This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.benefitoptions.az.gov or by calling 1-602-542-5008 or 1-800-304-3687.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.benefitoptions.az.gov or call 1-602-542-5008 or 1-800-304-3687 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay/visit	Not Covered	——————none——————
	Specialist visit	$30 co-pay/visit	Not Covered	——————none——————
	Other practitioner office visit	$10 co-pay/visit for OB/GYN	Not Covered	——————none——————
	Preventive care/screening/immunization	$15 co-pay/visit for primary care $10 co-pay/visit for OB/GYN	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Some testing may require pre-certification. See your plan document for more information on pre-certification limitations.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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	$10 co-pay/ prescription (retail) $20 co-pay/ prescription (mail order) $25 co-pay/ prescription (Choice90)	Not Covered	Covers up to a 30-day supply for retail; up to a 90-day supply for mail order; up to a 90-day supply for Choice90. Prescription medication with over-the-counter equivalents is not covered. Dispense as Written rules associated with how the plan will pay for a name-brand prescriptions may apply. See your plan document for more information on covered prescription drugs and limitations.
	Preferred brand drugs	$20 co-pay/ prescription (retail) $40 co-pay/ prescription (mail order) $50 co-pay/ prescription (Choice90)	Not Covered	
	Non-preferred brand drugs	$40 co-pay/ prescription (retail) $80 co-pay/ prescription (mail order) $100 co-pay/ prescription (Choice90)	Not Covered	
	Specialty drugs	$20 co-pay/ prescription	Not Covered	Limited to a 30-day supply. See your plan document for more information on Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 co-pay	Not Covered	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	$15 primary care $15 OB/GYN $30 specialist	Not Covered	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$125 co-pay	$125 co-pay	Must be a Medical Emergency as defined by your plan. Co-pay waived if admitted to hospital directly from emergency room but subject to hospital admission co-pay.
	Emergency medical transportation	No Charge	No charge	Non-medical emergency transportation requires pre-certification.
	Urgent care	$40 co-pay	Not Covered	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 co-pay	Not Covered	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fee	No Charge	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 co-pay	Not Covered	See your plan document for more information on pre-certification limitations and excluded services.
	Mental/Behavioral health inpatient services	$150 co-pay	Not Covered	
	Substance use disorder outpatient services	$15 co-pay	Not Covered	
	Substance use disorder inpatient services	$150 co-pay	Not Covered	
If you are pregnant	Prenatal and postnatal care	$10 co-pay for OB/GYN	Not Covered	————————none————————
	Delivery and all inpatient services	No Charge	Not Covered	See your plan document for more information on pre-certification limitations.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage is limited to 42 visits per member per plan year.
	Rehabilitation services	$15 co-pay	Not Covered	Coverage is limited to 60 visits per member per plan year.
	Habilitation services	Not Covered	Not Covered	——————none——————
	Skilled nursing care	No Charge	Not Covered	Coverage is limited to 90 days per member per plan year.
	Durable medical equipment	No Charge	Not Covered	See your plan document for more information on pre-certification limitations and excluded services.
	Hospice service	No Charge	Not Covered	See your plan document for more information on limitations and excluded services.
If your child needs dental or eye care	Eye exam	$15 physician co-pay	Not Covered	Screenings covered as part of well child health examination.
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult. Except for the treatment of an accidental injury to sound natural teeth where the continue 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
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- 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)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-602-542-5008 or 1-800-304-3687. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Aetna at 1-866-217-1953 or www.aetna.com; Blue Cross Blue Shield of Arizona at 1-866-287-1980 or www.azblue.com; Cigna at 1-800-968-7366 or www.cigna.com/stateofaz; UnitedHealthcare at 1-800-896-1067 or www.myuhc.com; MedImpact at 1-888-648-6769 or www.benefitoptions.az.gov; or Benefit Options at 1-602-548-5008 or 1-800-304-3687 or www.benefitptions.az.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,450
- **Patient pays** $90

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$90
Co-insurance	$0
Limits or exclusions	$0
Total	**$90**

Note: These numbers assume the patient has given notice of her pregnancy to the Plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-602-542-5008 or 1-800-304-3687 or visit us at www.benefitoptions.az.gov.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,100
- **Patient pays** $1,300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$1,200
Co-insurance	$0
Limits or exclusions	$100
Total	**$1,300**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-602-542-5008 or 1-800-304-3687 or visit us at www.benefitoptions.az.gov.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.