




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 contact www.benefitoptions.az.gov or call 1-800-304-3687 or 602 542-5008 to request a copy. 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.benefitoptions.az.gov or call 1-800-304-3687 or 602 542-5008 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-network: Tier 1 \$200 employee / \$400 family; Tier 2 \$1,000 employee / \$2,000 family. Out-of-network: Tier 3 \$5,000 employee / \$10,000 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> . Tier 1 <u>deductible</u> applies to Tier 2. Tier 2 <u>deductible</u> applies to Tier 1.
Are there services covered before you meet your <u>deductible</u> ?	Yes, In-network <u>Preventive care</u> services and <u>prescription drug coverage</u> 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> and <u>prescription drug coverage</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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Yes. In-network: \$7,350 employee / \$14,700 family Out-of-network: \$8,700 employee / \$17,400 family	The <u>out-of-pocket limit</u> is the most you could pay in a year of 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>balance-billing</u> charges, and 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.benefitoptions.az.gov or call 1-602-542-5008 or 1-800-304-3687 for a list of network providers .	This plan uses a provider network . You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. You will pay the most if you use a Tier 3 out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

 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	\$20 copay	50% coinsurance & balance billing may apply	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. Preventive care/screening limited to one visit per member per Plan Year. Age and frequency limits may apply. See your plan document for more information on limitations.
	Specialist visit	\$40 copay \$20 copay for OB/GYN	50% coinsurance & balance billing may apply	
	Preventive care/screening /immunization	No Charge	50% coinsurance & balance billing may apply	
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copay	50% coinsurance & balance billing may apply	None
	Imaging (CT/PET scans, MRIs)	\$100 copay	50% coinsurance & balance billing may apply	Some testing may require pre-certification . See your plan document for more information on pre-certification limitations.

If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.benefitoptions.az.gov	Generic drugs	\$15 copay /prescription (retail) \$30 copay /prescription (mail order) \$37.50 copay /prescription (Choice90)	Not Covered	Deductible does not apply. Covers up to a 30-day supply for retail; up to a 90-day supply for mail order; up to a 90-day supply for Choice90. Prescription medication with over-the-counter equivalents is not covered. Dispense as Written rules associated with how the plan will pay for a name-brand prescriptions may apply. Specialty drugs limited to a 30-day supply. See your plan document for more information on Specialty Pharmacy.
	Preferred brand drugs	\$40 copay /prescription (retail) \$80 copay /prescription (mail order) \$100 copay /prescription (Choice90)	Not Covered	
	Non-preferred brand drugs	\$60 copay /prescription (retail) \$120 copay /prescription (mail order) \$150 copay /prescription (Choice90)	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)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 copay	50% co-insurance & balance billing may apply	In-network office surgery is \$100 copay. Bariatric Surgery 20% coinsurance covered in-network only. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	\$100 copay	50% coinsurance & balance billing may apply	
If you need immediate medical attention	Emergency room care	\$200 copay	\$200 copay	Must be a Medical Emergency as defined by your plan . Copayment waived if admitted to hospital directly from the emergency room but subject to hospital admission copayment . Out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge.

	Emergency medical transportation	No Charge	No charge	Non-medical emergency transportation requires pre-certification .
	Urgent care	\$75 copay	50% coinsurance & balance billing may apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay	50% coinsurance & balance billing may apply	Bariatric Surgery 20% coinsurance covered in-network only. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	No Charge	50% coinsurance & balance billing may apply	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	\$20 copay	50% coinsurance & balance billing may apply	See your plan document for more information on limitations and excluded services.
	Mental/Behavioral health inpatient services	\$250 copay	50% coinsurance & balance billing may apply	See your plan document for more information on pre-certification limitations and excluded services.
	Substance use disorder outpatient services	\$20 copay	50% coinsurance & balance billing may apply	See your plan document for more information on limitations and excluded services.
	Substance use disorder inpatient services	\$250 copay	50% coinsurance & balance billing may apply	See your plan document for more information on pre-certification limitations and excluded services.
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 are pregnant	Office visits	\$20 copay for OB/GYN	50% coinsurance & balance billing may apply	None
	Childbirth/delivery professional services	No Charge	50% coinsurance & balance billing may apply	None
	Childbirth/delivery facility services	No Charge	50% coinsurance & balance billing may apply	None

If you need help recovering or have other special health needs	Home health care	No Charge	50% coinsurance & balance billing may apply	Coverage is limited to 42 visits per member per <u>plan</u> year.
	Rehabilitation services	\$40 copay	50% coinsurance & balance billing may apply	Coverage is limited to 60 visits per member per <u>plan</u> year.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	\$0 copay	50% coinsurance & balance billing may apply	Coverage is limited to 90 days per member per <u>plan</u> year.
	Durable medical equipment	\$0 copay	50% coinsurance & balance billing may apply	See your <u>plan</u> document for more information on pre-certification limitations and excluded services.
	Hospice services	\$0 copay	50% coinsurance & balance billing may apply	See your <u>plan</u> document for more information on limitations and excluded services.
If your child needs dental or eye care	Children's eye exam	\$0 copay	50% coinsurance & balance billing may apply	Screenings covered as part of well-child health examination.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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
- Cosmetic surgery
- Dental care (Adult. Except for the treatment of an accidental injury to sound natural teeth where the continued course of treatment is started within six months of the accident.)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Except for inpatient hospital setting)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery (see [plan](#) document for information on limitations and exclusions)
- Chiropractic care (limited to 20 visits per member, per [Plan](#) Year)
- Hearing aids (limited to one per ear, per [Plan](#) year)
- Long-term care (Acute)
- Routine eye care (Adult, if part of a routine health examination)
- Routine foot care (if medically necessary)
- Weight loss programs (see Wellness Program for more information)

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: Benefit Options at 1-602-548-5008 or 1-800-304-3687 or www.benefitoptions.az.gov. 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 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 1-866-287-1980 or www.azblue.com; UnitedHealthcare at 1-800-896-1067 or www.myuhc.com; MedImpact at 1-888-648-6769 or www.medimpact.com or Benefit Options at 1-602-548-5008 or 1-800-304-3687 or www.benefitoptions.az.gov.

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? 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](#).

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-542-5008 o al 1-800-304-3687.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-602-542-5008 or 1-800-304-3687.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-602-542-5008 or 1-800-304-3687.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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	\$200
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ Other copayment	\$300

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$560

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$80
■ Hospital (facility) copayment	\$0
■ Other copayment	\$520

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$820

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$100
■ Hospital (facility) copayment	\$200
■ Other copayment	\$200

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$700

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Benefit Options Wellness at 1-602-771-9355 or www.wellness.az.gov.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services

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