



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/2020INDbooksOn](http://azblue.com/2020INDbooksOn) 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](http://healthcare.gov/sbc-glossary) or by calling 1-877-475-8440 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	\$2,000/member and \$4,000/family	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>medical telehealth</u> ; level 1 <u>prescription drugs</u> ; <u>specialty drugs</u> ; <u>urgent care</u> visits; <u>mental health</u> 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-carebenefits/">https://www.healthcare.gov/coverage/preventive-carebenefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. \$350/member for Level 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 <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	\$6,000/member and \$12,000/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.

Important Questions	Answers	Why this Matters:
What is not included in the <u>out-of-pocket limit</u> ?	<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 an <u>in-network provider</u> ?	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> . 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 <u>referral</u> to see a <u>specialist</u> ?	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)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	<u>Primary care</u> 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	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. \$10 for medical telehealth consultations through BlueCare Anywhere <sup>SM</sup> . <u>Preventive</u> services 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	\$60 <u>copay</u> , <u>deductible</u> does not apply		
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	Cost share varies based on place of service and type of <u>provider</u> . <u>Precertification</u> may be required.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.azblue.com">www.azblue.com</a>	Generic drugs (Level 1)	\$10 <u>copay</u> /30 day supply; <u>deductible</u> does not apply	Not covered	\$350/member <u>deductible</u> for Level 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 Level 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.
	Preferred brand drugs (Level 2)	\$60 <u>copay</u> /30 day supply	Not covered	
	Non-preferred brand drugs (Level 3)	30-day supply at retail or mail order: Higher of 40% <u>coinsurance</u> or \$100 minimum.	Not covered	
		90-day supply at retail: Higher of 40% <u>coinsurance</u> or \$300 minimum. 90-day supply at mail order: Higher of 40% <u>coinsurance</u> or \$200 minimum.		
<u>Specialty drugs</u>	50% <u>coinsurance</u> , <u>deductible</u> waived	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 \$1,000 access fee for all bariatric surgeries. <u>Deductible</u> waived for ambulatory surgery center facility fee.
	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)	Non-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>Urgent care</u>	\$60 <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 \$1,000 access fee for all bariatric surgeries.
	Physician/surgeon fee			
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 ( <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>Inpatient</u> Services	20% <u>coinsurance</u>		
If you are pregnant	Office visits	Office visit <u>cost share</u> , <u>deductible</u> does not apply	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)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u> /Home infusion therapy	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	\$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. <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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Abortion</li><li>• Acupuncture</li><li>• Adult routine vision exam</li><li>• Alternative medicine</li><li>• Care that is not <u>medically necessary</u></li><li>• Cosmetic surgery, cosmetic services &amp; supplies</li><li>• Custodial care</li><li>• Dental care and orthodontic services (Adult) except as stated in <u>plan</u></li><li>• <u>DME</u> rental/repair charges that exceed <u>DME</u> allowed amount</li><li>• Experimental and investigational treatments except as stated in <u>plan</u></li></ul>	<ul style="list-style-type: none"><li>• Eyewear except as stated in <u>plan</u></li><li>• Fertility and infertility medication and treatment</li><li>• Flat feet treatment and services</li><li>• Genetic and chromosomal testing except as stated in <u>plan</u></li><li>• <u>Long-term care</u>, except long-term acute care</li><li>• Massage therapy other than allowed under medical coverage guidelines</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Orthodontic services (Pediatric) that are not dentally necessary</li><li>• Private-duty nursing, except when <u>medically necessary</u> or when skilled nursing not available</li><li>• Respite care</li><li>• Routine foot care</li><li>• Services from <u>providers</u> outside the <u>network</u>, except in emergencies and other limited situations when use preauthorized</li><li>• Sexual dysfunction treatment and services</li><li>• Weight loss programs</li></ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Bariatric surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids, up to 1 per ear, per calendar year.</li></ul>

**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](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 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**

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](#) provide 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](#).

-----*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 \$2,000
- Specialist copayment \$60
- 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>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$120
<u>Coinsurance</u>	\$1,600
<i>What isn't covered</i>	
Limits or <u>exclusions</u>	\$60
<b>The total Peg would pay is</b>	<b>\$3,780</b>

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,000
- Specialist copayment \$60
- 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>\$7,400</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$360
<u>Copayments</u>	\$950
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>exclusions</u>	\$60
<b>The total Joe would pay is</b>	<b>\$1,370</b>

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

- The plan's overall deductible \$2,000
- Specialist copayment \$60
- 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>\$1,900</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,560
<u>Copayments</u>	\$120
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>exclusions</u>	\$0
<b>The total Mia would pay is</b>	<b>\$1,680</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 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](mailto: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>.