Summary of Benefits and Coverage: What this <u>Plan</u> Covers & What You Pay for Covered Services Coverage Period: 01/01/2025-12/31/2025

City of Phoenix Savers Choice Actives Coverage for: Individual & Family | <u>Plan</u> Type: HSA-qualified EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>azblue.com/member</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary/</u> or call 602-864-4857 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$1,700/individual and \$3,400/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> .
Are there services covered before you meet your deductible?	Yes. Certain <u>in-network preventive</u> <u>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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet other <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network: \$3,400/individual and \$6,800/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.
What is not included in the out-of-pocket limit?	Premiums and costs for health care this plan 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.azblue.com 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</u> <u>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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

	Services You May Need	What You Will Pay		Limitations Evacutions 9 Other	
Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	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	
	Specialist visit	10% coinsurance	Not dovered	calendar year. Medical telehealth consultations covered through BlueCare Anywhere SM \$20 copay per consultation.	
	Preventive care/screening/ immunization	No charge, <u>deductible</u> does not apply	Not covered	Preventive services not required to be covered by state or federal law are not covered. 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.	
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	· 10% <u>coinsurance</u>	Not covered	None	
If you need drugs to treat your illness or condition	Prescription drugs Specialty drugs	Not covered		Excluded under this medical policy. Coverage may be available under separate prescription drug policy.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	10% coinsurance	Not covered	None	

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* For more information about limitations, exceptions, and prior authorization, see the <u>plan</u> or policy document at <u>www.azblue.com/member.</u>

Common Medical Event	Services You May Need	What You Will Pay Network Provider Out-of-Network Provider		Limitations, Exceptions, & Other	
		(You will pay the least)	(You will pay the most)	Important Information	
If you need immediate medical attention	Emergency room care	20% coinsurance		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</u> can't <u>balance bill</u> for the difference between the <u>allowed amount</u> and the billed charge.	
	Emergency medical transportation	10% coinsurance		None	
	Urgent care	10% coinsurance	Not covered	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None	
	Physician/surgeon fees				
	Long-term acute care	10% coinsurance	Not covered	None	
If you need mental health, behavioral health, or substance	Outpatient services	10% coinsurance	Not covered	Counseling telehealth consultations and Psychiatric telehealth consultations covered through BlueCare Anywhere SM \$20 copay per consultation.	
abuse services	Inpatient services	10% coinsurance	Not covered	None	
If you are pregnant	Office Visits		Not covered	Maternity care may include tests and services described elsewhere in the <u>SBC</u> (i.e. ultrasound). Cost sharing does not apply for in-network	
	Childbirth/delivery professional services	10% coinsurance			
	Childbirth/delivery facility services			preventive services.	

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	Services You May Need	What You Will Pay		Limitations Evacutions 9 Other	
Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	10% coinsurance	Not covered	Limited to 3 two-hour visits of care per member per day. Custodial care excluded.	
	Rehabilitation services • EAR = Extended Active Rehabilitation Facility • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy • C&PR = Cardiac rehabilitation, Pulmonary rehabilitation	10% coinsurance	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.	
	Habilitation services	Not covered	Not covered		
	Skilled nursing care In skilled nursing facility (SNF)	10% coinsurance	Not covered		
	Durable medical equipment	10% coinsurance	Not covered	Limit of 1 unit/pair/calendar year for prosthetics and orthotics. Limit of 1 hearing aid per ear/2 calendar years.	
	Hospice services	10% coinsurance	Not covered	None	
If your child needs dental or eye care	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 in-network.	
	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	

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* For more information about limitations, exceptions, and prior authorization, see the <u>plan</u> or policy document at <u>www.azblue.com/member.</u>

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.)

- Alternative medicine
- Cardiac and pulmonary rehabilitation exceeding 60 combined visits/calendar year
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care

Bariatric surgery

- Dental care except dental accidents
- DME rental/repair charges that exceed DME purchase price
- Experimental and investigational treatments except as stated in plan
- Eye wear 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
- Home health care and infusion therapy exceeding 3 two-hour visits of care per member per day
- Long-term care, except long-term acute care
- Massage therapy other than allowed under clinical evidence-based criteria
- Non-emergency care when traveling outside the U.S.

- 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 exam exceeding 1 visit per/1 year and a day
- Services, tests and procedures that are excluded under medical coverage guidelines
- Sexual dysfunction treatment and services
- Specialty and Prescription drugs
- Weight loss programs

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

- Acupuncture limited to 12 visits max per calendar Chiropractic care limited to 36 visits per calendar year
 - year
- Hearing aids, limited to one hearing aid per 2 calendar years

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 <u>plans</u> are not covered by the Federal <u>COBRA</u> 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 <u>Grievance</u> and <u>Appeals</u> Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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. 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.

^{*} For more information about limitations, exceptions, and prior authorization, see the <u>plan</u> or policy document at <u>www.azblue.com/member.</u>

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éi doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínígóó. Ata' halne'ígíí kojí' bich'j' hodíilnih 877-475-4799.

Chinese: 如果您,或是您正在協助的對象,有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題,您有權利免費以您的 母語得到幫助和訊息。洽詢一位翻譯員,請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة ,للتحدث مع مترجم اتصل ب 479-475-877.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود . را به طور رایگان دریافت نمایید .799-475-877 تماس حاصل نمایید.

Assyrian:

يہ نِسمَن، نِه بَدَوْوَهُ دِوْمُودُوهِ مَمَن، يَهِكُمُونَ حَوْقَةِ حَوْمُ Blue Cross Blue Shield of Arizona؛ نِسمَن، يَهِدُوهُ يَوْمُوهُ وَفِيوَدُ وَوَهُ عَلَيْهُ وَهُوهُ لَيْمُونُ وَهُو كَاءَ اللّهِ اللّهُ عَلَيْهُ وَاللّهُ 1475-877. كَاهُوهُ فِي فَا يُعْمُ لِكُونُ وَلَيْدُونُ وَلَيْدُ 1479-877.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีค่าถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

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

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About These Coverage Examples

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

Peg is Having a Baby		Managing Joe's Type 2 Diabetes		Mia's Simple Fracture	
(9 months of in-network pre-natal care and a hospital delivery)		(a year of routine in-network care of a well- controlled condition)		(in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u> ■ <u>Specialist coinsurance</u> ■ Hospital (facility) <u>coinsurance</u> ■ Other <u>coinsurance</u>	10%	 ■ The <u>plan's</u> overall <u>deductible</u> ■ <u>Specialist coinsurance</u> ■ Hospital (facility) <u>coinsurance</u> ■ Other <u>coinsurance</u> 	\$1,700 10% 20% 10%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,700 10% 20% 10%
This EXAMPLE event includes a Specialist office visits (prenatal can Childbirth/Delivery Professional S Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and Specialist visit (anesthesia)	are) ervices es	This EXAMPLE event includes se Primary care physician office visits disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucos	(including	This EXAMPLE event includes se Emergency room care (including m supplies) Diagnostic test (x-ray) Durable medical equipment (crutch Rehabilitation services (physical the	edical es)
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
<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
Coinsurance	\$1,090	Coinsurance	\$390	Coinsurance	\$110
What isn't covered	d	What isn't covered		What isn't covered	,
Limits or exclusions	\$50	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$2,840	The total Joe would pay is	\$2,110	The total Mia would pay is	\$1,810

The <u>plan</u> 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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