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 https://benefitoptions.az.gov/contact 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: **$0** employee or **$0** family per calendar year Out-of-network: **$5,000** employee or **$10,000** family per calendar year	See the Common Medical Events chart below for your costs for services this plan covers. Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, in-network preventive care services; in-network primary care and specialist visits; prescription drug coverage, emergency room care; in-network urgent care visits; in-network outpatient services; in-network hospital services; hospice.	This plan has a $0 in-network deductible. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services and prescription drug coverage 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?	In-network: **$7,350** employee or **$14,700** family per calendar year Out-of-network: **$8,700** employee or **$17,400** family per calendar year	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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 network 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	copay	50% coinsurance & balance billing may apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Preventive care/screening limited to one visit per member per Plan Year. Age and frequency limits may apply. See your plan document for more information on limitations.
	Specialist visit	$50 copay $30 copay for OB/GYN	50% coinsurance & balance billing may apply	
	Preventive care/screening/ immunization	No Charge	50% coinsurance & balance billing may apply	
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay	50% coinsurance & balance billing may apply	None
	Imaging (CT/PET scans, MRIs)	$105 copay	50% coinsurance & balance billing may apply	Some testing may require pre-certification. See your plan document for more information on pre-certification limitations.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.benefitoptions.az.gov	Generic drugs	$15 copay/prescription (retail) $30 copay/prescription (mail order) $37.50 copay/prescription (Choice90)	Not Covered	Deductible does not apply. Covers up to a 30-day supply for retail; up to a 90-day supply for mail order; up to a 90-day supply for Choice90. Prescription medication with over-the-counter equivalents is not covered. Dispense as Written rules associated with how the plan will
	Preferred brand drugs	$40 copay/prescription (retail) $80 copay/prescription (mail order) $100 copay/prescription (Choice90)	Not Covered	

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

	Non-preferred brand drugs	$60 copay/prescription (retail) $120 copay/prescription (mail order) $150 copay/prescription (Choice90)	Not Covered	pay for a name-brand prescriptions may apply. Specialty drugs limited to a 30-day supply. See your plan document for more information on Specialty Pharmacy.
Common Medical Event	**Services You May Need**	**What You Will Pay** **Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$155 copay	50% co-insurance & balance billing may apply	Bariatric Surgery 20% coinsurance covered in-network only. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	No Charge	50% coinsurance & balance billing may apply	
If you need immediate medical attention	Emergency room care	$255 copay		Must be a Medical Emergency as defined by your plan. Copayment waived if admitted to hospital directly from the emergency room, but subject to hospital admission copayment. Out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge.
	Emergency medical transportation	No Charge		Non-medical emergency transportation requires pre-certification.
	Urgent care	$85 copay	50% coinsurance & balance billing may apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$305 copay	50% coinsurance & balance billing may apply	Bariatric Surgery 20% coinsurance covered in-network only. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	No Charge	50% coinsurance & balance billing may apply	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$30 copay	50% coinsurance & balance billing may apply	See your plan document for more information on limitations and excluded services.
	Mental/Behavioral health inpatient services	$305 copay	50% coinsurance & balance billing may apply	See your plan document for more information on pre-certification limitations and excluded services.
	Substance use disorder outpatient services	$30 copay	50% coinsurance & balance billing may apply	See your plan document for more information on limitations and excluded services.

	Substance use disorder inpatient services	$305 copay	50% coinsurance & balance billing may apply	See your plan document for more information on pre-certification limitations and excluded services.
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions, & Other Important Information**
		Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
If you are pregnant	Office visits	$30 copay for OB/GYN	50% coinsurance & balance billing may apply	None
	Childbirth/delivery professional services	No Charge	50% coinsurance & balance billing may apply	None
	Childbirth/delivery facility services	No Charge	50% coinsurance & balance billing may apply	None
If you need help recovering or have other special health needs	Home health care	No Charge	50% coinsurance & balance billing may apply	Coverage is limited to 42 visits per member per plan year.
	Rehabilitation services	$50 copay	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	$0 copay	50% coinsurance & balance billing may apply	Coverage is limited to 90 days per member per plan year.
	Durable medical equipment	$0 copay	50% coinsurance & balance billing may apply	See your plan document for more information on pre-certification limitations and excluded services.
	Hospice services	$0 copay	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	$0 copay	50% coinsurance & balance billing may apply	Screenings covered as part of well-child health examination.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Benefit Options at 1-602-548-5008 or 1-800-304-3687 or www.benefitoptions.az.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross Blue Shield of Arizona at 1-866-287-1980 or www.azblue.com; UnitedHealthcare at 1-800-896-1067 or www.myuhc.com; MedImpact at 1-888-648-6769 or www.medimpact.com or Benefit Options at 1-602-548-5008 or 1-800-304-3687 or www.benefitoptions.az.gov.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-542-5008 o al 1-800-304-3687.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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 prenatal care and a hospital delivery)	
■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) copayment**	**$0**
■ **Other copayment**	**$0**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care) $0*
Childbirth/Delivery Professional Services $0
Childbirth/Delivery Facility Services $0
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$550
Coinsurance	$10
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$610**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) copayment**	**$305**
■ **Other copayment**	**$520**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$340
Coinsurance	$4230
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4590**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) copayment**	**$305**
■ **Other copayment**	**$305**

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	**$2800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$560
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$570**

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 602-771-9355 or www.wellness.az.gov.

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

L26794-0127

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