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

| **What is the overall deductible?** | **In-network** $1,300 employee $2,600 family  
Out-of network $2,600 employee / $5,200 family | **Why this Matters:** You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes. For non-preventive prescription drug coverage, $1,300 employee / $2,600 family. There are no other specific deductibles. | 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?** | Yes. In-network $2,000 employee / $4,000 family  
Out-of network $5,000 employee / $10,000 family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**. |
| **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. |

### Questions:

Call 1-602-542-5008 or 1-800-304-3687 or visit us at www.benefitoptions.az.gov.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.benefitoptions.az.gov or call 1-602-542-5008 or 1-800-304-3687 to request a copy.
State of Arizona: HSA Benefit Option  
Summary of Benefits and Coverage: What this Plan Covers & What it Costs  
Coverage Period: 01/01/2017 – 12/31/2017  
Coverage for: Employee / Family | Plan Type: HSA

- **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. This may change if you haven’t met your deductible.

- 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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
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<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>50% co-insurance</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>Some testing may require pre-certification. See your plan document for more information on pre-certification limitations.</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td></td>
<td>Generic drugs</td>
<td>Non-Preventive: 100% until deductible is met.</td>
<td>Preventive: $10 co-pay (retail), $20 co-pay (mail order), $25 co-pay (Choice90)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Non-Preventive: 100% until deductible is met.</td>
<td>Preventive: $20 co-pay (retail), $40 co-pay (mail order), $50 co-pay (Choice90)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prescription medication with over-the-counter equivalents is not covered. See your plan document for more information on covered prescription drugs and limitations.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Non-Preventive: 100% until deductible is met.</td>
<td>Preventive: $40 co-pay (retail), $80 co-pay (mail order), $100 co-pay (Choice90)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

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## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

### Coverage Period: 01/01/2017 – 12/31/2017

**Coverage for:** Employee / Family  |  **Plan Type:** HSA

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</tr>
</thead>
<tbody>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>$20 co-pay</td>
<td>Not covered</td>
<td>Limited to a 30-day supply. See your plan document for more information on Specialty Pharmacy.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>10% co-insurance</td>
<td>10% co-insurance</td>
<td>Must be a Medical Emergency as defined by your plan. Co-insurance waived if admitted to hospital directly from emergency room but subject to hospital admission co-pay.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% co-insurance</td>
<td>10% co-insurance</td>
<td>Non-medical emergency transportation requires pre-certification.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>See your plan document for more information on pre-certification limitations and excluded services.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>50% co-insurance</td>
<td>See your plan document for more information on pre-certification limitations.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No charge</td>
<td>50% co-insurance</td>
<td></td>
</tr>
</tbody>
</table>

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### Common Medical Event

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<th>Your cost if you use an In-network Provider</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>Coverage is limited to 42 visits per member per plan year.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>Coverage is limited to 60 visits per member per plan year.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>none</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>Coverage is limited to 90 days per member per plan year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>See your plan document for more information on pre-certification limitations and excluded services.</td>
</tr>
<tr>
<td>Hospice service</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
<td>See your plan document for more information on limitations and excluded services.</td>
</tr>
</tbody>
</table>

#### If you need help recovering or have other special health needs

- Home health care
- Rehabilitation services
- Habilitation services
- Skilled nursing care
- Durable medical equipment
- Hospice service

#### If your child needs dental or eye care

- Eye exam
- Glasses
- Dental check-up

### 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

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**Questions:** Call 1-602-542-5008 or 1-800-304-3687 or visit us at [www.benefitoptions.az.gov](http://www.benefitoptions.az.gov). If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.benefitoptions.az.gov](http://www.benefitoptions.az.gov) or call 1-602-542-5008 or 1-800-304-3687 to request a copy.
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, or Benefit Options at 1-602-548-5008 or 1-800-304-3687 or www.benefitoptions.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:
NAVAJO (Dine): Dine’ehgo shika at’ohwoł ninisingo, kwijjigo holne’ 1-602-542-5008 o 1-800-304-3687.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,870
- **Patient pays:** $2,670

**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: $2,600
- Co-pays: $0
- Co-insurance: $70
- Limits or exclusions: $0
- **Total:** $2,670

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,400
- **Patient pays:** $2,000

**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: $800
- Co-pays: $1,100
- Co-insurance: $0
- Limits or exclusions: $100
- **Total:** $2,000

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.

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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.