



⚠ 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/benefit2027g. 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/ or call 1-877-475-8440 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>In-network</u> and <u>out-of-network</u> combined: \$250 /individual or \$500 /family 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 10% <u>in-network</u> and 30% <u>out-of-network</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>In-network</u> : <u>primary care</u> and <u>specialist</u> visits, <u>urgent care</u> visits, mental health outpatient services, and routine eye exams are covered before you meet your <u>deductible</u> . <u>In-network</u> and <u>out-of-network</u> : <u>prescription drugs</u> , <u>emergency medical transportation</u> , and <u>hospice services</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> without <u>cost-sharing</u> and before you meet your <u>deductible</u> .
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>?	<u>In-network</u> : \$2,000 /individual or \$4,000 /family per calendar year <u>Out-of-network</u> : \$4,000 /individual or \$8,000 /family 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.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>deductibles</u> , <u>copays</u> , access fees, <u>out-of-network prior authorization</u> charges, <u>balance bills</u> , costs for health care this <u>plan</u> doesn't cover, and certain other charges listed in the benefit book.	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 a <u>network provider</u> ?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . 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 <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 (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	\$15 <u>copay</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u> & <u>balance bill</u>	<u>Copay</u> for <u>in-network</u> routine vision exam is \$15. <u>Specialist</u> cost sharing for most chiropractic services. Radiologist, pathologist, and dermapathologist always subject to <u>deductible</u> and <u>coinsurance</u> regardless of place of service. No charge for medical telehealth consultations through Telehealth from AZ Blue. Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	<u>Specialist</u> visit	\$25 <u>copay</u> , <u>deductible</u> does not apply		
	<u>Preventive care/screening/immunization</u>	Office visit <u>copay</u> (<u>deductible</u> does not apply) or 10% <u>coinsurance</u>	30% <u>coinsurance</u> & <u>balance bill</u>	<u>Cost share</u> varies based on place of service and <u>provider's network</u> status and type. <u>Deductible</u> waived for <u>out-of-network</u> mammography. Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
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 10% <u>coinsurance</u> .	30% <u>coinsurance</u> & <u>balance bill</u> may apply	<u>Cost share</u> varies based on place of service and <u>provider's network</u> status and type. Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	Imaging (CT/PET scans, MRIs)	No charge at <u>in-network</u> clinical laboratory.		

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.azblue.com	Tier 1	Copays (<u>deductible</u> does not apply): Retail: \$10 Mail Order: \$25	Copays (<u>deductible</u> does not apply): Retail: \$10 <u>copay</u> & <u>balance bill</u>	Some drugs require <u>prior authorization</u> and won't be covered without it. <u>Copay</u> covers up to 30-day supply (retail). 90-day supply is 2.5 <u>copays</u> for retail and mail order. Mail order not covered <u>out-of-network</u> .
	Tier 2	Copays (<u>deductible</u> does not apply): Retail: \$25 Mail Order: \$62.50	Copays (<u>deductible</u> does not apply): Retail: \$25 <u>copay</u> & <u>balance bill</u>	
	Tier 3	Copays (<u>deductible</u> does not apply): Retail: \$50 Mail Order: \$125	Copays (<u>deductible</u> does not apply): Retail: \$50 <u>copay</u> & <u>balance bill</u>	
	Tier 4	Copays (<u>deductible</u> does not apply): Retail: \$80 Mail Order: \$200	Copays (<u>deductible</u> does not apply): Retail: \$80 <u>copay</u> & <u>balance bill</u>	
	<u>Specialty drugs</u>	Copays (<u>deductible</u> does not apply): Tier A: \$30 Tier B: \$60 Tier C: \$90 Tier D: \$120	Not covered	Specialty <u>copay</u> covers up to a 30-day supply. Some drugs require <u>prior authorization</u> and won't be covered without it.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	Physician/surgeon fees		30% <u>coinsurance</u> & <u>balance bill</u> may apply	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 access fee/member/facility/day, then 10% <u>coinsurance</u>		Access fee waived if you are admitted as an inpatient to the hospital. <u>Out-of-network providers</u> can't <u>balance bill</u> for the difference between the <u>allowed amount</u> and the billed charge.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> , <u>deductible</u> does not apply		None.
	<u>Urgent care</u>	\$25 <u>copay</u> /provider/day, <u>deductible</u> does not apply	30% <u>coinsurance</u> & <u>balance bill</u>	Copay applies only to providers specifically contracted for urgent care.

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 a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u> & <u>balance bill</u> may apply	
	Long-term acute care (LTAC)	10% <u>coinsurance</u> except 50% <u>coinsurance</u> after 365 days of LTAC	30% <u>coinsurance</u> except 50% <u>coinsurance</u> after 365 days LTAC, plus <u>balance bill</u> for all days of LTAC	Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> for office or home visits (<u>deductible</u> does not apply). <u>Cost share</u> waived for all other locations.	30% <u>coinsurance</u> & <u>balance bill</u> may apply	<u>Cost share</u> varies based on place of service and provider's <u>network</u> status and type. \$15 <u>copay</u> for counseling or psychiatric telehealth consultations through Telehealth from AZ Blue. Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	Inpatient services	10% <u>coinsurance</u>		<u>Cost share</u> waived for professional services. Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
If you are pregnant	Office Visits	Office visit <u>copay</u> (<u>deductible</u> does not apply), or 10% <u>coinsurance</u>	30% <u>coinsurance</u> & <u>balance bill</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u> & <u>balance bill</u> may apply	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u> & <u>balance bill</u>	

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 need help recovering or have other special health needs	<u>Home health care</u> /Home infusion therapy	10% <u>coinsurance</u>	30% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	<u>Rehabilitation services</u> • EAR = Extended Active Rehabilitation Facility • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy	10% <u>coinsurance</u> except 50% <u>coinsurance</u> after 60 days per calendar year of EAR care	30% <u>coinsurance</u> except 50% <u>coinsurance</u> after 60 days per calendar year of EAR, plus <u>balance bill</u> for all days of EAR care	Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. *Limited coverage available for <u>habilitation services</u> to treat autism spectrum disorder for groups of 51 or more eligible employees.
	<u>Habilitation services</u>	Not covered*	Not covered*	
	<u>Skilled nursing care</u> in skilled nursing facility (SNF)	10% <u>coinsurance</u> except 50% <u>coinsurance</u> after 90 days per calendar year of SNF care	30% <u>coinsurance</u> except 50% <u>coinsurance</u> after 90 days per calendar year of SNF, plus <u>balance bill</u> for all days of SNF care	Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	<u>Durable medical equipment</u>	Office visit <u>copay</u> (<u>deductible</u> does not apply) or 10% <u>coinsurance</u>	30% <u>coinsurance</u> & <u>balance bill</u>	<u>Cost share</u> varies based on place of service and provider's <u>network</u> status & type. Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	<u>Hospice services</u>	No charge	No charge except <u>balance bill</u>	Claim may be denied or \$300 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u> & <u>balance bill</u>	None.
	Children's glasses	Not covered	Not covered	Excluded.
	Children's dental check-up	Not covered	Not covered	Excluded.

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 | • Eyewear except as stated in <u>plan</u> | • Naturopathic services |
| • Autism spectrum disorders (not covered for groups of 2-50 eligible employees, but covered for other groups) | • Fertility and infertility medication and treatment | • <u>Out-of-network</u> mail order prescriptions and <u>specialty</u> self-injectable medications |
| • Care that is not <u>medically necessary</u> | • Flat feet treatment and services | • Private-duty nursing |
| • Cosmetic surgery, cosmetic services & supplies | • Genetic and chromosomal testing, except as stated in <u>plan</u> | • Respite care, except as stated in <u>plan</u> |
| • Custodial care | • <u>Habilitation services</u> , except certain autism services for groups of 51 or more eligible employee | • Routine eye care, except routine vision exams |
| • Dental care except as stated in <u>plan</u> | • Hearing aids | • Routine foot care |
| • <u>DME</u> rental/repair charges that exceed <u>DME</u> purchase price | • Homeopathic services | • Sexual dysfunction treatment and services |
| • Experimental and investigational treatments except as stated in <u>plan</u> | • <u>Long-term care</u> , except long-term acute care | • Smoking cessation programs and medications |
| | • Massage therapy other than allowed under evidence-based criteria | • Weight loss programs and medications |

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

- | | | |
|---------------------|---------------------|--|
| • Bariatric surgery | • Chiropractic care | • Non-emergency care when traveling 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:

- 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>.
- Healthcare.gov at www.HealthCare.gov or call 1-800-318-2596
- Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

For more information on your rights to continue coverage, contact the insurer at 1-877-475-8440. You may also contact your state insurance department at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Blue Cross Blue Shield of Arizona at 1-877-475-8440.
- You may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.

Does this plan provide Minimum Essential Coverage? Yes

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.

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 yánílti'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'í'ígíí éí t'áá jiik'eh hóló. Kohjì' 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 serbisyon tulon 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، فستتوفر 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 دسترس، بهطور رایگان موجود میباشند. صحبت می کنید، 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>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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>	\$250
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$970
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$1,320

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>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$640
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$710

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$210
<u>Coinsurance</u>	\$280
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$740

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

Discrimination is Against the Law

Blue Cross® Blue Shield® of Arizona (AZ Blue) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). **AZ Blue** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

AZ Blue:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - 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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 **AZ Blue** 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:

Section 1557 Coordinator
P.O. Box 13466
Phoenix, AZ 85002-3466
Call 602-864-2288; TTY 711
or email us at 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>.

This notice is available at AZ Blue's website: azblue.com/nondiscrimination-notice.

LE50140 01/27

C09089-0127