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 **$500** employee / **$1,000** family Out-of-network **$1,000** employee / **$2,000** family	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 services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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 **$1,000** employee / **$2,000** family Out-of-network **$4,000** employee / **$8,000** family	The out-of-pocket limit is the most you could pay in a year of covered services.
What is not included in the out-of-pocket limit?	• Charges in excess of Reasonable and Customary • All charges associated with a non-covered service	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).
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	$20 copayment	50% coinsurance	——————none——————
	Specialist visit	$40 copayment $20 copayment for OB/GYN	50% coinsurance	——————none——————
	Preventive care/screening/ immunization	$0 copayment for primary care	50% coinsurance	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	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$100 copayment	50% coinsurance	Some testing may require pre-certification. See your plan document for more information on pre-certification limitations.

[* 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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.benefitoptions.az.gov	Generic drugs	Preventative: $0 $15 copayment/ prescription (retail) $30 copayment/ prescription (mail order) $37.50 copayment/ 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	Preventative: $0 Non-Preventive: $40 copayment/ prescription (retail) $100 copayment/ prescription (mail order) $80 copayment/ prescription (Choice90)	Not Covered	
	Non-preferred brand drugs	Preventative: $0 Non-Preventive: $60 copayment/ prescription (retail) $150 copayment/ prescription (mail order) $120 copayment/ prescription (Choice90)	Not Covered	
	Specialty drugs	Generic $15 copayment/ Preferred brand $40 copayment/ Non-preferred brand $60	Not Covered	Limited to a 30-day supply. 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)	
		copayment		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment	50% co-insurance	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	$20 primary care $20 OB/GYN $40 specialist	50% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copayment	$200 copayment	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	$75 copayment	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment	50% coinsurance	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	No Charge	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$20 primary care $40 specialist	50% coinsurance	
	Mental/Behavioral health inpatient services	$250 copayment	50% coinsurance	
	Substance use disorder outpatient services	$20 primary care $40 specialist	50% coinsurance	
	Substance use disorder inpatient services	$250 copayment	50% coinsurance	
If you are pregnant	Office visits	$20 copayment for OB/GYN	50% coinsurance	
	Childbirth/delivery professional services	No Charge	50% coinsurance	
	Childbirth/delivery facility services	No Charge	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	50% coinsurance	Coverage is limited to 42 visits per member per plan year.
	Rehabilitation services	$40 copayment	50% coinsurance	Coverage is limited to 60 visits per member per plan year.
	Habilitation services	Not Covered	Not Covered	——————none——————
	Skilled nursing care	No Charge	50% coinsurance	Coverage is limited to 90 days per member

[* 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)	
				per plan year.
	Durable medical equipment	No Charge	50% coinsurance	See your plan document for more information on pre-certification limitations and excluded services.
	Hospice services	No Charge	50% coinsurance	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 copayment	50% coinsurance	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
- 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 (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)

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

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

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: 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; 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 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 section.

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

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 plan's overall deductible	$500
Specialist copayment	$0
Hospital (facility) copayment	$0
Other *[cost sharing]*	$80

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	$500
Copayments	$20
Coinsurance	$N/A
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$580**

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

The plan's overall deductible	$500
Specialist copayment	$0
Hospital (facility) copayment	$0
Other *[cost sharing]*	$600

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$1,100**

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

The plan's overall deductible	$500
Specialist copayment	$200
Hospital (facility) copayment	$200
Other *[cost sharing]*	$

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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