 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$4,000
- Specialist copayment \$75
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$50 |
| <u>Copayments</u> | \$1,070 |
| <u>Coinsurance</u> | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,140 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$4,000
- Specialist copayment \$75
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,940 |
| <u>Copayments</u> | \$510 |
| <u>Coinsurance</u> | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,450 |

The plan would be responsible for the other costs of these EXAMPLE covered services.

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to enable people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

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