The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, visit azblue.com/member. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-595-5993 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Coverage for Individual Only: <u>In-network</u> : \$750/individual <u>Out-of-network</u> : \$1,750/individual Coverage for Family: <u>In-network</u> : \$1,500/family <u>Out-of-network</u> : \$3,500/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. Unless a <u>copay</u> , fee, or other percent is shown, the <u>coinsurance</u> percent of the <u>allowed amount</u> that you pay for most services is 20% <u>in-network</u> and 50% <u>out-of-network</u> . <u>In-network deductible</u> also accumulates to the <u>out-of-network deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>in-network preventive</u> services; prescription drugs.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network: \$2,750 /individual or \$5,500 /family <u>Out-of-network</u> : \$6,500 /individual or \$13,000 /family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>out-of-network prior</u> <u>authorization</u> charges, <u>balance bills</u> , and costs for health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.azblue.com or call 1-866- 595-5993 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay		Limitations, Exceptions, & Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u>	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Chiropractic services	
	<u>Specialist</u> visit	20% <u>coinsurance</u> after <u>deductible</u>		limited to 20 visits per year. Acupuncture has a \$500 maximum per year. No charge for telemedicine consultations through your <u>network</u> <u>provider</u> or medical telehealth consultations through BlueCare Anywhere SM .	
	Preventive care/screening/ immunization	No charge, <u>deductible</u> does not apply	Most services not covered. If covered, 50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	Preventive services not required to be covered by state or federal law are not covered. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Only mammography (<u>deductible</u> is waived) and foreign travel immunizations are covered <u>out-of- network</u> .	
If you have a test	Diagnostic test (x-ray, blood work)	No charge, <u>deductible</u> does not apply	E00/ coincurance offer	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out of patwork cap issue. Cost shore waived if lab is	
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance</u> <u>bill</u> may apply	<u>out-of-network</u> services. <u>Cost share</u> waived if lab is only service received during physician office visit and at contracted, freestanding, independent clinical labs. <u>Cost share</u> varies based on place of service and <u>provider</u> 's <u>network</u> status & type.	

Common Medical Event	Services You May Need	What Yo Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Tier 1	\$10 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	\$10 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply		
	Tier 2	\$30 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	\$30 <u>copav</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply	Some drugs require <u>prior</u> <u>authorization</u> and won't be covered without it. 90-day supply costs 2	
If you need drugs to treat your illness or condition	Tier 3	\$50 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	\$50 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply	<u>copays</u> for mail order. Mail order not covered <u>out-of-network</u> .	
More information about prescription drug coverage is available at www.azblue.com	Tier 4	\$100 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	\$100 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply		
	Specialty drugs	<u>Copays</u> (<u>deductible</u> does not apply): Tier A: \$30 Tier B: \$60 Tier C: \$90 Tier D: \$120	Not covered	Specialty <u>copay</u> covers up to a 30-day supply. No coverage without <u>prior authorization</u> .	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for	
If you have outpatient - surgery	Physician/surgeon fees	deductible	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u> may apply	out-of-network services. Bariatric surgery subject to 50% coinsurance in-network and out-of-network.	
If you need immediate medical attention	Emergency room care	\$100 access fee per member/facility/day, then 20% <u>coinsurance</u> after <u>deductible</u>		Access fee is waived if you are admitted as an inpatient to the hospital and you pay inpatient <u>deductible</u> and <u>coinsurance</u> . Admittance for observation is not inpatient. <u>Out-of-network</u> <u>providers</u> can't <u>balance bill</u> for the difference between the <u>allowed amount</u> and the billed charge.	
	Emergency medical transportation	No charge, <u>deduc</u>	<u>tible</u> does not apply	None	

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	<u>Urgent care</u>	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	None
If you have a hospital	Facility fee (e.g., hospital room) Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u> 50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u> may apply	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services. Bariatric surgery subject to 50% coinsurance in-network and out-of-network.
stay	Long-term acute care	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge, <u>deductible</u> does not apply or 20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u> may apply	Prior authorization may be required. Behavioral/Mental health visits in an office, or virtual (office) setting do not require <u>prior</u> <u>authorization</u> . Behavioral therapy (e.g. therapy for Autism and related services) provided in an outpatient setting does require <u>prior</u> <u>authorization</u> . Prior authorization is not required for emergency situations. Claim may be denied or \$500 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services. No charge applies to office, home, walk-in clinic visits. Coinsurance applies to all other locations. No charge for Counseling and Psychiatric telemedicine consultations through your <u>network</u> <u>provider</u> or telehealth consultations through BlueCare AnywhereSM.
	Inpatient services	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u> may apply	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Office Visits	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	Maternity ears may include tests and convises
If you are pregnant			50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u> may apply	Maternity care may include tests and services described elsewhere in the <u>SBC</u> (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>in-network</u> preventive services.
	Childbirth/delivery facility services		50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	preventive services.
	Home health care/Home infusion therapy	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.
f you need help recovering or have other special health needs	Rehabilitation services• EAR = Extended ActiveRehabilitation Facility• PT/OT/ST = PhysicalTherapy, OccupationalTherapy, Speech Therapy	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 60 combined visits for PT/OT/ST per member per calendar year. <u>Plan</u> does not cover
	Habilitation services	Not covered	Not covered	
	Skilled nursing care In skilled nursing facility (SNF)	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	group physical and occupational therapy. Limit of 240 days/calendar year for SNF.
	Durable medical equipment	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.
	Hospice services	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u> & <u>balance bill</u>	No charge for member under age 5 in-network.
	Children's glasses	Not covered	Not covered	Excluded
	Children's dental check-up	Not covered	Not covered	Excluded

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.)

- Care that is not <u>medically necessary</u>
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care except dental accidents
- <u>DME</u> rental/repair charges that exceed <u>DME</u> purchase price
- Experimental and investigational treatments except as stated in <u>plan</u>
- Eyewear except after cataract surgery
- Fertility and infertility medication and treatment
- Flat feet treatment and services except as stated in <u>plan</u>

- Genetic and chromosomal testing except as stated

 in <u>plan</u>
- Habilitation services
- Hearing aids
- Inpatient SNF treatment exceeding 240 days per calendar year
- Long-term care, except long-term acute care
- Massage therapy other than allowed under evidence-based criteria
- <u>Out-of-network</u> preventive care except mammography and foreign travel immunizations
- <u>Out-of-network</u> Mail Order drugs and <u>out-of-network</u>
 <u>Specialty</u> drugs

- Physical, occupational and speech therapy exceeding 60 visits per year
- <u>Preventive services</u> not required to be covered by state or federal law
- Private-duty nursing
- Respite care except as stated in plan
- Routine foot care
- Services, tests and procedures that are excluded under medical coverage guidelines
- Sexual dysfunction treatment and services
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
 Alternative medicine (acupuncture services limited to \$500 maximum) Bariatric surgery 	 Chiropractic care limited to 20 visits per year Non-emergency care when traveling outside the U.S 	Routine eye care	

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:

- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Church <u>plans</u> are not covered by the Federal <u>COBRA</u> continuation coverage rules. If the coverage is insured, individuals should contact the Arizona Department of Insurance (602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area) regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318- 2596.

Your Grievance and <u>Appeals</u> Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-866-595-5993. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.
- For non-federal governmental group health plans and church plans that are group health plans, contact Blue Cross Blue Shield of Arizona at 1-866-595-5993. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area or https://difi.az.gov/consumer/i/health.

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.

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yiťéego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí ťáadoo le'é yína'ídíłkidgo beehaz'áanii hóló díí ťáá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您, 或是您正在協助的對象, 有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題, 您有權利免費以您的 母語得到幫助和訊息。洽詢一位翻譯員, 請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة المتحدث مع مترجم اتصل ب 479-475-877.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望 の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید .4799-475-877 تماس حاصل نمایید.

Assyrian:

يد نسمه، ښيچ فغيوقه دېسونوس عمه، ديمكمون دوشته دوم Blue Cross Blue Shield of Arizona نسمه، ديمكمون شعومه دونده، ښيخه مخموندوه، ديگندس كوهوون نجر هر مخدكهنه، مود عمه، نجك وكيهه، ويننه 1799-475-877.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

ี Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีค่าถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About These Coverage Examples

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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	\$750
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,700

In this example, Peg would pay:

Cost Sharing		
Deductibles	\$750	
Copayments	\$0	
Coinsurance	\$2,000	
What isn't covered		
Limits or exclusions	\$50	
The total Peg would pay is	\$2,800	

The plan's overall deductible	7 C
controlled condition)	
(a year of routine in-network care of a well-	
Managing Joe's Type 2 Diabetes	

The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist coinsurance</u>	20%
Hospital (facility) <u>coinsurance</u>	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600

In this example, Joe would pay:

Cost Sharing		
Deductibles	\$750	
Copayments	\$480	
Coinsurance	\$90	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,340	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The <u>plan's</u> overall <u>deductible</u>	\$750
Specialist <u>coinsurance</u>	20%
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

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	\$2,800

In this example, Mia would pay:

Cost Sharing		
Deductibles	\$750	
Copayments	\$110	
Coinsurance	\$380	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,240	

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

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