Coverage Period: On and after 01/01/18

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 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 or by calling 1-877-475-8440 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network providers: \$6,650/member and \$13,300/family Out-of-network providers: \$7,150/member and \$14,300/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 fee or other percent is shown, the <u>coinsurance</u> percent of the <u>allowed</u> <u>amount</u> that you pay for most services is 0% "no charge after deductible" <u>in-network</u> and 50% <u>out-of-network</u> .
Are there services covered before you meet your deductible?	Yes. Certain <u>in-network preventive</u> services 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 <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network providers: \$6,650/member and \$13,300/family Out-of-network providers: \$13,300/member and \$26,600/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>	Premiums, out-of-network precertification penalty charges, balance-bills, and costs for health care this plan 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 in-network provider?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network providers.	This <u>plan</u> uses a <u>provider 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 <u>provider's</u> 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 specialist you choose without a referral.



All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common Medical Event	Services You May Need	What Yo In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a boolth	Primary care visit to treat an injury or illness Specialist visit	No charge after deductible	50% <u>coinsurance</u> & <u>balance bill</u>	None.
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No charge, deductible does not apply.	50% <u>coinsurance</u> & <u>balance bill</u>	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)	No charge after	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Precertification</u> required for some imaging services. \$500 charge, which does not apply to
	Imaging (CT/PET scans, MRIs)	<u>deductible</u>		out-of-pocket limit, if no precertification obtained for some out-of-network services.

Common Medical Event	Services You May Need	What Yo In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
If you need drugs to treat your illness or condition	Prescription drugs (except specialty drugs)	No charge after deductible	50% <u>coinsurance</u> & <u>balance bill</u>	Mail order, <u>Specialty</u> , and 90-day retail supplies of drugs are not covered <u>out-of-network</u> . Some drugs require <u>precertification</u> and won't be	
More information about prescription drug coverage is available at www.azblue.com	Specialty drugs	No charge after deductible	Not covered	covered without it. Only <u>formulary</u> drugs are covered unless a <u>formulary</u> exception is approved.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No charge after	50% coinsurance &	Precertification required for some outpatient services. \$500 charge, which does not apply to	
surgery	Physician/surgeon fees	<u>deductible</u>	balance bill	out-of-pocket limit, if no precertification obtained for some out-of-network services. Additional \$1,000 access fee for all bariatric surgeries.	
If you need immediate	Emergency room care	No charge after	No charge after	None.	
medical attention	Emergency medical transportation	<u>deductible</u>	<u>deductible</u>	THORIC.	
	<u>Urgent care</u>	No charge after deductible	50% <u>coinsurance</u> & <u>balance bill</u>	None.	

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have a hospital	Facility fee (e.g., hospital room)	No charge after	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required for some scheduled services. \$500 charge, which does not apply to out-of-pocket limit, if no precertification for out-of-
stay	Physician/surgeon fee	<u>deductible</u>		network stay. Additional \$1,000 access fee for all bariatric surgeries.
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	No charge after	50% <u>coinsurance</u> & <u>balance bill</u>	None.
	Inpatient Services	deductible		<u>Precertification</u> required. \$500 charge, which does not apply to out-of-pocket limit, if no <u>precertification</u> for <u>out-of-network</u> services.
	Office visits	No charge after deductible	50% <u>coinsurance</u> & <u>balance bill</u>	
If you are pregnant	Childbirth/delivery professional services			None.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	No charge after deductible	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required. \$500 charge, which does not apply to out-of-pocket limit, if no precertification for out-of-network services. Limit of 42 visits (of up to 4 hours)/calendar year.

		What Yo	u Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	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	Rehabilitation services • EAR = Extended Active Rehabilitation Facility • SNF = Skilled Nursing Facility Habilitation services Skilled nursing care	No charge after deductible	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required for inpatient facility admission. \$500 charge, which does not apply to out-of-pocket limit, if precertification not obtained for out-of-network admission and some out-of-network services. Annual limits: 90 inpatient days for EAR and SNF combined, and a 60-visit limit each for outpatient rehabilitative and habilitative services.
	Durable medical equipment	No charge after deductible	50% <u>coinsurance</u> & <u>balance bill</u>	None.
	Hospice services	No charge after deductible	50% <u>coinsurance</u> & <u>balance bill</u>	None.
If your child needs dental or eye care	Children's eye exam	No charge after deductible	50% <u>coinsurance</u> & <u>balance bill</u>	Limit of 1 routine vision exam/calendar year. Innetwork cost share waived for member under age 5.
	Children's glasses	No charge after deductible	50% <u>coinsurance</u> & <u>balance bill</u>	Limit of 1 pair of glasses or contact lenses/calendar year.
	Children's dental check-up	No charge after deductible	No charge after deductible except balance bill	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 <u>medically necessary</u>
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care and orthodontic services (Adult) except as stated in <u>plan</u>
- <u>DME</u> rental/repair charges that exceed <u>DME</u> purchase price
- Experimental and investigational treatments except as stated in <u>plan</u>
- Eyewear except as stated in <u>plan</u>
- Flat feet treatment and services
- Genetic and chromosomal testing, except as stated in <u>plan</u>
- <u>Habilitation</u> 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
- <u>Inpatient</u> 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
- <u>Out-of-network</u> Mail Order, out-of-network <u>Specialty</u>, and out-of-network 90 day retail supplies of drugs
- Pediatric dental check-ups exceeding 2 checkups 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 <u>medically</u> <u>necessary</u> or when <u>skilled nursing</u> not available
- <u>Rehabilitation</u> outpatient services exceeding 60 visits per calendar year
- Respite care
- Routine foot care
- Routine <u>vision</u> exam (child) exceeding 1 vision exam 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.
- 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.
- 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 <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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. 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

-----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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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>	\$6,650
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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>	\$6,650	
Copayments	\$0	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or <u>exclusions</u>	\$60	
The total Peg would pay is	\$6,710	

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

■ The plan's overall deductible	\$6,650
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

<u>Diagnostic tests</u> (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$7,400

In this example, Joe would pay:

Cost Sharing			
<u>Deductibles</u>	\$6,650		
<u>Copayments</u>	\$0		
<u>Coinsurance</u>	\$0		
What isn't covered			
Limits or <u>exclusions</u>	\$60		
The total Joe would pay is	\$6,710		

Mia's Simple Fracture

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

■ The plan's overall deductible	\$6,650
■ Specialist coinsuance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches) Rehabilitation services (physical therapy)

Total Example Cost \$1,900

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or <u>exclusions</u>	\$0
The total Mia would pay is	\$1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínígóó. Ata' halne'ígíí kojí' bich'i' hodíilnih 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 877-475-479.

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 로전화하십시오.

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 .877-479 تماس حاصل نمایید .

Assyrian:

ي، نِسمة،، نِا سَةِ فِخَوِهِهُ دِهِبَودَهِهِ عَمَاءَ، يَهِكُمَمَةَ، فَوَدَهِهِ حَمَاءَ، يَهِمَاهُ عَلَيْهِ فَع كَهُمَوهِ هِ نَظِيرَ فَعَلَيْهِ فَعَامِهُ فَعَامُهُ عَمَاهُ Blue Cross Blue Shield of Arizona بُسمة، يَهِمَاهُ فِقَعَمَاهُ فَعَامُهُ وَمِنْهُ وَمِنْهُ عَلَيْهُ وَمِعَامُهُ وَمِعَامُهُ عَلَيْهُ وَمِعَامُهُ عَلَيْهُ وَمِعَامُهُ عَلَيْهُ وَمُعَامِعُهُ وَمِعَامُهُ عَلَيْهُ وَمِعَامُهُ عَلَيْهُ وَعَلَيْهُ وَمِعَامُهُ عَلَيْهُ وَمُعَامِعُ مِعْمُ وَمُعَامِعُ عَلَيْهُ وَمِعَامُهُ وَمِعْمُ وَمُعَامِعُ وَمُعَامِعُ وَمُعَامِعُ مُعَامُ وَمُعَامِعُ وَمُعَامِعُ وَمُعَامِعُ وَمُعَامِعُ وَمُعَامِعُ وَمُعَامِعُ وَمُعَامِعُ وَمُعَامِعُ وَمُعَامُ و

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 หรือคนที่คุณกาลังช่วยเหลือมีค่าถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมลในภาษาของคณได้โดยไม่มีค่าใช้จ่าย พดคยกับล่าม โทร 877-475-4799 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, croeqazblue.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 https://www.hhs.gov/ocr/office/file/index.html.

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