

 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](http://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](http://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 <a href="#">deductible</a> ?	For In-network: \$200 employee / \$400 family	You must pay all the costs up to the <a href="#">deductible</a> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <a href="#">deductible</a> 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 <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In-network preventative care	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,350 Individual/\$14,700 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.benefitoptions.az.gov">www.benefitoptions.az.gov</a> 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 <a href="#">provider</a> , 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 <a href="#">provider</a> for some services. Plans use the term in-network, preferred, or participating for <a href="#">providers</a> in their network. See the chart starting on page 2 for how this plan pays different kinds of <a href="#">providers</a> .
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

**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.

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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copayment</a>	Not Covered	-----none-----
	<a href="#">Specialist</a> visit	\$40 <a href="#">copayment</a> \$20 <a href="#">copayment</a> for OB/GYN	Not Covered	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	\$0 <a href="#">copayment</a>	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copayment</a>	Not Covered	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](http://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)	
<p><b>If you need drugs to treat your illness or condition</b>  More information about <a href="http://www.benefitoptions.az.gov">prescription drug coverage</a> is available at <a href="http://www.benefitoptions.az.gov">www.benefitoptions.az.gov</a></p>	Generic drugs	Preventive: \$0 Non- preventive: \$15 <a href="#">copayment</a> /prescription (retail) \$30 <a href="#">copayment</a> /prescription (mail order) \$37.50 <a href="#">copayment</a> /prescription (Choice90)	Not Covered	<p>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.</p> <p>Prescription medication with over-the-counter equivalents is not covered.</p> <p>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.</p>
	Preferred brand drugs	Preventive: \$0 Non- preventive \$40 <a href="#">copayment</a> /prescription (retail) \$80 <a href="#">copayment</a> /prescription (mail order) \$100 <a href="#">copayment</a> /prescription (Choice90)	Not Covered	
	Non-preferred brand drugs	Preventive: \$0 Non- preventive \$60 <a href="#">copayment</a> /prescription (retail) \$120 <a href="#">copayment</a> /prescription (mail order) \$150 <a href="#">copayment</a> /prescription (Choice90)	Not Covered	
	<a href="#">Specialty drugs</a>	Generic \$15 <a href="#">copayment</a> / Preferred brand \$40 <a href="#">copayment</a> / Non-	Not Covered	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.benefitoptions.az.gov](http://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)	
		preferred brand: \$60 <a href="#">copayment</a>		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <a href="#">copayment</a>	Not Covered	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	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">copayment</a>	\$200 <a href="#">copayment</a>	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.
	<a href="#">Emergency medical transportation</a>	No Charge	No charge	Non-medical emergency transportation requires pre-certification.
	<a href="#">Urgent care</a>	\$75 <a href="#">copayment</a>	Not Covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">copayment</a>	Not Covered	Bariatric Surgery 20% co-insurance. See your plan document for more information on pre-certification limitations.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	\$20 <a href="#">copayment</a>	Not Covered	
	Mental/Behavioral health inpatient services	\$250 <a href="#">copayment</a>	Not Covered	
	Substance use disorder outpatient services	\$20 <a href="#">copayment</a>	Not Covered	
	Substance use disorder inpatient services	\$250 <a href="#">copayment</a>	Not Covered	
If you are pregnant	Office visits	\$20 co-pay for OB/GYN	Not Covered	
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	Coverage is limited to 42 visits per member per plan year.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copayment</a>	Not Covered	Coverage is limited to 60 visits per member per plan year.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	-----none-----

[\* For more information about limitations and exceptions, see the plan or policy document at [www.benefitoptions.az.gov](http://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)	
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	Coverage is limited to 90 days per member per plan year.
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	See your plan document for more information on pre-certification limitations and excluded services.
	<a href="#">Hospice services</a>	No Charge	Not Covered	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 physician <a href="#">copayment</a>	Not Covered	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"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• 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.)</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul>
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**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"> <li>• Bariatric surgery (see plan document for information on limitations and exclusions)</li> <li>• Chiropractic care (limited to 20 visits per member, per Plan Year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (limited to one per ear, per Plan year)</li> <li>• Long-term care (Acute)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult, if part of a routine health examination)</li> <li>• Routine foot care (if medically necessary)</li> </ul>
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**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](http://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](http://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: Aetna at 1-866-217-1953 or [www.aetna.com](http://www.aetna.com); Blue Cross Blue Shield of Arizona at 1-866-287-1980 or [www.azblue.com](http://www.azblue.com); Cigna at 1-800-968-7366 or [www.cigna.com/stateofaz](http://www.cigna.com/stateofaz); UnitedHealthcare at 1-800-896-1067 or [www.myuhc.com](http://www.myuhc.com); MedImpact at 1-888-648-6769 or [www.medimpact.com](http://www.medimpact.com) or Benefit Options at 1-602-548-5008 or 1-800-304-3687 or [www.benefitoptions.az.gov](http://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, kwijjigo 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.*-----

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](#) \$200
- [Specialist](#) copayment \$0
- Hospital (facility) copayment \$0
- Other [*cost sharing*] \$60

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$60
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$260</b>

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

- The [plan's](#) overall [deductible](#) \$200
- [Specialist](#) copayment \$80
- Hospital (facility) copayment \$0
- Other [*cost sharing*] \$2,000

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$2,100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Joe would pay is</b>	<b>\$2,300</b>

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

- The [plan's](#) overall [deductible](#) \$200
- [Specialist](#) copayment \$200
- Hospital (facility) copayment \$0
- Other [*cost sharing*] \$240

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$440
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$640</b>