

 **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, visit azblue.com/member. 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.healthcare.gov/sbc-glossary/ or call 1-877-475-8440 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-network</u> : \$200 /individual and \$400 /family per calendar year <u>Out-of-network</u> : \$2,000 /individual and \$4,000 /family per calendar year	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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . 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> .
Are there services covered before you meet your deductible?	Yes. Certain <u>in-network</u> <u>preventive services</u> ; <u>prescription drugs</u> ; <u>emergency room care</u> ; <u>in-network</u> <u>urgent care</u> visits.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, \$100 for dental plan benefits. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
What is the medical out-of-pocket limit for this plan?	<u>In-network</u> : \$4,000 /individual and \$10,000 /family per calendar year <u>Out-of-network</u> : \$10,000 /individual and Unlimited /family per calendar year	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 the prescription drug out-of-pocket limit for this plan?	<u>In-network</u> : \$1,000 /individual and \$2,000 /family per calendar year <u>Out-of-network</u> : \$10,000 /individual and Unlimited /family per calendar year	
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>out-of-network</u> <u>prior 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 <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network 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). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
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	PCMH providers: \$10 copay , deductible does not apply Other providers: 20% coinsurance	50% coinsurance & balance bill	Claim may be denied or \$500 charge if no prior authorization for out-of-network services. Limit of 20 chiropractic visits/calendar year; Acupuncture covered, limit 12 visits/calendar year when rendered by an MD, DO or chiropractor who is also a licensed acupuncturist. \$10 copay for medical telehealth consultations through BlueCare Anywhere SM .
	Specialist visit	PCMH OBGYN providers: \$10 copay , deductible does not apply Other providers: 20% coinsurance		
	Preventive care/screening/immunization	No charge, deductible does not apply	50% coinsurance & balance bill	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 preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance & balance bill may apply	Cost share varies based on place of service and provider's network status and type. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.
	Imaging (CT/PET scans, MRIs)			

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 through MedImpact at www.medimpact.com or 1-800-788-2949	Level 1	\$10 per prescription 30 day (retail); \$20 per prescription - 90 day Retail or (home delivery)	40% <u>coinsurance</u> /prescription (retail); Not covered (home delivery)	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs.
	Level 2	\$20 per prescription 30 day (retail); \$40 per prescription - 90 day Retail or (home delivery)	40% <u>coinsurance</u> /prescription (retail); Not covered (home delivery)	Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. <u>Copays</u> apply each time you fill a prescription supply.
	Level 3	\$50 per prescription 30 day (retail); \$90 per prescription 90 day Retail or (home delivery)	40% <u>coinsurance</u> /prescription (retail); Not covered (home delivery)	Some drugs require prior authorization and won't be covered without it. If a brand name drug is dispensed in place of a generic when a generic drug is available, you will pay the brand <u>copayment</u> plus the difference in cost between the generic and brand name drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Additional \$200 access fee for all bariatric surgeries.
	Physician/surgeon fees		50% <u>coinsurance</u> & <u>balance bill</u> may apply	
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copay</u> , <u>deductible</u> does not apply		<u>Copay</u> 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 providers</u> can't <u>balance bill</u> for the difference between the <u>allowed amount</u> and the billed charge.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>		None
	<u>Urgent care</u>	\$100 <u>copay</u> , <u>deductible</u> does not apply		None

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 a hospital stay	Facility fee (e.g., hospital room)	\$200 access fee plus 20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Additional \$200 access fee for all bariatric surgeries.
	Physician/surgeon fees		50% <u>coinsurance</u> & <u>balance bill</u> may apply	
	Long-term acute care	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. 60 day limit combined with EAR and SNF.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u> may apply	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. \$10 <u>copay</u> for counseling and \$10 <u>copay</u> for Psychiatric telehealth consultations through BlueCare Anywhere SM .
	Inpatient services	\$200 access fee plus 20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u> may apply	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
If you are pregnant	Office Visits	PCMH OBGYN providers: \$10 <u>copay</u> , <u>deductible</u> does not apply Other providers: 20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Depending on the type of services, a <u>coinsurance</u> or <u>deductible</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 preventive services</u> .
	Childbirth/delivery professional services		50% <u>coinsurance</u> & <u>balance bill</u> may apply	
	Childbirth/delivery facility services	\$200 access fee plus 20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	

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 help recovering or have other special health needs	<u>Home health care</u> /Home infusion therapy	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 6 hours of care/member/day. Custodial care excluded.
	<u>Rehabilitation services</u> • EAR = Extended Active Rehabilitation Facility • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 60 days/calendar year for EAR, LTAC and SNF combined. Limit of 60 combined visits/calendar year for PT/OT/ST/CT/Pulmonary therapy. Cardiac therapy limit of 36 visits. <u>Plan</u> does not cover group physical and occupational therapy.
	<u>Habilitation services</u>	Not covered	Not covered	
	<u>Skilled nursing care</u> In skilled nursing facility (SNF)	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. <u>Cost share</u> varies based on place of service and provider's <u>network</u> status and type. Limit of 1 hearing aid per member per ear every 5 calendar years.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
If your child needs dental or eye care	Children's eye exam	\$10 <u>copayment</u> /visit. <u>deductible</u> does not apply.	You pay 100%. Plan reimburses up to \$45 per exam (minus \$10 <u>copayment</u> for exam & eyeglasses).	One vision exam payable each 12 months. One pair of frames is payable each 24 months. One pair of lenses payable every 12 months. Your cost sharing for vision services does not count toward your medical plan's <u>out-of-pocket limit</u> . Medical <u>deductible</u> does not apply. Vision coverage is through VSP.
	Children's glasses	No charges for lenses. \$10 <u>copayment</u> for frames up to \$225/frame. You pay frame cost over \$225/frame.	You pay 100%. Plan reimburses up to \$70 per frame and up to \$30/single lens. You pay any amount over \$70/frame and \$30/single lens.	
	Children's dental check-up	No charge for <u>preventive</u> and basic services	No charge for <u>preventive</u> and basic services	Dental coverage is through Delta Dental of AZ

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Acupuncture exceeding 12 visits • Alternative medicine • Care that is not <u>medically necessary</u> • Cosmetic surgery, cosmetic services & supplies • Custodial care • <u>DME</u> rental/repair charges that exceed <u>DME</u> purchase price • Experimental and investigational treatments except as stated in <u>plan</u> • 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> • <u>Habilitation services</u> • <u>Home health care</u> and infusion therapy exceeding 6 hours of care per member per day • Inpatient EAR and inpatient SNF treatment exceeding 60 days combined per calendar year • <u>Long-term care</u>, except long-term acute care up to a 60 days benefit <u>plan</u> maximum • Massage therapy other than allowed under evidence-based criteria	• <u>Preventive services</u> not required to be covered by state or federal law • Private-duty nursing • Respite care except as stated in <u>plan</u> • 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 <u>plan</u> document.)		
• Bariatric surgery, limited to one surgery per lifetime • Chiropractic care limited 20 visits per year	• Hearing aids, limited to \$750 one hearing aid per member per ear every 5 calendar years	• Non-emergency care when traveling outside the U.S. • Wigs limited to \$350

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 www.cciio.cms.gov.
- Church plans are not covered by the Federal COBRA 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 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 provide complete information on how 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:

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. 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 1-877-475-8440. 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.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-475-4799.

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 602-864-4884.

Navajo: Diné bee yánitłi'gogo, saad bee aná'awo' bee áka'anída'awo'ít'á dá jik'eh ná hóló. Bee ahít hane'go bee nida'anishí t'á dá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoót'i'ígíí éí t'á dá jik'eh hóló. Kohji' 1-877-475-4799.

Chinese Simplified: 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-877-475-4799。

Chinese Traditional: 如果您說[中文], 我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務, 以無障礙格式提供資訊。請致電 1-877-475-4799。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-475-4799.

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-475-4799.

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-475-4799.

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-475-4799.

Korean: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-475-4799.

Russian: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-475-4799.

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-475-4799.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-475-4799 ।

Farsi (Persian)

با شماره همجنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترسی، به‌طور رایگان موجود می‌باشند. صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. فارسی اگر توجه: 1-877-475-4799.

Thai: หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-475-4799.

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-475-4799。

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



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 <u>plan's</u> overall <u>deductible</u>	\$200
■ Specialist <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$230
<u>Coinsurance</u>	\$2,430
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$2,910

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ Specialist <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$670
<u>Coinsurance</u>	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,090

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ 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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$350
<u>Coinsurance</u>	\$440
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$990

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

Discrimination is Against the Law

Blue Cross® Blue Shield® of Arizona (AZ Blue) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). **AZ Blue** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

AZ Blue:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

If you believe that **AZ Blue** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Section 1557 Coordinator
P.O. Box 13466
Phoenix, AZ 85002-3466
Call 602-864-2288; TTY 711
or email us at crc@azblue.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **AZ Blue Section 1557 Coordinator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at AZ Blue's website: azblue.com/nondiscrimination-notice.

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