


**⚠️ 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](https://www.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/](https://www.healthcare.gov/sbc-glossary/) or call **602-864-4857** to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In-network: <b>\$1,700</b> /individual and <b>\$3,400</b> /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> , the overall family must be met before the <u>plan</u> begins to pay. 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 10% <u>in-network</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Certain <u>in-network preventive services</u> are covered before you meet <u>deductible</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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet other <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	In-network: <b>\$3,400</b> /individual and <b>\$6,800</b> /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 out-of-pocket limits until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://www.azblue.com">www.azblue.com</a> or call 602-864-4857 for a list of <u>in-network providers</u> .	This plan uses a <u>provider network</u> . This plan does not cover services by <u>out-of-network providers</u> except in very limited circumstances. 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	Not covered	Limit of 1 routine vision exam/per calendar year. Limit of 36 chiropractic visits/calendar year. Acupuncture covered for up to 12 visits max per calendar year. Medical telehealth consultations covered through BlueCare Anywhere <sup>SM</sup> \$20 copay per consultation.  <u>Preventive services</u> 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 visit</u>	10% <u>coinsurance</u>		
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	Not covered	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)			
<b>If you need drugs to treat your illness or condition</b>	<u>Prescription drugs</u>	Not covered		Excluded under this medical policy. Coverage may be available under separate prescription drug policy.
	<u>Specialty drugs</u>			
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees			

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 immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>		If you are admitted as an inpatient to the hospital you pay inpatient <u>deductible</u> and <u>coinsurance</u> . <u>Out-of-network providers can't balance bill</u> for the difference between the <u>allowed amount</u> and the billed charge.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>		None
	<u>Urgent care</u>	10% <u>coinsurance</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees			
	Long-term acute care	10% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	Not covered	Counseling telehealth consultations and Psychiatric telehealth consultations covered through BlueCare Anywhere <sup>SM</sup> \$20 copay per consultation.
	Inpatient services	10% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office Visits	10% <u>coinsurance</u>	Not covered	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 preventive services</u> .
	Childbirth/delivery professional services			
	Childbirth/delivery facility 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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u> /Home infusion therapy	10% <u>coinsurance</u>	Not covered	Limited to 3 two-hour visits of care per member per day. Custodial care excluded.
	<u>Rehabilitation services</u> • EAR = Extended Active Rehabilitation Facility • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy • C&PR = Cardiac rehabilitation, Pulmonary rehabilitation	10% <u>coinsurance</u>	Not covered	Limit of 60 combined visits/calendar year for PT/OT/ST/CT. Precertification required for visits beyond the 60-visit limit. Limit 60 visits/calendar year for C&PR.
	<u>Habilitation services</u>	Not covered	Not covered	
	<u>Skilled nursing care</u> In skilled nursing facility (SNF)	10% <u>coinsurance</u>	Not covered	
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered	Limit of 1 unit/pair/calendar year for prosthetics and orthotics. Limit of 1 hearing aid per ear/2 calendar years.
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	0% <u>coinsurance</u> after <u>deductible</u>	Not covered	Limit of 1 routine vision exam/per calendar year. No charge for members under age 5 <u>in-network</u> .
	Children's glasses	No charge, deductible does not apply	Not covered	Limit of 1 pair of eyeglasses and contact lenses/calendar year.
	Children's dental check-up	Not covered	Not covered	Excluded

**Excluded Services & Other Covered Services:**

<b>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>.)</b>		
<ul style="list-style-type: none"><li>• Alternative medicine</li><li>• Cardiac and pulmonary rehabilitation exceeding 60 combined visits/calendar year</li><li>• Care that is not medically necessary</li><li>• Cosmetic surgery, cosmetic services &amp; supplies</li><li>• Custodial care</li><li>• Dental care except dental accidents</li><li>• DME rental/repair charges that exceed DME purchase price</li><li>• Experimental and investigational treatments except as stated in plan</li><li>• Eye wear except after cataract surgery</li></ul>	<ul style="list-style-type: none"><li>• Fertility and infertility medication and treatment</li><li>• Flat feet treatment and services except as stated in <u>plan</u></li><li>• Genetic and chromosomal testing except as stated in <u>plan</u></li><li>• <u>Habilitation services</u></li><li>• <u>Home health care</u> and infusion therapy exceeding 3 two-hour visits of care per member per day</li><li>• <u>Long-term care</u>, except long-term acute care</li><li>• Massage therapy other than allowed under clinical evidence-based criteria</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/1 year and a day</li><li>• Services, tests and procedures that are excluded under medical coverage guidelines</li><li>• Sexual dysfunction treatment and services</li><li>• Specialty and Prescription drugs</li><li>• Weight loss programs</li></ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>		
<ul style="list-style-type: none"><li>• Acupuncture limited to 12 visits max per calendar year</li><li>• Bariatric surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care limited to 36 visits per calendar year</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids, limited to one hearing aid per 2 calendar years</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 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 602-864-4857. 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 602-864-4857. 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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$1,700	■ The <u>plan's</u> overall <u>deductible</u>	\$1,700	■ The <u>plan's</u> overall <u>deductible</u>	\$1,700
■ <u>Specialist coinsurance</u>	10%	■ <u>Specialist coinsurance</u>	10%	■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	10%	■ Other <u>coinsurance</u>	10%	■ Other <u>coinsurance</u>	10%
<b>This EXAMPLE event includes services like:</b> <u>Specialist</u> office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> ( <i>ultrasounds and blood work</i> ) <u>Specialist visit</u> ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> <u>Primary care physician</u> office visits ( <i>including disease education</i> ) <u>Diagnostic tests</u> ( <i>blood work</i> ) <u>Prescription drugs</u> <u>Durable medical equipment</u> ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> <u>Emergency room care</u> ( <i>including medical supplies</i> ) <u>Diagnostic test</u> ( <i>x-ray</i> ) <u>Durable medical equipment</u> ( <i>crutches</i> ) <u>Rehabilitation services</u> ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,700	<u>Deductibles</u>	\$1,700	<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,090	<u>Coinsurance</u>	\$390	<u>Coinsurance</u>	\$110
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$50	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,840</b>	<b>The total Joe would pay is</b>	<b>\$2,110</b>	<b>The total Mia would pay is</b>	<b>\$1,810</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 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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