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/2023INDbooksOn. 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 1-877-475-8440 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/individual and **$0**/family	See the Common Medical Events chart below for your costs for services this plan covers. Unless a copay, fee, or other percent is shown, the coinsurance percent of the allowed amount that you pay for most services is 40% in-network.
Are there services covered before you meet your deductible?	Yes. In-network services are covered, except tier 2 and 3 prescription drugs.	This plan covers in-network services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$300**/individual for tier 2 and 3 prescription drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$3,000**/individual and **$6,000**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on 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 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.
Will you pay less if you use a network provider?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network providers.	This plan does not cover services by out-of-network providers except in very limited circumstances. You will pay the most if you use an out-of-network provider. You will pay less if you use a provider in the plan's network. Be aware your network provider might use an out-of-network provider for some services (such as lab work). You might receive a bill from an out-of-network provider for the difference between the provider's charge and what your plan pays (balance billing). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. You need a referral to see most specialists.	This plan will pay some or all of the costs to see a specialist for covered services, but only if you have a referral before you see the specialist.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge for first 2 PCP visits/member, then $15 copay	Not covered	Precertification may be required. $5 copay for medical telehealth consultations through BlueCare Anywhere℠.
	Specialist visit	$40 copay	Not Covered	Limit of 20 chiropractic visits per member/calendar year. Specialist copay for most chiropractic services. Precertification may be required.
	Preventive care/screening/ immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	Not covered	Cost share varies based on place of service and type of provider. Precertification may be required.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	Cost share varies based on place of service and type of provider. Precertification may be required.

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/2023INDbooksOn.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.azblue.com	Generic drugs (Tier 1a/1b)	Tier 1a: No charge Tier 1b: $6 copay/30-day supply	Not covered	90-day supply is 3 copays retail and 2 copays mail for tier 1 prescription drugs. Some drugs require precertification or a formulary exception and won't be covered without it. Tier1a Drug List at https://azblue.com/pharmacy-management/Tier1a-Drug-List
	Preferred brand drugs (Tier 2)	$75 copay/30-day supply; subject to $300 prescription deductible	Not covered	$300/member deductible for tier 2 prescription drugs before copays or coinsurance apply. 90-day supply is 3 copays retail and 2 copays mail for tier 2 prescription drugs. Some drugs require precertification or a formulary exception and won't be covered without it.
	Non-preferred brand drugs (Tier 3)	50% coinsurance; subject to $300 prescription deductible	Not covered	$300/member deductible for tier 3 prescription drugs before copays or coinsurance apply. Some drugs require precertification or a formulary exception and won't be covered without it.
	Specialty drugs	50% coinsurance	Not covered	Some drugs require precertification or a formulary exception and won't be covered without it
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	Precertification may be required.
	Physician/surgeon fees	40% coinsurance	Not covered	Precertification may be required. Additional $500 access fee for all bariatric surgeries.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	Out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge.
	Emergency medical transportation	40% coinsurance	40% coinsurance	None.
	Urgent care	$40 copay/provider/day, deductible does not apply	Not covered	None.

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/2023INDbooksOn.

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 hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	Precertification may be required.
	Physician/surgeon fees	40% coinsurance	Not covered	Precertification may be required. Additional $500 access fee for all bariatric surgeries.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay	Not covered	Precertification may be required. Cost share varies based on place of service and type of provider. $5 for counseling and psychiatric telehealth consultations through BlueCare Anywhere℠.
	Inpatient services	40% coinsurance	Not covered	Precertification may be required.
If you are pregnant	Office Visits	$40 copay	Not covered	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	40% coinsurance	Not covered	Only 1 copay is collected for services included in delivering physician's global charge. Depending on type of services, copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	40% coinsurance	Not covered	Depending on type of services, copayment, coinsurance, or deductible may apply.

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/2023INDbooksOn.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	40% coinsurance	Not covered	Precertification may be required. Limit of 42 visits (of up to 4 hours)/calendar year.
	Rehabilitation services	40% coinsurance	Not covered	Precertification may be required. Annual limits: 90 inpatient days for Extended Active Rehabilitation Facility (EAR) and Skilled Nursing Facility (SNF) combined, and 60 outpatient visits each for rehabilitative and habilitative services.
	Habilitation services	40% coinsurance	Not covered	Precertification may be required. Annual limits: 90 inpatient days for EAR and SNF combined, and 60 outpatient visits each for rehabilitative and habilitative services.
	Skilled nursing care	40% coinsurance	Not covered	Precertification may be required. Annual limits: 90 inpatient days for EAR and SNF combined, and 60 outpatient visits each for rehabilitative and habilitative services.
	Durable medical equipment	40% coinsurance	Not covered	Precertification may be required.
	Hospice services	No charge	Not covered	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	$15 copay/visit	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. Precertification may be required.
	Children's dental check-up	No charge	Not covered	Limit of 2 dental check-ups & cleanings/calendar year.

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/2023INDbooksOn.

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 medical coverage guidelines • 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

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/2023INDbooksOn.

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 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.

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 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.

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/2023INDbooksOn.

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 hóló̜ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á̜ doo bá̜á̜h ílínígóó. Ata' halne'ígíí koji̜' bich'i̜' hodíílnih 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:

ܐܢ ܐܢܬܘܢ، ܝܢ ܚܕ ܦܪܨܘܦܐ ܕܐܢܬܘܢ ܒܝܬܘܢ ܥܕܪܢܐ ܠܗ، ܐܝܬ ܠܘܟܘܢ ܒܘܩܪܐ ܒܘܬ Blue Cross Blue Shield of Arizona، ܐܝܬ ܠܘܟܘܢ ܙܕܩܐ ܕܡܩܒܠܝܬܘܢ ܗܝܪܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܐ ܕܝܘܟܘܢ ܡܓܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܝ ܠ 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 หรือคนที่คุณกาลังช่วยเหลือมีคำถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

To see examples of how this <u>plan</u> 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	$0
Specialist copayment	$40
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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*	$0
Copayments	$40
Coinsurance	$2,960
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$3,050**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	
Deductibles*	$0
Copayments	$370
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$410**

Mia's Simple Fracture

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	
Deductibles*	$0
Copayments	$90
Coinsurance	$920
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,010**

*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.