




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> ?	In-network <b>\$1,500</b> employee / <b>\$3,000</b> family Out-of-network <b>\$5,000</b> employee / <b>\$10,000</b> family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the plan begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, In-network <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	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. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Yes. In-network <b>\$3,500</b> employee / <b>\$7,000</b> family Out-of-network <b>\$8,700</b> employee / <b>\$17,400</b> family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> 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.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
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.

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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then Check what your <a href="#">plan</a> will pay for.  <a href="#">Preventive care/screening</a> limited to one visit per member per Plan Year. Age and frequency limits may apply. See your plan document for more information on limitations.
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	Some testing may require <a href="#">pre-certification</a> . See your plan document for more information on <a href="#">pre-certification</a> limitations.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.benefitoptions.az.gov">www.benefitoptions.az.gov</a>	Generic drugs	\$15 <a href="#">copay</a> /prescription-retail \$30 <a href="#">copay</a> /prescription-mail order \$37.50 <a href="#">copay</a> /prescription-Choice90	Not Covered	Non-preventive prescription drug: 100% before <a href="#">deductible</a> is met.  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.
	Preferred brand drugs	\$40 <a href="#">copay</a> /prescription-retail \$80 <a href="#">copay</a> /prescription-mail order \$100 <a href="#">copay</a> /prescription-Choice90	Not Covered	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 prescription may apply. Specialty drugs limited to a 30-day supply.
	Non-preferred brand drugs	\$60 <a href="#">copay</a> /prescription-retail \$120 <a href="#">copay</a> /prescription-mail order \$150 <a href="#">copay</a> /prescription-Choice90	Not Covered	See your plan document for more information on Specialty Pharmacy.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	Bariatric Surgery 20% <a href="#">coinsurance</a> covered in-network only. See your plan document for more information on <a href="#">pre-certification</a> limitations.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	Must be a Medical Emergency as defined by your plan. Out-of-network providers can't <a href="#">balance bill</a> for the difference between the allowed amount and the billed charge.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	Non-medical emergency transportation requires <a href="#">pre-certification</a> .
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	Bariatric Surgery 20% <a href="#">coinsurance</a> covered in-network only. See your plan document for more information on <a href="#">pre-certification</a> limitations.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	See your plan document for more information on limitations and excluded services.
	Mental/Behavioral health inpatient services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	See your plan document for more information on <a href="#">pre-certification</a> limitations and excluded services.
	Substance use disorder outpatient services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	See your plan document for more information on limitations and excluded services.
	Substance use disorder inpatient services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	See your plan document for more information on <a href="#">pre-certification</a> limitations and excluded services.
If you are pregnant	Office visits	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	See your plan document for more information.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	See your plan document for more information.
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	See your plan document for more information.

[\* 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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	Coverage is limited to 42 visits per member per plan year.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	Coverage is limited to 60 visits per member per plan year.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	None
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	Coverage is limited to 90 days per member per plan year.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	See your plan document for more information on <a href="#">pre-certification</a> limitations and excluded services.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> may apply	See your plan document for more information on limitations and excluded services.
<b>If your child needs dental or eye care</b>	Children's eye exam	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> & <a href="#">balance billing</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<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 continued 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 (Except for inpatient hospital setting)</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> 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> <li>Weight loss programs (see Wellness Program for more information)</li> </ul>

[\* For more information about limitations and exceptions, see the plan or policy document at [www.benefitoptions.az.gov](http://www.benefitoptions.az.gov) .]

**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: Blue Cross Blue Shield of Arizona at 1-866-287-1980 or [www.azblue.com](http://www.azblue.com); 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**

[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, kwijigo 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.*

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**About these Coverage Examples:**

[\* For more information about limitations and exceptions, see the plan or policy document at [www.benefitoptions.az.gov](http://www.benefitoptions.az.gov) .]





**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](#) \$1,500
- [Specialist](#) [coinsurance](#) \$0
- Hospital (facility) [coinsurance](#) \$700
- Other [copayment](#) / [coinsurance](#) \$410

**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>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,670</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist](#) [coinsurance](#) \$0
- Hospital (facility) [coinsurance](#) \$0
- Other [copayment](#) / [coinsurance](#) \$340

**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>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,860</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist](#) [coinsurance](#) \$30
- Hospital (facility) [coinsurance](#) \$10
- Other [coinsurance](#) \$70

**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>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,610</b>

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 1-602-771-9355 or [www.wellness.az.gov](http://www.wellness.az.gov).

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services