




⚠ 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/2022INDbooksOn. 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 <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> .
Are there services covered before you meet your deductible?	Yes. <u>In-network</u> services are covered, except tier 2 and 3 <u>prescription drugs</u> .	This <u>plan</u> covers <u>in-network</u> 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.
Are there other deductibles for specific services?	Yes. \$50/individual for tier 2 and 3 <u>prescription drugs</u> .	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?	\$1,000/individual and \$2,000/family	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.
What is not included in the out-of-pocket limit?	<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> .
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 <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 plan 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). This <u>plan</u> does not cover services by <u>out-of-network providers</u> except in very limited circumstances. Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes. You need a <u>referral</u> to see most <u>specialists</u> .	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services, but only if you have a <u>referral</u> before you see the <u>specialist</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 office</u> or clinic	Primary care visit to treat an injury or illness	No charge for first 2 PCP visits/member, then \$5 <u>copay</u>	Not covered	Each member has <u>cost share</u> waived for up to 2 PCP office visits/year then <u>copay</u> applies. <u>Specialist copay</u> for most chiropractic services. Limit of 20 chiropractic visits per member/calendar year. <u>Precertification</u> may be required. \$5 <u>copay</u> for medical telehealth consultations through BlueCare Anywhere SM . <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	\$10 <u>copay</u>		
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	<u>Cost share</u> varies based on place of service and type of <u>provider</u> . <u>Precertification</u> may be required.
	Imaging (CT/PET scans, MRIs)			

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	Tier 1a /1b (Generic drugs)	Tier 1a: No charge Tier 1b: \$5 <u>copay</u> /30 day supply	Not covered	\$50/member <u>deductible</u> for tier 2 and 3 <u>prescription drugs</u> before <u>copays</u> or <u>coinsurance</u> apply. 90-day supply costs 3 <u>copays</u> (retail pharmacy) and 2 <u>copays</u> (mail order) for tier 1 and 2 <u>prescription drugs</u> . If a generic drug is available, pay the generic <u>copay</u> + the price difference between the <u>allowed amount</u> for the brand and generic drugs. Some drugs require <u>precertification</u> and won't be covered without it. Only <u>formulary</u> drugs are covered unless a <u>formulary</u> exception is approved. Find out if your prescriptions are on the BCBSAZ Tier1a Drug List at https://azblue.com/pharmacy-management/Tier1a-Drug-List
	Tier 2 (Preferred brand drugs)	\$10 <u>copay</u> /30 day supply; subject to \$50 prescription <u>deductible</u>	Not covered	
	Tier 3 (Non-preferred brand drugs)	50% <u>coinsurance</u> ; subject to \$50 prescription <u>deductible</u>	Not covered	
	<u>Specialty drugs</u>	50% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	<u>Precertification</u> may be required. Additional \$250 access fee for all bariatric surgeries.
	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>	20% <u>coinsurance</u>		None.
	<u>Emergency medical transportation</u>			
	<u>Urgent care</u>	\$20 <u>copay/provider/day</u> , <u>deductible</u> does not apply	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	<u>Precertification</u> may be required. Additional \$250 access fee for all bariatric surgeries.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit <u>cost share</u> applies to office, home, walk-in clinic visits. Amount varies based on PCP/Specialist (PCP No charge for first 2 PCP visits/member, then \$5 copay; Specialist \$10 copay). 20% <u>coinsurance</u> applies to all other locations.	Not covered	<u>Precertification</u> may be required. <u>Cost share</u> varies based on place of service and type of <u>provider</u> . \$5 for counseling and psychiatric telehealth consultations through BlueCare Anywhere SM .
	Inpatient services	20% <u>coinsurance</u>		
If you are pregnant	Office Visits	Office visit <u>cost share</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. 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>		
	Childbirth/delivery facility services	20% <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/Home infusion therapy</u>	20% <u>coinsurance</u>	Not covered	<u>Precertification</u> may be required. Limit of 42 visits (of up to 4 hours)/calendar year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	<u>Precertification</u> may be required. 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>	20% <u>coinsurance</u>	Not covered	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	<u>Precertification</u> may be required.
	<u>Hospice services</u>	No charge	Not covered	<u>Precertification</u> may be required.
If your child needs dental or eye care	Children's eye exam	\$5 <u>copay/visit</u> , <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>Precertification</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.)

- 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

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 <http://www.id.state.az.us/>
- 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.

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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$10
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$990
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$1,050

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$10
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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 **\$5,600**

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$10
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$230

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$10
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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 **\$2,800**

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$460
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$490

*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.

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