



**⚠ 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/benefit2027](http://azblue.com/benefit2027). 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-877-475-8440 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                                                                                                                                                                                                          | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
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| <b>What is the overall deductible?</b>                             | <b>\$8,000/individual or \$16,000/family</b> per calendar year                                                                                                                                                                                                                                                                                                                   | 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 30% <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, tier 1 <u>prescription</u> drugs, <u>specialty</u> drugs, <u>emergency</u> medical transportation, <u>urgent care</u> visits, <u>hospice services</u> , children's eye exams, 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 annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.<br><br>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> .                                              |
| <b>Are there other deductibles for specific services?</b>          | Yes. \$750/member for Tier 2 and 3 <u>prescription</u> medications.                                                                                                                                                                                                                                                                                                              | You must pay off 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>              | <b>\$9,950/individual or \$19,900/family</b> per calendar year                                                                                                                                                                                                                                                                                                                   | 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.                                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the out-of-pocket limit?</b>            | Premiums and costs for health care this plan doesn't cover.                                                                                                                                                                                                                                                                                                                      | Even though you pay these expenses, they don't count toward the out-of-pocket limit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| Important Questions                                              | Answers                                                                                                                        | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| <b>Will you pay less if you use a <u>network provider</u>?</b>   | 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> does not cover services by <u>out-of-network providers</u> except in very limited circumstances. 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 <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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | 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                                                                                                                                                                                                                                 |
|----------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                      |                                                         | Network Provider<br>(You will pay the least)                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                        |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | <u>Primary care</u> visit to treat an injury or illness | \$55 <u>copay/provider/day</u> , <u>deductible</u> does not apply                       | Not covered                                        | No charge for medical telehealth consultations through Telehealth from AZ Blue.                                                                                                                                                                                                        |
|                                                                      | <u>Specialist</u> visit                                 | \$125 <u>copay/provider/day</u> , <u>deductible</u> does not apply                      | Not covered                                        | <u>Specialist copay</u> for most chiropractic services. Limit of 20 chiropractic visits per member/ calendar year.                                                                                                                                                                     |
|                                                                      | <u>Preventive care/screening/immunization</u>           | No charge                                                                               | Not covered                                        | <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. |
| <b>If you have a test</b>                                            | <u>Diagnostic test</u> (x-ray, blood work)              | Office visit <u>copay</u> ( <u>deductible</u> does not apply) or 30% <u>coinsurance</u> | Not covered                                        | <u>Cost share</u> varies based on place of service and <u>provider's network</u> status & type.                                                                                                                                                                                        |
|                                                                      | Imaging (CT/PET scans, MRIs)                            | Office visit <u>copay</u> ( <u>deductible</u> does not apply) or 30% <u>coinsurance</u> | Not covered                                        | <u>Cost share</u> varies based on place of service and <u>provider's network</u> status & type.                                                                                                                                                                                        |

| Common Medical Event                                                                                                                                                                              | Services You May Need                          | What You Will Pay                                                                                                                                         |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                   |                                                | Network Provider<br>(You will pay the least)                                                                                                              | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.azblue.com">www.azblue.com</a> | Tier 1a / 1b                                   | Tier 1a: \$3 <u>copay</u> /30 day supply, <u>deductible</u> does not apply<br>Tier 1b: \$35 <u>copay</u> /30 day supply, <u>deductible</u> does not apply | Not covered                                        | 90-day supply is 2.5 <u>copays</u> for retail and mail order. Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it. View the Tier 1a Drug List at <a href="https://azblue.com/pharmacy-management/Tier1a-Drug-List">https://azblue.com/pharmacy-management/Tier1a-Drug-List</a>                                                                                                                                 |
|                                                                                                                                                                                                   | Tier 2                                         | \$115 <u>copay</u> /30 day supply                                                                                                                         | Not covered                                        | \$750/member <u>deductible</u> for Tier 2 and 3 <u>prescription</u> drugs before <u>copays</u> or <u>coinsurance</u> apply. 90-day supply is 2.5 <u>copays</u> for retail and mail order. If a generic drug is available, pay the generic <u>cost share</u> + the price difference between the <u>allowed amount</u> for the brand and generic drugs. Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it.     |
|                                                                                                                                                                                                   | Tier 3                                         | \$205 <u>copay</u> /30 day supply                                                                                                                         | Not covered                                        | \$750/member <u>deductible</u> for Tier 2 and 3 <u>prescription</u> drugs before <u>copays</u> or <u>coinsurance</u> apply. 90-day supply is for 2.5 <u>copays</u> for retail and mail order. If a generic drug is available, pay the generic <u>cost share</u> + the price difference between the <u>allowed amount</u> for the brand and generic drugs. Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it. |
|                                                                                                                                                                                                   | <u>Specialty drugs</u>                         | 50% <u>coinsurance</u> , <u>deductible</u> does not apply                                                                                                 | Not covered                                        | Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it.                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you have outpatient surgery</b>                                                                                                                                                             | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u>                                                                                                                                    | Not covered                                        | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                   | Physician/surgeon fees                         | 30% <u>coinsurance</u>                                                                                                                                    | Not covered                                        | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                                                                                              |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Network Provider<br>(You will pay the least)                                                                                                                                                   | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                   |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | 30% <u>coinsurance</u>                                                                                                                                                                         |                                                    | None.                                                                                                                                                                                                                                                                             |
|                                                                           | <u>Emergency medical transportation</u>   | 30% <u>coinsurance</u> , <u>deductible</u> does not apply                                                                                                                                      |                                                    | None.                                                                                                                                                                                                                                                                             |
|                                                                           | <u>Urgent care</u>                        | \$125 <u>copay/provider/day</u> , <u>deductible</u> does not apply                                                                                                                             | Not covered                                        | Copay applies only to providers specifically contracted for urgent care.                                                                                                                                                                                                          |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 30% <u>coinsurance</u>                                                                                                                                                                         | Not covered                                        | None.                                                                                                                                                                                                                                                                             |
|                                                                           | Physician/surgeon fees                    | 30% <u>coinsurance</u>                                                                                                                                                                         | Not covered                                        | None.                                                                                                                                                                                                                                                                             |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | <u>Copay</u> applies to office, home, walk-in clinic visits ( <u>deductible</u> does not apply). Amount varies based on PCP/Specialist. 30% <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> .<br>\$20 <u>copay</u> for counseling or \$45 <u>copay</u> for psychiatric telehealth consultations through Telehealth from AZ Blue.                                                               |
|                                                                           | Inpatient services                        | 30% <u>coinsurance</u>                                                                                                                                                                         | Not covered                                        | None.                                                                                                                                                                                                                                                                             |
| If you are pregnant                                                       | Office Visits                             | Office visit <u>copay</u> ( <u>deductible</u> does not apply) or 30% <u>coinsurance</u>                                                                                                        | Not covered                                        | 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 | 30% <u>coinsurance</u>                                                                                                                                                                         | Not covered                                        | Depending on type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.                                                                                                                                                                            |
|                                                                           | Childbirth/delivery facility services     | 30% <u>coinsurance</u>                                                                                                                                                                         | Not covered                                        | Depending on type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.                                                                                                                                                                            |

| Common Medical Event                                                  | Services You May Need                                                                                 | What You Will Pay                                                                       |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                           |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                                                                                       | Network Provider<br>(You will pay the least)                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                  |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u> /Home infusion therapy                                                        | 30% <u>coinsurance</u>                                                                  | Not covered                                        | Limit of 42 visits (of up to 4 hours)/calendar year.                                                                                                                                                                             |
|                                                                       | <u>Rehabilitation services</u><br>• PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy | 30% <u>coinsurance</u>                                                                  | Not covered                                        | Annual limits: 90 inpatient days for Extended Active Rehabilitation Facility (EAR) and Skilled Nursing Facility (SNF) combined, and a 60-visit limit each for outpatient <u>rehabilitative</u> and <u>habilitative</u> services. |
|                                                                       | <u>Habilitation services</u>                                                                          | 30% <u>coinsurance</u>                                                                  | Not covered                                        | Annual limits: 90 inpatient days for EAR and SNF combined, and a 60-visit limit each for outpatient <u>rehabilitative</u> and <u>habilitative</u> services.                                                                      |
|                                                                       | <u>Skilled nursing care</u>                                                                           | 30% <u>coinsurance</u>                                                                  | Not covered                                        | Annual limits: 90 inpatient days for EAR and SNF combined, and a 60-visit limit each for outpatient <u>rehabilitative</u> and <u>habilitative</u> services.                                                                      |
|                                                                       | <u>Durable medical equipment</u>                                                                      | Office visit <u>copay</u> ( <u>deductible</u> does not apply) or 30% <u>coinsurance</u> | Not covered                                        | <u>Cost share</u> varies based on place of service and type of <u>provider</u> .                                                                                                                                                 |
|                                                                       | <u>Hospice services</u>                                                                               | No charge                                                                               | Not covered                                        | None.                                                                                                                                                                                                                            |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                                                                                   | No charge                                                                               | Not covered                                        | Limit of 1 routine vision exam/calendar year.                                                                                                                                                                                    |
|                                                                       | Children's glasses                                                                                    | No charge                                                                               | Not covered                                        | Limit of 1 pair of glasses or contact lenses/calendar year.                                                                                                                                                                      |
|                                                                       | 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.)

- 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
- Home health care and infusion therapy exceeding 42 visits (of up to 4 hours)/calendar year
- Long-term care, except long-term acute care
- Massage therapy other than allowed under evidence-based criteria
- 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 care
- 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:

- 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 or <https://difi.az.gov/consumer/i/health>.

**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.

## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English:** Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-475-4799.

**Spanish:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 602-864-4884.

**Navajo:** Diné bee yániit'i'gogo, saad bee aná'awo' bee áka'anída'awo'it'áá jiik'eh ná hóló. Bee ahít hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjí' 1-877-475-4799.

**Chinese Simplified:** 如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-475-4799。

**Chinese Traditional:** 如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-877-475-4799。

**Tagalog:** Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-475-4799.

**French:** Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-475-4799.

**Vietnamese:** Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-475-4799.

**German:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-475-4799.

**Korean:** 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-475-4799.

**Russian:** Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-475-4799.

### Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-475-4799.

**Hindi:** यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-475-4799 ।

### Farsi (Persian)

با شماره همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترسی، به‌طور رایگان موجود می‌باشند. صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. فارسی اگر توجه: 1-877-475-4799.

**Thai:** หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-475-4799.

**Japanese:** 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-475-4799。

*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 <u>plan's</u> overall <u>deductible</u> | \$8,000 |
| ■ <u>Specialist copayment</u>                 | \$125   |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles*</u>               | \$8,000        |
| <u>Copayments</u>                 | \$140          |
| <u>Coinsurance</u>                | \$590          |
| What isn't covered                |                |
| Limits or exclusions              | \$50           |
| <b>The total Peg would pay is</b> | <b>\$8,780</b> |

### 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> | \$8,000 |
| ■ <u>Specialist copayment</u>                 | \$125   |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

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>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles*</u>               | \$330          |
| <u>Copayments</u>                 | \$1,600        |
| <u>Coinsurance</u>                | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,950</b> |

### Mia's Simple Fracture

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$8,000 |
| ■ <u>Specialist copayment</u>                 | \$125   |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

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>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles*</u>               | \$1,350        |
| <u>Copayments</u>                 | \$210          |
| <u>Coinsurance</u>                | \$280          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,840</b> |

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" on Page 1.

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

## Discrimination is Against the Law

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  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

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Section 1557 Coordinator  
P.O. Box 13466  
Phoenix, AZ 85002-3466  
Call 602-864-2288; TTY 711  
or email us at [crc@azblue.com](mailto:crc@azblue.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **AZ Blue Section 1557 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, D.C. 20201  
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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