



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](http://azblue.com/member) or call 1-877-475-8440. 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 [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary) or by calling 1-877-475-8440 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not applicable.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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> ?	\$2,000/member and \$4,000/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 <u>out-of-pocket limit</u> ?	<u>Premiums</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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.azblue.com">www.azblue.com</a> or call 1-877-475-8440 for a list of <u>network providers</u> .	This <u>plan</u> does not cover services by <u>out-of-network providers</u> except in very limited circumstances.  This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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.

Important Questions	Answers	Why this Matters:
Do you need a <b>referral</b> to see a <b>specialist</b> ?	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	<u>Primary care</u> visit to treat an injury or illness	\$10 <u>copay</u>	Not covered	Some drugs administered during an office visit may require <u>precertification</u> . Limit of 1 routine vision exam/ <u>plan</u> year at \$15 <u>copay</u> . Specialist <u>copay</u> for most chiropractic care. Benefit limit of 12 <u>medically necessary</u> visits to a chiropractic physician for treatment of neck and back pain. \$5 <u>copay</u> for Medical telehealth consultations through BlueCare Anywhere. <u>Preventive</u> services not required to be covered by state or federal law are not covered. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	\$30 <u>copay</u>		
	<u>Preventive care/screening/immunization</u>	No charge		
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Office visit <u>copay</u> or no charge	Not covered	<u>Cost share</u> varies based on place of service and <u>provider</u> 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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic Tier 1	Generic <u>Co-pay</u> \$7/30 day supply	Not covered	Some medications require <u>precertification</u> and will not be filled without it. 90-day supply costs 3 <u>co-pays</u> at retail pharmacy and 2 <u>co-pays</u> at mail order. Mail order and 90-day supply not covered <u>out-of-network</u> .
	Preferred Tier 2	Preferred <u>Co-pay</u> \$25/30 day supply	Not covered	
	Non-Preferred Tier 3	Non-Preferred <u>Co-pay</u> \$45/30 day supply	Not covered	
	<u>Specialty</u>	Flat \$60	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	<u>Precertification</u> required for some outpatient services or drugs.
	Physician/surgeon fees			
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$250 <u>copay</u>		If admitted as an inpatient to the hospital, <u>copay</u> is waived.
	<u>Emergency medical transportation</u>	No charge		None
	<u>Urgent care</u>	\$30 <u>copay</u>	Not covered	<u>Copay</u> applies only to facilities specifically contracted for <u>urgent care</u> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 <u>copay</u> per member / per admission	Not covered	<u>Precertification</u> required for some non-emergency services or drugs.
	Physician/surgeon fee	No charge		
	Long-term acute care (LTAC)	\$250 <u>copay</u> per member / per admission	Not covered	<u>Precertification</u> required. Limit of 365 total LTAC days per member.

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient Services	No charge	Not covered	\$10 <u>copay</u> for Counseling telehealth consultations and Psychiatric telehealth consultations through BlueCare Anywhere.
	Inpatient Services	\$250 <u>copay</u> per member / per admission	Not covered	<u>Precertification</u> required.
<b>If you are pregnant</b>	Office visits	Office visit <u>copay</u>	Not covered	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>preventive services</u> .
	Childbirth/delivery professional services	\$250 <u>copay</u> per member / per admission		
	Childbirth/delivery facility services			
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u> /Home infusion therapy	No charge	Not covered	Some drugs require <u>precertification</u> and won't be covered without it. Limited to 6 hours of care per member per day.
	<u>Rehabilitation services</u> <ul style="list-style-type: none"> <li>• EAR = Extended Active Rehabilitation Facility</li> <li>• PT/OT/ST = Physical therapy, occupational therapy, speech therapy</li> </ul>	<ul style="list-style-type: none"> <li>• EAR: \$250 <u>copay</u> per member / per admission then no charge except 50% <u>coinsurance</u> days 61-120</li> <li>• PT/OT/ST: No charge except 50% <u>coinsurance</u> after 20 visits</li> </ul>	Not covered	<u>Precertification</u> required for inpatient facility admission. Limit of 120 inpatient days/ <u>plan</u> year for EAR and 180 inpatient days/ <u>plan</u> year for SNF. For PT/OT/ST 50% coinsurance applies exceeding 20 visits per <u>plan</u> year.
	<u>Habilitation services</u>	Not covered	Not covered	
	<u>Skilled nursing care</u> in skilled nursing facility (SNF)	No charge except 50% <u>coinsurance</u> days 91-180	Not covered	
	<u>Durable medical equipment</u>	Office visit <u>copay</u> or no charge	Not covered	<u>Cost share</u> varies based on place of service and <u>provider</u> type. Limit of 1 hearing aid per member per ear every 24 months.
	<u>Hospice services</u>	No charge	Not covered	None

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 your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u>	Not covered	Limit of 1 routine vision exam/ <u>plan</u> year. No charge for members under age 5 <u>in-network</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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Alternative medicine</li> <li>• Care that is not <u>medically necessary</u></li> <li>• Cosmetic surgery, cosmetic services &amp; supplies</li> <li>• Custodial care</li> <li>• Dental care except as stated in <u>plan</u></li> <li>• <u>DME</u> rental/repair charges that exceed <u>DME</u> purchase price</li> <li>• Experimental and investigational treatments, except as stated in <u>plan</u></li> <li>• Eyewear except as stated in <u>plan</u></li> <li>• Fertility and infertility medication and treatment</li> <li>• Flat feet treatment and services</li> </ul>	<ul style="list-style-type: none"> <li>• Genetic and chromosomal testing, except as stated in <u>plan</u></li> <li>• <u>Habilitation</u> services</li> <li>• <u>Home health care</u> and infusion therapy exceeding 6 hours of care per member per day</li> <li>• Inpatient EAR treatment exceeding 120 days per <u>plan</u> year and inpatient SNF treatment exceeding 180 days per <u>plan</u> year</li> <li>• <u>Long-term care</u>, except long-term acute care up to a 365 days benefit <u>plan</u> maximum</li> <li>• Massage therapy other than allowed under medical coverage guidelines</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Preventive services</u> not required to be covered by state or federal law</li> <li>• Private-duty nursing</li> <li>• Respite care, except as stated in <u>plan</u></li> <li>• Routine foot care</li> <li>• Routine vision exam exceeding 1 visit per <u>plan</u> year</li> <li>• Services from <u>out-of-network providers</u> except for emergencies and when care is <u>preauthorized</u></li> <li>• Services, tests and procedures that are excluded under medical coverage guidelines</li> <li>• Sexual dysfunction treatment and services</li> <li>• Weight loss programs and medications</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (up to 12 visits per <u>plan</u> year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids, limited to one hearing aid per member per ear every 24 months</li> </ul>

**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](http://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](http://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](http://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:

- 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](http://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.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet 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.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

**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** n/a
- **Specialist copayment** \$30
- **Hospital (facility) copayment** \$250
- **Other coinsurance** n/a

**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:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$330
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>exclusions</u>	\$60
<b>The total Peg would pay is</b>	<b>\$390</b>

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

- **The plan's overall deductible** n/a
- **Specialist copayment** \$30
- **Hospital (facility) copayment** \$250
- **Other coinsurance** n/a

**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** \$7,400

**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$670
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>exclusions</u>	\$60
<b>The total Joe would pay is</b>	<b>\$730</b>

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

- **The plan's overall deductible** n/a
- **Specialist copayment** \$30
- **Hospital (facility) copayment** \$250
- **Other coinsurance** n/a

**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** \$1,900

**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$310
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>exclusions</u>	\$0
<b>The total Mia would pay is</b>	<b>\$310</b>

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 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.

If you believe that BCBSAZ 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: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, [crc@azblue.com](mailto:crc@azblue.com). You can file a grievance in person or by mail or email. If you need help filing a grievance, BCBSAZ's Civil Rights 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, DC 20201, 1 (800) 368-1019, 1 (800) 537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.