


⚠ 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. 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/ or call **1-855-818-0239** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<p><u>In-network</u>: \$425/individual and \$850/family per calendar year</p> <p><u>Out-of-network</u>: \$850/individual and \$1,700/family per calendar year</p>	<p>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 15% <u>in-network</u> and 40% <u>out-of-network</u>. Claims applied to the <u>in-network deductible</u> will also apply to the <u>out-of-network deductible</u> and claims applied to the <u>out-of-network deductible</u> will also apply to the <u>in-network deductible</u>.</p>
Are there services covered before you meet your deductible?	<p>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</u> visits.</p>	<p>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/.</p>
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<p><u>In-network</u>: \$1,900/individual and \$3,800/family per calendar year</p> <p><u>Out-of-network</u>: \$3,800/individual and \$7,600/family per calendar year</p>	<p>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. Claims applied to the <u>in-network out-of-pocket limit</u> will also apply to the <u>out-of-network out-of-pocket limit</u> and claims applied to the <u>out-of-network out-of-pocket limit</u> will also apply to the <u>in-network out-of-pocket limit</u>.</p>

Important Questions	Answers	Why This Matters:
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>out-of-network prior authorization charges</u> , <u>balance-bills</u> , and costs for health care this <u>plan</u> doesn't cover. <u>Copayments</u> do not count toward the <u>out-of-pocket limits</u> but do count toward the legally mandated \$10,600/member and \$21,200/family <u>cost-sharing</u> limits.	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 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</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.
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</u> office 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>	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. <u>Specialist copay</u> for most chiropractic services. For chiropractic and acupuncture services each, there is a maximum of 12 visits per member, per calendar year. \$20 <u>copay</u> for Medical telehealth consultations through BlueCare Anywhere. <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</u> visit	\$50 <u>copay</u> , <u>deductible</u> does not apply		
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	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)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Office visit <u>copay</u> , <u>deductible</u> does not apply or 15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	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 provider's <u>network</u> status and type.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com or 1-844-581-4864	Generic <u>drugs</u>	\$10/prescription	Reimbursement is based on the billed charges less the applicable <u>copayment</u> . Submit proof of purchase to Express-Scripts for reimbursement.	Coverage listed is for retail pharmacies and limited to 30 day supply. Mail order cost: Up to 90 day supply for the cost of 2 retail <u>copays</u> . 90 day retail option: \$30 Tier 1 generic 20% Tier 2 preferred brand– (\$90 min, \$150 max) 30% Tier 3 non-preferred brand– (\$180 min, \$300 max)
	Preferred brand <u>drugs</u>	20% <u>copay</u> : \$30 minimum, \$50 maximum		
	Non-preferred brand <u>drugs</u>	30% <u>copay</u> : \$60 minimum, \$100 maximum		
	<u>Specialty drugs</u>	<u>Copayments</u> are the same as retail above	Not Available	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	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</u> , <u>deductible</u> does not apply		If admitted to hospital, <u>copay</u> is waived and you pay inpatient <u>deductible</u> and <u>coinsurance</u> . Admittance for observation is not inpatient. <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>	15% <u>coinsurance</u>		None
	<u>Urgent care</u>	\$35 <u>copay</u> , <u>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)	15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	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	15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	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, per calendar year combined with EAR and SNF.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> , <u>deductible</u> does not apply or 15% <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	15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	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</u> , <u>deductible</u> does not apply or 15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	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 preventive services</u> .
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	15% <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)	
If you need help recovering or have other special health needs	<u>Home health care</u> /Home infusion therapy	15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	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	15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	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, per calendar year combined with EAR, SNF and LTAC. <u>Plan</u> does not cover group physical and occupational therapy.
	<u>Habilitation services</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	
	<u>Skilled nursing care</u> In skilled nursing facility (SNF)	15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u> may apply	
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	<u>Hospice services</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	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.
If your child needs dental or eye care	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:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care except as stated in plan
- DME rental/repair charges that exceed DME purchase price
- Experimental and investigational treatments except as stated in plan
- Eyewear except as stated in plan
- Flat feet treatment and services
- Genetic and chromosomal testing, except as stated in plan
- Hearing aids
- Home health care and infusion therapy exceeding 6 hours per member per day limited to 60 days per member per year
- Homeopathic services
- Hospice services beyond 12 months per member
- Infertility medication and treatment (except diagnosis of infertility)
- Long-term care, except long-term acute care up to 60 days per member, per calendar year combined with EAR and SNF
- Massage therapy other than allowed under evidence-based criteria
- Naturopathic services
- Preventive services not required to be covered by state or federal law
- Private-duty nursing
- Respite care, except as stated in plan
- Routine eye care
- Routine foot care
- Services, tests and procedures that are excluded under medical coverage guidelines
- Sexual dysfunction treatment and services
- Weight loss programs except as stated in the benefit plan

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

- Acupuncture (12 visit limit)
- Bariatric surgery (in-network)
- Chiropractic care (12 visit limit)
- Non-emergency care when traveling outside the U.S.

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 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 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. 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.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-475-4799.

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 602-864-4884.

Navajo: Diné bee yánitłi'gogo, saad bee aná'awo' bee áka'anída'awo'ít'á dá jik'eh ná hóló. Bee ahít hane'go bee nida'anishí t'á dá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoót'i'ígíí éí t'á dá jik'eh hóló. Kohji' 1-877-475-4799.

Chinese Simplified: 如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-475-4799。

Chinese Traditional: 如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-877-475-4799。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-475-4799.

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-475-4799.

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-475-4799.

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-475-4799.

Korean: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-475-4799.

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-475-4799.

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-475-4799.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-475-4799 |

Farsi (Persian)

با شماره همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. فارسی اگر توجه: 1-877-475-4799.

Thai: หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-475-4799.

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-475-4799。

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 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 \$425
- Specialist copayment \$50
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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:

Cost Sharing	
<u>Deductibles</u>	\$425
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$1,420
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$1,945

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$425
- Specialist copayment \$50
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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 \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$670
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$740

Mia's Simple Fracture

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

- The plan's overall deductible \$425
- Specialist copayment \$50
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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 \$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$425
<u>Copayments</u>	\$260
<u>Coinsurance</u>	\$230
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$915

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:
 - Qualified sign language interpreters
 - 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:
 - Qualified interpreters
 - 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.

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