



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, contact www.benefitoptions.az.gov or call 1-800-304-3687 or 602-542-5008 to request a copy. 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.benefitoptions.az.gov or call 1-800-304-3687 or 602-542-5008 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-Network</u> : \$0 employee or \$0 family per calendar year <u>Out-of-network</u> : \$5,000 employee or \$10,000 family per calendar year	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. Generally, you must pay all 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your <u>deductible</u> ?	Yes, <u>in-network preventive care</u> services; <u>in-network primary care</u> and <u>specialist</u> visits; <u>prescription drug coverage</u> , <u>emergency room care</u> ; <u>in-network urgent care</u> visits; <u>in-network outpatient</u> services; <u>in-network hospital</u> services; <u>hospice</u> .	This <u>plan</u> has a \$0 <u>in-network deductible</u> . But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> and <u>prescription drug coverage</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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>In-network</u> : \$7,350 employee or \$14,700 family per calendar year <u>Out-of-network</u> : \$8,700 employee or \$17,400 family per calendar year	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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and 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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.benefitoptions.az.gov or call	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 plan pays (<u>balance billing</u>). Be

	1-602-542-5008 or 1-800-304-3687 for a list of network providers .	aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral .

 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 provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay	50% coinsurance & balance billing may apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Preventive care/screening limited to one visit per member per Plan Year. Age and frequency limits may apply. See your plan document for more information on limitations.
	Specialist visit	\$45 copay \$25 copay for OB/GYN	50% coinsurance & balance billing may apply	
	Preventive care/screening /immunization	No Charge	50% coinsurance & balance billing may apply	
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copay	50% coinsurance & balance billing may apply	None
	Imaging (CT/PET scans, MRIs)	\$100 copay	50% coinsurance & balance billing may apply	Some testing may require pre-certification . See your plan document for more information on pre-certification limitations.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.benefitoptions.az.gov	Generic drugs	\$15 copay /prescription (retail) \$30 copay /prescription (mail order) \$37.50 copay /prescription (Choice90)	Not Covered	Deductible does not apply. Covers up to a 30-day supply for retail; up to a 90-day supply for mail order; up to a 90-day supply for Choice90.
	Preferred brand drugs	\$40 copay /prescription (retail) \$80 copay /prescription (mail order) \$100 copay /prescription (Choice90)	Not Covered	Prescription medication with over-the-counter equivalents is not covered. Dispense as Written rules associated with how the plan will pay for a name-brand prescriptions may apply. Specialty drugs limited to a 30-day supply.
	Non-preferred brand drugs	\$60 copay /prescription (retail) \$120 copay /prescription (mail order)	Not Covered	See your plan document for more information on Specialty Pharmacy.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.benefitoptions.az.gov.

		\$150 copay /prescription (Choice90)		
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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay	50% co-insurance & balance billing may apply	Bariatric Surgery 20% coinsurance covered <u>in-network</u> only. See your <u>plan</u> document for more information on pre-certification limitations.
	Physician/surgeon fees	\$150 copay	50% coinsurance & balance billing may apply	
If you need immediate medical attention	Emergency room care	\$250 copay		Must be a Medical Emergency as defined by your <u>plan</u> . Copayment waived if admitted to hospital directly from the emergency room, but subject to hospital admission copayment . Out-of-network providers can't balance bill for the difference between the <u>allowed amount</u> and the billed charge.
	Emergency medical transportation	No Charge		Non-medical emergency transportation requires pre-certification .
	Urgent care	\$80 copay	50% coinsurance & balance billing may apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 copay	50% coinsurance & balance billing may apply	Bariatric Surgery 20% coinsurance covered <u>in-network</u> only. See your <u>plan</u> document for more information on pre-certification limitations.
	Physician/surgeon fees	No Charge	50% coinsurance & balance billing may apply	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	\$25 copay	50% coinsurance & balance billing may apply	See your <u>plan</u> document for more information on limitations and excluded services.
	Mental/Behavioral health inpatient services	\$300 copay	50% coinsurance & balance billing may apply	See your <u>plan</u> document for more information on pre-certification limitations and excluded services.
	Substance use disorder outpatient services	\$25 copay	50% coinsurance & balance billing may apply	See your <u>plan</u> document for more information on limitations and excluded services.
	Substance use disorder inpatient services	\$300 copay	50% coinsurance & balance billing may apply	See your <u>plan</u> document for more information on pre-certification limitations and excluded services.

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 are pregnant	Office visits	\$25 copay for OB/GYN	50% coinsurance & balance billing may apply	None
	Childbirth/delivery professional services	No Charge	50% coinsurance & balance billing may apply	None
	Childbirth/delivery facility services	No Charge	50% coinsurance & balance billing may apply	None
If you need help recovering or have other special health needs	Home health care	No Charge	50% coinsurance & balance billing may apply	Coverage is limited to 42 visits per member per plan year.
	Rehabilitation services	\$45 copay	50% coinsurance & balance billing may apply	Coverage is limited to 60 visits per member per plan year.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	\$0 copay	50% coinsurance & balance billing may apply	Coverage is limited to 90 days per member per plan year.
	Durable medical equipment	\$0 copay	50% coinsurance & balance billing may apply	See your plan document for more information on pre-certification limitations and excluded services.
	Hospice services	\$0 copay	50% coinsurance & balance billing may apply	See your plan document for more information on limitations and excluded services.
If your child needs dental or eye care	Children's eye exam	\$0 copay	50% coinsurance & balance billing may apply	Screenings covered as part of well-child health examination.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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
- Cosmetic surgery
- Dental care (Adult, except for the treatment of an accidental injury to sound natural teeth, where the continued course of treatment is started within six months of the accident).
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Except for inpatient hospital setting)

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

- Bariatric surgery (see [plan](#) document for information on limitations and exclusions)
- Chiropractic care (limited to 20 visits per member, per [Plan](#) Year)
- Hearing aids (limited to one per ear, per [Plan](#) year)
- Long-term care (Acute)
- Routine eye care (Adult, if part of a routine health examination)
- Routine foot care (if medically necessary)
- Weight loss programs (see Wellness Program for more information)

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: Benefit Options at 1-602-548-5008 or 1-800-304-3687 or www.benefitoptions.az.gov. 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 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: Blue Cross Blue Shield of Arizona at 1-866-287-1980 or www.azblue.com; UnitedHealthcare at 1-800-896-1067 or www.myuhc.com; MedImpact at 1-888-648-6769 or www.medimpact.com or Benefit Options at 1-602-548-5008 or 1-800-304-3687 or www.benefitoptions.az.gov.

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](#).

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-542-5008 o al 1-800-304-3687.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-602-542-5008 or 1-800-304-3687.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-602-542-5008 or 1-800-304-3687.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 prenatal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$45
■ Hospital (facility) copayment	\$300
■ Other copayment	\$0

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	\$0
---------------------------	------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
---------------------	--

Deductibles	\$0
-----------------------------	-----

Copayments	\$680
----------------------------	-------

Coinsurance	\$10
-----------------------------	------

<i>What isn't covered</i>	
---------------------------	--

Limits or exclusions	\$50
----------------------	------

The total Peg would pay is	\$740
-----------------------------------	--------------

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$45
■ Hospital (facility) copayment	\$300
■ Other copayment	\$520

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	\$565
---------------------------	--------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
---------------------	--

Deductibles	\$0
-----------------------------	-----

Copayments	\$290
----------------------------	-------

Coinsurance	\$4,210
-----------------------------	---------

<i>What isn't covered</i>	
---------------------------	--

Limits or exclusions	\$20
----------------------	------

The total Joe would pay is	\$4,520
-----------------------------------	----------------

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$45
■ Hospital (facility) copayment	\$300
■ Other copayment	\$300

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	\$6,00
---------------------------	---------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
---------------------	--

Deductibles	\$0
-----------------------------	-----

Copayments	\$720
----------------------------	-------

Coinsurance	\$10
-----------------------------	------

<i>What isn't covered</i>	
---------------------------	--

Limits or exclusions	\$0
----------------------	-----

The total Mia would pay is	\$730
-----------------------------------	--------------

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact Benefit Options Wellness at 602-771-9355 or www.wellness.az.gov.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services

Discrimination is Against the Law

Blue Cross® Blue Shield® of Arizona (AZ Blue) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). **AZ Blue** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

AZ Blue:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
 - o Qualified interpreters
 - o Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

If you believe that **AZ Blue** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Section 1557 Coordinator
P.O. Box 13466
Phoenix, AZ 85002-3466
Call 602-864-2288; TTY 711
or email us at crc@azblue.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **AZ Blue Section 1557 Coordinator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at AZ Blue's website: azblue.com/nondiscrimination-notice.

L24316-0126