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** 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** or by calling **1-877-475-8440** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network providers: **$500**/member and **$1,000**/family Out-of-network providers: **$2,000**/member and **$4,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Unless a copay, fee, or other percent is shown, the coinsurance percent of the allowed amount that you pay for most services is 20% in-network and 60% out-of-network.
Are there services covered before you meet your deductible?	Yes. Certain in-network preventive services; in-network primary care and specialist visits; prescription drugs; in-network urgent care visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network providers: **$5,000**/member and **$10,000**/family Out-of-network providers: **$12,700**/member and **$25,400**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, out-of-network precertification charges, balance-bills, and costs for health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use an in-network provider?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay, deductible does not apply	60% coinsurance & balance bill	Precertification may be required. $300 charge if no precertification for out-of-network services. Specialist copay for most chiropractic services. No charge for Medical telehealth consultations through BlueCare Anywhere. Covered services from naturopaths, homeopaths and acupuncture limited to 8 visits/member/plan year subject to in-network specialist copay.
	Specialist visit	$40 copay, deductible does not apply		
	Preventive care/screening/ immunization	No charge, deductible does not apply	Most services not covered. If covered, 60% coinsurance & balance bill	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. Only mammography (deductible waived) and foreign travel immunizations are covered out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Office visit copay, deductible does not apply or 20% coinsurance	60% coinsurance & balance bill	Precertification may be required. $300 charge if no precertification for out-of-network services.Cost share is waived if lab is only service received during physician office visit and at contracted, freestanding, independent clinical labs. Cost share varies based on place of service and provider's network status and type.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.azblue.com	Level 1 prescription drugs	$10 copay/30 day supply, deductible does not apply	$10 copay/30 day supply & balance bill, deductible does not apply	Some drugs require precertification and won't be covered without it. 90-day supply costs 2 copays for mail order and for retail pharmacy, copay applies for each 30-day supply. Mail order and 90-day retail supply not covered out-of-network.
	Level 2 prescription drugs	$30 copay/30 day supply, deductible does not apply	$30 copay/30 day supply & balance bill, deductible does not apply	
	Level 3 prescription drugs	$50 copay/30 day supply, deductible does not apply	$50 copay/30 day supply & balance bill, deductible does not apply	
	Specialty drugs	Copays (deductible does not apply): Level A: $30 Level B: $60 Level C: $90 Level D: $120	Not covered	Specialty copay covers up to a 30-day supply. No coverage without precertification.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	60% coinsurance & balance bill	Precertification may be required. $300 charge if no precertification for out-of-network services.
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$200 access fee per member/facility/day, then 20% coinsurance		If admitted as inpatient to hospital, access fee is waived.
	Emergency medical transportation	20% coinsurance, deductible does not apply		None
	Urgent care	$50 copay, deductible does not apply	60% coinsurance & balance bill	Copay applies only to facilities specifically contracted for urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	60% coinsurance & balance bill	Precertification may be required. $300 charge if no precertification for out-of-network services.
	Physician/surgeon fee			
	Long-term acute care (LTAC)	20% coinsurance	60% coinsurance & balance bill	Precertification may be required. $300 charge if no precertification for out-of-network services. Limit of 365 total LTAC days per member.
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	Office visit copay, deductible does not apply or 20% coinsurance. Copay amount varies based on PCP/Specialist	60% coinsurance & balance bill	Copay applies to office and home visits. No charge for all other locations. No charge for Counseling telehealth consultations and Psychiatric telehealth consultations through BlueCare Anywhere.
	Inpatient Services	20% coinsurance	60% coinsurance & balance bill	Precertification may be required. $300 charge if no precertification for out-of-network services.
If you are pregnant	Office visits	Office visit copay, deductible does not apply or 20% coinsurance	60% coinsurance & balance bill	Only one copay is collected for services included in delivering physician's global charge. Depending on type of services, copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in SBC (i.e. ultrasound). Cost sharing does not apply for in-network preventive services.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	20% coinsurance		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-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	Home health care/Home infusion therapy	20% coinsurance	60% coinsurance & balance bill	Precertification may be required. $300 charge if no precertification for out-of-network services. Limited to 6 hours of care per member per day.
	Rehabilitation services • EAR = Extended Active Rehabilitation Facility • PT/OT/ST = Physical therapy, occupational therapy, speech therapy	20% coinsurance except 50% coinsurance for days 61-120 of EAR	60% coinsurance & balance bill except 50% coinsurance & balance bill for days 61-120 of EAR	Precertification may be required. $300 charge if no precertification for out-of-network services. Limit of 120 days/plan year for EAR and 180 days/plan year for SNF. Plan does not cover group physical and occupational therapy.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care in skilled nursing facility (SNF)	20% coinsurance except 50% coinsurance for days 91-180	60% coinsurance & balance bill except 50% coinsurance & balance bill for days 91-180	
	Durable medical equipment	Office visit copay, deductible does not apply, or 20% coinsurance	60% coinsurance & balance bill	Precertification may be required. $300 charge if no precertification for out-of-network services. Cost share varies based on place of service and provider's network status and type. Hearing aids are covered in-network and out-of-network subject to 60% coinsurance, deductible does not apply.
	Hospice services	No charge, deductible does not apply	No charge except balance bill, deductible does not apply	Precertification may be required. $300 charge if no precertification for out-of-network services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded. Screening for members under age 5 covered under "Preventive care / screening / immunization."
	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Alternative medicine • 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 • Fertility and infertility medication and treatment • Flat feet treatment and services • Genetic and chromosomal testing, except as stated in plan	• Habilitation services • Home health care and infusion therapy exceeding 6 hours of care per member per day • Inpatient EAR treatment exceeding 120 days per plan year and inpatient SNF treatment exceeding 180 days per plan year • Long-term care, except long-term acute care up to a 365 days benefit plan maximum • Massage therapy other than allowed under medical coverage guidelines • Out-of-network Mail Order, out-of-network Specialty drugs, and out-of-network 90-day retail supply of drugs	• Out-of-network preventive care except mammography and foreign travel immunizations • 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 eye care for members over age 5 • Services, tests and procedures that are excluded under medical coverage guidelines • Sexual dysfunction treatment and services • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (up to 8 visits per member per year, combined with some other covered services)	• Bariatric surgery • Chiropractic care • Hearing aids	• 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 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. 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** **$500**
- **Specialist copayment** **$40**
- **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$120
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,580**

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** **$40**
- **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$110
Copayments	$1,020
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,190**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$280
Coinsurance	$170
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 éí doodago Háida bíjá anilyeedígíí t’áadoo le’é yína’ídíłkidgo beehaz’áanii hólǫ́ díí t’áá hazaadk’ehjí háká a’doowołgo bee haz’ą́ doo bą́ą́h ílínígóó. Ata’ halne’ígíí kojį’ bich’į’ 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 877-475-4799.

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. 877-475-4799 تماس حاصل نمایید.

Assyrian:
ܒܝ ܢܫܚܦ، ܐܘ ܡܢܐ ܕܥܒܕܬܘܢ ܥܡܗ ܬܚܘ، ܐܝܬܘܬܐ ܕܥܠܬܐ ܥܠ ܡܕܝܢܬܐ ܕܒܠܘܬܐ ܕܟܠܝܠܬܐ ܕܐܪܝܙܘܢܐ ܕܐܝܟܢܐ ܕܡܬܝܠܬ ܠܟ ܡܕܝܢܬܐ ܕܝܠܟ ܕܐܝܟܢܐ ܕܡܬܝܠܬ ܠܟ ܡܕܝܢܬܐ ܕܝܠܟ ܕܐܝܟܢܐ ܕܡܬܝܠܬ Blue Cross Blue Shield of Arizona، ܢܫܚܦ، ܐܝܬܘܬܐ ܕܥܠܬܐ ܥܠ ܡܕܝܢܬܐ ܕܒܠܘܬܐ ܕܟܠܝܠܬܐ ܕܐܪܝܙܘܢܐ ܕܐܝܟܢܐ ܕܡܬܝܠܬ ܠܟ ܡܕܝܢܬܐ ܕܝܠܟ ܕܐܝܟܢܐ ܕܡܬܝܠܬ ܠܟ ܡܕܝܢܬܐ ܕܝܠܟ ܕܐܝܟܢܐ ܕܡܬܝܠܬ 877-475-4799.

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

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. 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.

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