


**⚠ 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/2024INDbooksOn](http://azblue.com/2024INDbooksOn). 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>\$1,700/individual and \$3,400/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 30% <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 office visits</u> ; tier 1 <u>prescription drugs</u> ; <u>specialty drugs</u> ; <u>urgent care visits</u> ; mental health office visits; <u>hospice services</u> ; child eye exams; children’s eyeglasses; and children’s dental check-ups are covered <u>in-network</u> 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</u> services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services 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>	Yes. <b>\$400/individual</b> for tier 2 and 3 <u>prescription drugs</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	<b>\$7,250/individual and \$14,500/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 on 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>	<u>Premiums</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:
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 1-877-475-8440 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. You will pay the most if you use an <u>out-of-network provider</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). You might receive a bill from an <u>out-of-network provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). 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	No charge for first 2 PCP visits/member, then \$15 <u>copay</u> , <u>deductible</u> does not apply	Not covered	\$10 <u>copay</u> for medical telehealth consultations through BlueCare Anywhere <sup>SM</sup> .
	<u>Specialist</u> visit	\$50 <u>copay</u> , <u>deductible</u> does not apply	Not Covered	Limit of 20 chiropractic visits per member/calendar year. <u>Specialist copay</u> for most chiropractic services.
	<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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	Not covered	<u>Cost share</u> varies based on place of service and type of <u>provider</u> .
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	Not covered	<u>Cost share</u> varies based on place of service and type of <u>provider</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 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>	Generic drugs (Tier 1a/1b)	Tier 1a: \$3 <u>copay</u> /30-day supply; prescription <u>deductible</u> does not apply Tier 1b: \$15 <u>copay</u> /30-day supply; prescription <u>deductible</u> does not apply	Not covered	90-day supply is 3 <u>copays</u> retail and 2 <u>copays</u> mail for tier 1 <u>prescription drugs</u> . Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it. Tier 1a Drug List at <a href="https://azblue.com/pharmacy-management/Tier1a-Drug-List">https://azblue.com/pharmacy-management/Tier1a-Drug-List</a>
	Preferred brand drugs (Tier 2)	\$70 <u>copay</u> /30-day supply;	Not covered	\$400/member <u>deductible</u> for tier 2 <u>prescription drugs</u> before <u>copays</u> or <u>coinsurance</u> apply. 90-day supply is 3 <u>copays</u> retail and 2 <u>copays</u> mail for tier 2 <u>prescription drugs</u> . Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it.
	Non-preferred brand drugs (Tier 3)	50% <u>coinsurance</u>	Not covered	\$400/member <u>deductible</u> for tier 3 <u>prescription drugs</u> before <u>copays</u> or <u>coinsurance</u> apply. 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> waived	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)	30% <u>coinsurance</u>	Not covered	<u>Deductible</u> waived for ambulatory surgery center facility fee.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	Additional \$1,000 access fee for all bariatric surgeries.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Out-of-network</u> providers can't <u>balance bill</u> for the difference between the <u>allowed amount</u> and the billed charge.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None.

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 immediate medical attention</b>	<u>Urgent care</u>	\$60 <u>copay/provider/day</u> , <u>deductible</u> does not apply	Not covered	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	None.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	Additional \$1,000 access fee for all bariatric surgeries.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$50 <u>copay</u> , <u>deductible</u> does not apply	Not covered	<u>Cost share</u> varies based on place of service and type of <u>provider</u> . \$10 for counseling and psychiatric telehealth consultations through BlueCare Anywhere <sup>SM</sup> .
	Inpatient services	30% <u>coinsurance</u>	Not covered	None.
<b>If you are pregnant</b>	Office Visits	\$50 <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	30% <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	30% <u>coinsurance</u>	Not covered	Depending on type of services, <u>copayment</u> , <u>coinsurance</u> , <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	30% <u>coinsurance</u>	Not covered	Limit of 42 visits (of up to 4 hours)/calendar year.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	Not covered	Annual limits: 90 <u>inpatient</u> days for Extended Active Rehabilitation Facility (EAR) and Skilled Nursing Facility (SNF) combined, and 60 <u>outpatient</u> visits each for <u>rehabilitative</u> and <u>habilitative</u> services.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	Not covered	Annual limits: 90 <u>inpatient</u> days for EAR and SNF combined, and 60 <u>outpatient</u> visits each for <u>rehabilitative</u> and <u>habilitative</u> services.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	Not covered	Annual limits: 90 <u>inpatient</u> days for EAR and SNF combined, and 60 <u>outpatient</u> visits each for <u>rehabilitative</u> and <u>habilitative</u> services.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not covered	None.
	<u>Hospice services</u>	No charge	Not covered	None.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$15 <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.
	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.)

- Abortion
- 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
- 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 services
- 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:

- 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>
- Healthcare.gov at [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596
- 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).

For more information on your rights to continue coverage, contact the insurer at 1-877-475-8440. You may also contact your state insurance department at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.

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:

- Blue Cross Blue Shield of Arizona at 1-877-475-8440.
- 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**

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? Not Applicable**

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 \$1,700
- Specialist copayment \$50
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**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>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$1,700
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$4,290</b>

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$1,700
- Specialist copayment \$50
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**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>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$330
<u>Copayments</u>	\$820
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,170</b>

### Mia's Simple Fracture

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

- The plan's overall deductible \$1,700
- Specialist copayment \$50
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**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>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$1,700
<u>Copayments</u>	\$110
<u>Coinsurance</u>	\$180
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,990</b>

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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.

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