




**⚠ 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/GroupPlanDoc2024](http://azblue.com/GroupPlanDoc2024). 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 1-877-475-8440 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<b>\$5,000/individual or \$10,000/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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> , <u>primary care</u> and <u>specialist</u> office visits, <u>prescription drugs</u> , <u>specialty drugs</u> , <u>emergency medical transportation</u> , <u>emergency room care</u> , <u>urgent care</u> visits, <u>hospice services</u> , children's eye exams, children's eyeglasses, and children's dental check-ups are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.  For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<b>\$8,150/individual or \$16,300/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 out-of-pocket limit?</b>	Premiums 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:
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.azblue.com">www.azblue.com</a> or call 1-877-475-8440 for a list of <u>in-network providers</u> .	This <u>plan</u> does not cover services by <u>out-of-network providers</u> except in very limited circumstances. 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <u>provider's office</u> or clinic</b>	<u>Primary care</u> visit to treat an injury or illness	\$40 <u>copay/provider/day</u> , <u>deductible</u> does not apply	Not covered	<u>Prior authorization</u> may be required. No charge for medical telehealth consultations through BlueCare Anywhere <sup>SM</sup> .
	<u>Specialist</u> visit	\$90 <u>copay/provider/day</u> , <u>deductible</u> does not apply	Not covered	<u>Specialist copay</u> for most chiropractic services. Limit of 20 chiropractic visits per member/calendar year. <u>Prior authorization</u> may be required.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	<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.
<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>	Not covered	<u>Cost share</u> varies based on place of service and <u>provider's network</u> status & type. <u>Prior authorization</u> may be required.
	Imaging (CT/PET scans, MRIs)	Office visit <u>copay</u> ( <u>deductible</u> does not apply) or 20% <u>coinsurance</u>	Not covered	<u>Cost share</u> varies based on place of service and <u>provider's network</u> status & type. <u>Prior authorization</u> may be required.

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 drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.azblue.com">www.azblue.com</a>	Tier 1a / 1b	Tier 1a: \$3 <u>copay</u> /30 day supply, <u>deductible</u> does not apply Tier 1b: \$35 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	Not covered	90-day supply is 2.5 <u>copays</u> (retail) or 2 <u>copays</u> (mail order). Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it. View the Tier 1a Drug List at <a href="https://azblue.com/pharmacy-management/Tier1a-Drug-List">https://azblue.com/pharmacy-management/Tier1a-Drug-List</a>
	Tier 2	\$90 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	Not covered	90-day supply is 2.5 <u>copays</u> (retail) or 2 <u>copays</u> (mail order). If a generic drug is available, pay the generic <u>cost share</u> + the price difference between the <u>allowed amount</u> for the brand and generic drugs. Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it.
	Tier 3	\$180 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	Not covered	90-day supply is 2.5 <u>copays</u> (retail) or 2 <u>copays</u> (mail order). If a generic drug is available, pay the generic <u>cost share</u> + the price difference between the <u>allowed amount</u> for the brand and generic drugs. Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it.
	<u>Specialty drugs</u>	50% <u>coinsurance</u> , <u>deductible</u> does not apply	Not covered	Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	<u>Prior authorization</u> may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	Additional \$1,000 access fee for all bariatric surgeries. <u>Prior authorization</u> may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>		None.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> , <u>deductible</u> does not apply		None.
	<u>Urgent care</u>	\$90 <u>copay/provider/day</u> , <u>deductible</u> does not apply	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	<u>Prior authorization</u> may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	Additional \$1,000 access fee for all bariatric surgeries. <u>Prior authorization</u> may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Copay</u> applies to office, home, walk-in clinic visits ( <u>deductible</u> does not apply). Amount varies based on PCP/Specialist. 20% <u>coinsurance</u> applies to all other locations.	Not covered	<u>Cost share</u> varies based on place of service and type of <u>provider</u> . <u>Prior authorization</u> may be required. \$20 <u>copay</u> for counseling or \$45 <u>copay</u> psychiatric telehealth consultations through BlueCare Anywhere <sup>SM</sup> .
	Inpatient services	20% <u>coinsurance</u>	Not covered	<u>Prior authorization</u> may be required.
If you are pregnant	Office Visits	Office visit <u>copay</u> , <u>deductible</u> does not apply	Not covered	Depending on type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in SBC (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>in-network preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	Only 1 <u>copay</u> is collected for services included in delivering physician's global charge. Depending on type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	Depending on type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.

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>	Not covered	<u>Prior authorization</u> may be required. Limit of 42 visits (of up to 4 hours)/calendar year.
	<u>Rehabilitation services</u> • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy	20% <u>coinsurance</u>	Not covered	<u>Prior authorization</u> may be required. Annual limits: 90 inpatient days for Extended Active Rehabilitation Facility (EAR) and Skilled Nursing Facility (SNF) combined, and a 60-visit limit each for outpatient <u>rehabilitative</u> and <u>habilitative</u> services.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not covered	<u>Prior authorization</u> may be required. Annual limits: 90 inpatient days for EAR and SNF combined, and a 60-visit limit each for outpatient <u>rehabilitative</u> and <u>habilitative</u> services.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	<u>Prior authorization</u> may be required. Annual limits: 90 inpatient days for EAR and SNF combined, and a 60-visit limit each for outpatient <u>rehabilitative</u> and <u>habilitative</u> services.
	<u>Durable medical equipment</u>	Office visit <u>copay</u> ( <u>deductible</u> does not apply) or 20% <u>coinsurance</u>	Not covered	<u>Cost share</u> varies based on place of service and type of <u>provider</u> . <u>Prior authorization</u> may be required.
	<u>Hospice services</u>	No charge	Not covered	<u>Prior authorization</u> may be required.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$40 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	Limit of 1 routine vision exam/calendar year. No charge for member under age 5.
	Children's glasses	No charge	Not covered	Limit of 1 pair of glasses or contact lenses/calendar year. <u>Prior authorization</u> may be required.
	Children's dental check-up	No charge	Not covered	Limit of 2 dental check-ups & cleanings/calendar year.

## 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.)

- Acupuncture
- Adult routine vision exam
- Alternative medicine
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care and orthodontic services (Adult) except as stated in plan
- DME rental/repair charges that exceed DME allowed amount
- 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
- Home health care and infusion therapy exceeding 42 visits (of up to 4 hours)/calendar year
- Long-term care, except long-term acute care
- Massage therapy other than allowed under evidence-based criteria
- Non-emergency care when traveling outside the U.S.
- Orthodontic services (Pediatric) that are not dentally necessary
- Private-duty nursing, except when medically necessary or when skilled nursing not available
- Respite care
- Routine foot care
- Services from providers outside the network, except in emergencies and other limited situations when use preauthorized
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids, up to 1 per ear, per calendar year

**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 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](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 1-877-475-8440. 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 or <https://difi.az.gov/consumer/i/health>.

**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.





## 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 \$5,000
- Specialist copayment \$90
- 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$990
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$6,140</b>

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$5,000
- Specialist copayment \$90
- 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,670</b>

### Mia's Simple Fracture

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

- The plan's overall deductible \$5,000
- Specialist copayment \$90
- 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,350
<u>Copayments</u>	\$180
<u>Coinsurance</u>	\$190
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,720</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.