


**⚠** 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). 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-818-0239 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In-network and out-of-network combined: <b>\$500/individual and \$1,000/family</b>	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 40% <u>out-of-network</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Certain <u>in-network preventive services</u> ; <u>in-network primary care</u> and <u>specialist visits</u> ; <u>prescription drugs</u> ; <u>emergency room care</u> ; <u>in-network urgent care visits</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.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <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>\$2,000/individual and \$4,000/family</b> Out-of-network: <b>\$4,000/individual and \$8,000/family</b>	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, <u>out-of-network 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:
Is there a lifetime limit on what the <u>plan</u> pays?	Yes. \$2,000,000	The <u>plan</u> will pay for covered services only up to this limit during your lifetime, even if your own need is greater. You're responsible for all expenses above the limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of visits.
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 1-855-818-0239 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 charge</u> 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 office</u> or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> , <u>deductible</u> does not apply	40% <u>coinsurance</u> & <u>balance bill</u>	<p><u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.</p> <p><u>Specialist copay</u> for most chiropractic services. For chiropractic and acupuncture services each, there is a \$300 maximum per member, per calendar year. \$20 <u>copay</u> for Medical telehealth consultations through BlueCare Anywhere.</p> <p><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. \$600 maximum per member, per calendar year for ages 6 and up. Mammogram and colonoscopy/sigmoidoscopy screening do not count towards the maximum.</p>
	<u>Specialist</u> visit	\$30 <u>copay</u> , <u>deductible</u> does not apply		
	<u>Preventive care/screening/immunization</u>	\$20 <u>copay</u> , <u>deductible</u> does not apply Except \$30 <u>copay</u> , <u>deductible</u> does not apply for colonoscopy and sigmoidoscopy screening	40% <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)	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Office visit <u>copay</u> , <u>deductible</u> does not apply or 20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	Prior <u>authorization</u> may be required. Claim may be denied or \$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 and type.
	Imaging (CT/PET scans, MRIs)			
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or 1-844-581-4864	Generic <u>drugs</u>	\$10 retail \$20 mail order	Reimbursement is based on the billed charges less the applicable <u>copayment</u> .	Coverage is limited to 30 supply retail and 90 day supply mail order.  90 day retail option: \$30 <u>copayment</u> generic \$90 <u>copayment</u> formulary brand \$180 <u>copayment</u> non-formulary brand  All <u>copayment</u> amounts are per prescription.
	Preferred brand <u>drugs</u>	\$30 retail \$60 mail order		
	Non-preferred brand <u>drugs</u>	\$60 retail \$120 mail order	Submit proof of purchase to Express-Scripts for reimbursement.	
	<u>Specialty drugs</u>	<u>Copayments</u> are the same as retail above	Not Available	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	Prior <u>authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	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>	\$150 <u>copay, deductible</u> does not apply	40% <u>coinsurance</u>	If admitted to hospital, <u>copay</u> is waived and 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.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>		None
	<u>Urgent care</u>	\$35 <u>copay, deductible</u> does not apply	40% <u>coinsurance</u> & <u>balance bill</u>	<u>Copay</u> applies only to facilities specifically contracted for <u>urgent care</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	Physician/surgeon fees			
	Long-term acute care	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 60 days per member combined with EAR and SNF.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay, deductible</u> does not apply or 20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	<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 & Psychiatric telehealth consultations through BlueCare Anywhere.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
If you are pregnant	Office Visits	\$20 <u>copay, deductible</u> does not apply or 20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	Coverage is limited to employees, spouses and dependents only. 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> preventive services.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	20% <u>coinsurance</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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u> /Home infusion therapy	20% <u>coinsurance</u>	40% <u>coinsurance &amp; balance bill</u>	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limited to 6 hours of care per member per day. Maximum of 60 days per member, per calendar year. Custodial care excluded.
	<u>Rehabilitation services</u> • EAR = Extended Active Rehabilitation Facility • PT/ST/OT = Physical Therapy, Occupational Therapy, Speech Therapy	20% <u>coinsurance</u>	40% <u>coinsurance &amp; balance bill</u> may apply	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance &amp; balance bill</u>	Limit of 60 days per member combined EAR, SNF and LTAC. <u>Plan</u> does not cover group physical and occupational therapy.
	<u>Skilled nursing care</u> In skilled nursing facility (SNF)	20% <u>coinsurance</u>	40% <u>coinsurance &amp; balance bill</u> may apply	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance &amp; balance bill</u>	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance &amp; balance bill</u>	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Coverage is limited to 12 months.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered		Excluded. Screening for members under age 5 covered under " <u>Preventive care / screening / immunization.</u> "
	Children's glasses	Not covered		Excluded
	Children's dental check-up	Not covered		Excluded

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b>		
<ul style="list-style-type: none"><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>• Flat feet treatment and services</li><li>• Genetic and chromosomal testing, except as stated in <u>plan</u></li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• <u>Home health care</u> and infusion therapy exceeding 6 hours per member per day limited to 60 days per member per year</li><li>• Homeopathic services</li><li>• Hospice services beyond 12 months per member</li><li>• Infertility medication and treatment (except diagnosis of infertility)</li><li>• <u>Long-term care</u>, except long-term acute care up to a 60 days combined with EAR and SNF</li><li>• Massage therapy other than allowed under evidence-based criteria</li></ul>	<ul style="list-style-type: none"><li>• Naturopathic services</li><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 eye care except as stated in the benefit <u>plan</u></li><li>• Routine foot care</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</li></ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b>		
<ul style="list-style-type: none"><li>• Acupuncture (\$300 limit)</li><li>• Bariatric surgery (<u>in-network</u>)</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care (\$300 limit)</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</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 1-855-818-0239 . 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 1-855-818-0239 . 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 \$500
- Specialist copayment \$50
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$1,890
What isn't covered	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$2,490</b>

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$500
- Specialist copayment \$50
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$770</b>

### Mia's Simple Fracture

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

- The plan's overall deductible \$500
- Specialist copayment \$50
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$220
<u>Coinsurance</u>	\$290
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,010</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.

L20152-0124