




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 deductible ? | In-network \$1,500 employee / \$3,000 family Out-of-network \$5,000 employee / \$10,000 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible ? | Yes, In-network Preventive care services are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | Yes. In-network \$3,500 employee / \$7,000 family Out-of-network \$8,700 employee / \$17,400 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out-of-pocket limit must be met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| 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 participating providers. | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an 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 | 10% coinsurance | 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 | 10% coinsurance | 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) | 10% coinsurance | 50% coinsurance & balance billing may apply | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 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 | Non-preventive prescription drug: 100% before deductible is met. 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. |
| | Preferred brand drugs | \$40 copay /prescription-retail \$80 copay /prescription-mail order \$100 copay /prescription-Choice90 | Not Covered | 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 prescription may apply. Specialty drugs limited to a 30-day supply. |
| | Non-preferred brand drugs | \$60 copay /prescription-retail \$120 copay /prescription-mail order \$150 copay /prescription-Choice90 | Not Covered | See your plan document for more information on Specialty Pharmacy. |

[* For more information about limitations and exceptions, see the plan or policy document at www.benefitoptions.az.gov .]

| 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) | 10% coinsurance | 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 | 10% coinsurance | 50% coinsurance & balance billing may apply | |
| If you need immediate medical attention | Emergency room care | 10% coinsurance | 10% coinsurance & balance billing may apply | Must be a Medical Emergency as defined by your plan. Out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance & balance billing may apply | Non-medical emergency transportation requires pre-certification . |
| | Urgent care | 10% coinsurance | 50% coinsurance & balance billing may apply | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 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 | 10% coinsurance | 50% coinsurance & balance billing may apply | |
| If you need mental health, behavioral health, or substance abuse services | Mental/Behavioral health outpatient services | 10% coinsurance | 50% coinsurance & balance billing may apply | See your plan document for more information on limitations and excluded services. |
| | Mental/Behavioral health inpatient services | 10% coinsurance | 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 | 10% coinsurance | 50% coinsurance & balance billing may apply | See your plan document for more information on limitations and excluded services. |
| | Substance use disorder inpatient services | 10% coinsurance | 50% coinsurance & balance billing may apply | See your plan document for more information on pre-certification limitations and excluded services. |
| If you are pregnant | Office visits | 10% coinsurance | 50% coinsurance & balance billing may apply | See your plan document for more information. |
| | Childbirth/delivery professional services | 10% coinsurance | 50% coinsurance & balance billing may apply | See your plan document for more information. |
| | Childbirth/delivery facility services | 10% coinsurance | 50% coinsurance & balance billing may apply | See your plan document for more information. |

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| 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 | Home health care | 10% coinsurance | 50% coinsurance & balance billing may apply | Coverage is limited to 42 visits per member per plan year. |
| | Rehabilitation services | 10% coinsurance | 50% coinsurance & balance billing may apply | Coverage is limited to 60 visits per member per plan year. |
| | Habilitation services | Not Covered | Not Covered | None |
| | Skilled nursing care | 10% coinsurance | 50% coinsurance & balance billing may apply | Coverage is limited to 90 days per member per plan year. |
| | Durable medical equipment | 10% coinsurance | 50% coinsurance & balance billing may apply | See your plan document for more information on pre-certification limitations and excluded services. |
| | Hospice services | 10% coinsurance | 50% coinsurance & balance billing may apply | See your plan document for more information on limitations and excluded services. |
| If your child needs dental or eye care | Children's eye exam | 10% coinsurance | 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 .) | | |
|---|---|--|
| <ul style="list-style-type: none"> Acupuncture Cosmetic surgery | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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.) | | |
|---|--|---|
| <ul style="list-style-type: none"> Bariatric surgery (see plan document for information on limitations and exclusions) Chiropractic care (limited to 20 visits per member, per Plan Year) | <ul style="list-style-type: none"> Hearing aids (limited to one per ear, per Plan year) Long-term care (Acute) | <ul style="list-style-type: none"> 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) |

[* For more information about limitations and exceptions, see the plan or policy document at www.benefitoptions.az.gov .]

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:

[* For more information about limitations and exceptions, see the plan or policy document at www.benefitoptions.az.gov .]



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](#) \$1,500
- [Specialist](#) [coinsurance](#) \$0
- Hospital (facility) [coinsurance](#) \$700
- Other [copayment](#) / [coinsurance](#) \$410

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 | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$10 |
| Coinsurance | \$1,100 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,670 |

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist](#) [coinsurance](#) \$0
- Hospital (facility) [coinsurance](#) \$0
- Other [copayment](#) / [coinsurance](#) \$340

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 | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$300 |
| Coinsurance | \$40 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,860 |

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist](#) [coinsurance](#) \$30
- Hospital (facility) [coinsurance](#) \$10
- Other [coinsurance](#) \$70

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 | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$10 |
| Coinsurance | \$100 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,610 |

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