



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/GroupPlanDoc2018](http://azblue.com/GroupPlanDoc2018) 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:
What is the overall <u>deductible</u> ?	<u>In-network providers</u> : \$6,000/member and \$12,000/family <u>Out-of-network providers</u> : \$6,500/member and \$13,000/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> and 50% <u>out-of-network</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>In-network primary care</u> and <u>specialist office visits</u> ; <u>in-network preventive services</u> ; level 1 <u>prescription drugs</u> ; <u>emergency medical transportation</u> ; <u>in-network urgent care</u> visits; hospice services; <u>in-network child eye exams</u> ; 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 <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> .
Are there other <u>deductibles</u> for specific services?	Yes. \$650/member for Level 2 and 3 prescription medications.	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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>In-network providers</u> : \$7,350/member and \$14,700/family <u>Out-of-network providers</u> : \$14,700/member and \$29,400/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 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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>out-of-network precertification</u> penalty charges, <u>balance-bills</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 an <u>in-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> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge 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.
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
		In-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	<u>Primary care</u> visit to treat an injury or illness	\$40 <u>copay/provider/day</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Specialist copay</u> for most chiropractic services.  <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	\$85 <u>copay/provider/day</u> , <u>deductible</u> does not apply		
	<u>Preventive care/screening/immunization</u>	No charge, deductible waived		
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Office visit <u>copay</u> ( <u>deductible</u> does not apply) or 20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Cost share</u> varies based on place of service and <u>provider's network</u> status & type. <u>Precertification</u> required for some imaging services. \$500 charge, which does not apply to <u>out-of-pocket limit</u> , if no <u>precertification</u> obtained for some <u>out-of-network</u> services.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-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>	<u>Generic drugs</u> (Level 1)	\$40 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	\$40 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply	\$650/member <u>deductible</u> for Level 2 and 3 <u>prescription</u> drugs before <u>copays</u> or <u>coinsurance</u> apply. Mail order, <u>Specialty</u> , and 90-day retail supplies of <u>drugs</u> are not covered <u>out-of-network</u> . 90-day supply costs 3 <u>copays</u> (retail pharmacy) or 2 <u>copays</u> (mail order). If <u>generic</u> available, member pays level 1 <u>copay</u> + price difference for <u>brand drug</u> . Some <u>drugs</u> require <u>precertification</u> and won't be covered without it. Only <u>formulary</u> <u>drugs</u> are covered unless a <u>formulary</u> exception is approved.
	Preferred <u>brand drugs</u> (Level 2)	\$100 <u>copay</u> /30 day supply	\$100 <u>copay</u> /30 day supply & <u>balance bill</u> does not apply	
	Non-preferred <u>brand drugs</u> (Level 3)	\$200 <u>copay</u> /30 day supply	\$200 <u>copay</u> /30 day supply & <u>balance bill</u> does not apply	
	<u>Specialty drugs</u>	50% <u>coinsurance</u> , <u>deductible</u> does not apply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Precertification</u> required for some outpatient services. \$500 charge, which does not apply to <u>out-of-pocket limit</u> , if no <u>precertification</u> obtained for some <u>out-of-network</u> services. Additional \$1,000 access fee for all bariatric surgeries.
	Physician/surgeon fees			
<b>If you need immediate medical attention</b>	<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>	\$85 <u>copay</u> /provider/day, <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-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)	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Precertification</u> required for some scheduled services. \$500 charge, which does not apply to <u>out-of-pocket limit</u> , if no <u>precertification</u> for <u>out-of-network</u> stay. 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	Copay applies to office, home, walk-in clinic visits. Amount varies based on PCP/Specialist. 20% <u>coinsurance</u> applies to all other locations. <u>Deductible</u> does not apply to <u>copay</u> .	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Cost share</u> varies based on place of service and <u>provider's network</u> status & type.
	<u>Inpatient</u> Services	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Precertification</u> required. \$500 charge, which does not apply to <u>out-of-pocket limit</u> , if no <u>precertification</u> for <u>out-of-network</u> services.
If you are pregnant	Office visits	Physician: Office visit <u>copay</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	None.
	Childbirth/delivery professional services	20% <u>coinsurance</u>		
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	
If you need help recovering or have other special health needs	<u>Home health care</u> /Home infusion therapy	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Precertification</u> required. \$500 charge, which does not apply to <u>out-of-pocket limit</u> , if no <u>precertification</u> for <u>out-of-network</u> services. Limit of 42 visits (of up to 4 hours)/calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-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>Rehabilitation services</u> • EAR = Extended Active <u>Rehabilitation Facility</u> • SNF = <u>Skilled Nursing Facility</u>	20% <u>coinsurance</u>	50% <u>coinsurance &amp; balance bill</u>	<u>Precertification</u> required for inpatient facility admission. \$500 charge, which does not apply to <u>out-of-pocket limit</u> , if <u>precertification</u> not obtained for <u>out-of-network</u> admission. Annual limits: 90 <u>inpatient</u> days for <u>EAR</u> and <u>SNF</u> 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>	50% <u>coinsurance &amp; balance bill</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance &amp; balance bill</u>	
	<u>Durable medical equipment</u>	Office visit <u>copay</u> ( <u>deductible</u> does not apply) or 20% <u>coinsurance</u> .	50% <u>coinsurance &amp; balance bill</u>	<u>Cost share</u> varies based on place of service and <u>provider's network</u> status & type.
	<u>Hospice services</u>	No charge, <u>deductible</u> does not apply	No charge except <u>balance bill</u> , <u>deductible</u> does not apply	None.
If your child needs dental or eye care	Children's eye exam	\$40 <u>copay/visit</u> , <u>deductible</u> does not apply	50% <u>coinsurance &amp; balance bill</u>	Limit of 1 routine <u>vision</u> exam/calendar year. <u>Copay</u> waived for member under age 5.
	Children's glasses	No charge, <u>deductible</u> does not apply	50% <u>coinsurance &amp; balance bill</u> , <u>deductible</u> does not apply	Limit of 1 pair of glasses or contact lenses/calendar year.
	Children's dental check-up	No charge, <u>deductible</u> does not apply	No charge except <u>balance bill</u> , <u>deductible</u> does not apply	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
- 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 purchase price
- Experimental and investigational treatments except as stated in plan
- Eyewear except as stated in plan
- Flat feet treatment and services
- Genetic and chromosomal testing, except as stated in plan
- Habilitation outpatient services exceeding 60 visits per calendar year
- Home health care and infusion therapy exceeding 42 visits (of up to 4 hours) per calendar year
- Homeopathic services
- Infertility medication and treatment
- Inpatient EAR & SNF treatment exceeding 90 days per calendar year
- Long-term care, except long-term acute care
- Massage therapy other than allowed under medical coverage guidelines
- Naturopathic services
- Orthodontic services (Pediatric) that are not dentally necessary
- Out-of-network Mail Order, out-of-network Specialty, and out-of-network 90 day retail supplies of drugs
- Pediatric dental check-ups exceeding 2 check-ups and cleanings per calendar year
- Pediatric glasses or contact lenses exceeding 1 pair of glasses or contact lenses per calendar year
- Private-duty nursing, except when medically necessary or when skilled nursing not available
- Rehabilitation outpatient services exceeding 60 visits per calendar year
- Respite care
- Routine foot care
- Routine vision exam (child) exceeding 1 visit per calendar year
- 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
- Non-emergency care when travelling outside the U.S.

**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.

**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.

-----*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 \$6,000
- Specialist copayment \$85
- 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$6,000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or <u>exclusions</u>	\$60
<b>The total Peg would pay is</b>	<b>\$7,060</b>

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

- The plan's overall deductible \$6,000
- Specialist copayment \$85
- 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$360
<u>Copayments</u>	\$2,360
<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>\$2,780</b>

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

- The plan's overall deductible \$6,000
- Specialist copayment \$85
- 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,560
<u>Copayments</u>	\$160
<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>\$1,720</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 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>.