BluePreferred 70/2500 Statewide

Blue Cross® Blue Shield® of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

Coverage Period: On and after 01/01/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.azblue.com/GroupPlanDoc2017N** or by calling 1-877-475-8440.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network and out-of-network combined: **$2,500/**member and **$5,000/**family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Your **deductible** is based on a calendar year and starts over each January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Unless a copay, fee, or other percent is shown, the coinsurance percent of the allowed amount that you pay for most services is 30% in-network and 50% out-of-network. Copays, access fees, balance bills, payments for excluded services, and precertification charges don't count to the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$6,350**/member and **$12,700** family Out-of-network: **$12,000**/member and **$24,000**/family	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, precertification charges, balance-bills, and costs for health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. You must keep paying them even if you reach your **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network **providers**.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your benefit book for more information about **excluded services**.

Questions: Call 1-877-475-8440 or visit us at www.azblue.com.
If you aren't clear about any of the underlined/bolded terms used in this form, see the Glossary.
You can view the Glossary at **www.cciio.cms.gov** or call 1-877-475-8440 to request a copy.

- **Copays** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use **in-network providers** by charging you lower cost share for their services. A noncontracted provider can charge full billed charges, and the plan will reimburse you based only on the **allowed amount**, minus your cost share.

Common Medical Event	Services You May Need	Your Cost If You Use An In-network Provider	Your Cost If You Use An Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care (PCP) visit to treat an injury or illness	$25 copay/office visit or 30% coinsurance.	50% coinsurance & balance bill	Each member has copay cost share for up to 3 in-network physician office visits/year (PCP &Specialist combined), then 30% coinsurance applies. Copay visits measured per provider per day. Limit of 1 routine vision exam/calendar year at PCP copay, which does not count toward the 3-visit limit. Specialist cost share for most chiropractic services.
	Specialist visit	$40 copay/office visit or 30% coinsurance.		
	Other practitioner office visit	30% coinsurance		
	Preventive care/screening/immunization	No charge	50% coinsurance & balance bill	Preventive services not required to be covered by state or federal law are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	Office visit copay or 30% coinsurance	50% coinsurance & balance bill	Cost share varies based on place of service and provider's network status & type, and whether 3-visit copay limit met.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.azblue.com.	Level 1 prescription drugs	$15 copay/30 day supply	$15 copay/30 day supply & balance bill	Some drugs require precertification and won't be covered without it. 90-day supply costs 3 copays (retail pharmacy) and 2 copays (mail order). Mail order not covered out-of-network.
	Level 2 prescription drugs	$35 copay/30 day supply	$35 copay/30 day supply & balance bill	
	Level 3 prescription drugs	$65 copay/30 day supply	$65 copay/30 day supply & balance bill	
	Level 4 prescription drugs	$120 copay/30 day supply	$120 copay/30 day supply & balance bill	

Common Medical Event	Services You May Need	Your Cost If You Use An		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you need drugs to treat your illness or condition	Specialty drugs	Level A: $50 copay Level B: $100 copay Level C: $150 copay Level D: $200 copay	Not covered	Specialty copay covers up to a 30-day supply. No coverage without precertification.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance & balance bill	Additional $1,000 access fee for all bariatric surgeries.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$250 copay/facility/day	$250 copay/facility/day	If admitted to hospital, copay is waived and you pay inpatient deductible and coinsurance for facility and ancillary services in the ER.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None.
	Urgent care	$60 copay/provider/day	50% coinsurance & balance bill	Copay applies only to facilities specifically contracted for urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance & balance bill	Precertification required. $300 charge if no precertification for out-of-network stay. Additional $1,000 access fee for all bariatric surgeries.
	Physician/surgeon fee			
	Long-term acute care (LTAC)	30% coinsurance days 1-100 and 50% coinsurance days 101-365	50% coinsurance & balance bill	Precertification required. $300 charge if no precertification for out-of-network stay. Limit of 365 total LTAC days per member.
If you have mental health, behavioral health, or substance abuse needs *(Continued on page 4)*	Mental/Behavioral health outpatient services	No charge or 30% coinsurance	50% coinsurance & balance bill	Cost share varies based on place of service and provider's network status and type. No charge applies to office, home, walk-in clinic visits. Coinsurance applies to all other locations.
	Mental/Behavioral health inpatient services	30% coinsurance	50% coinsurance & balance bill	Precertification required. $300 charge if no precertification for out-of-network services.

Common Medical Event	Services You May Need	Your Cost If You Use An In-network Provider	Your Cost If You Use An Out-of-network Provider	Limitations & Exceptions
(Continued from page 3) **If you have mental health, behavioral health, or substance abuse needs**	Substance use disorder outpatient services	No charge or 30% coinsurance	50% coinsurance & balance bill	Cost share varies based on place of service and provider's network status and type. No charge applies to office, home, walk-in clinic visits. Coinsurance applies to all other locations.
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance & balance bill	Precertification required. $300 charge if no precertification for out-of-network facility stay.
If you are pregnant	Prenatal and postnatal care	Physician: Office visit copay or 30% coinsurance	50% coinsurance & balance bill	Only 1 copay is collected for services included in delivering physician's global charge if member hasn't met 3 visit office copay limit.
	Delivery and all inpatient services	30% coinsurance	50% coinsurance & balance bill	
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	30% coinsurance	50% coinsurance & balance bill	Some drugs require precertification and won't be covered without it. Limited to 6 hours of care per member per day.
	Rehabilitation services • EAR = Extended Active Rehabilitation Facility • SNF = Skilled Nursing Facility	30% coinsurance except 50% coinsurance for: ▪ days 61-120 of EAR ▪ days 91-180 of SNF	50% coinsurance & balance bill	Precertification required for facility admission. $300 charge if not obtained for out-of-network admission. Limit of 120 days/calendar year for EAR and 180 days/calendar year for SNF. *Limited coverage available for habilitation services to treat autism spectrum disorder.
	Habilitation services	Not covered*	Not covered*	
	Skilled nursing care	30% coinsurance	50% coinsurance & balance bill	
	Durable medical equipment	Office visit copay or 30% coinsurance	50% coinsurance & balance bill	Cost share varies based on place of service, provider's network status & type, and whether office visit limit met.
	Hospice service	No charge	No charge except balance bill	None

Common Medical Event	Services You May Need	Your Cost If You Use An		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If your child needs dental or eye care	Eye exam	$25 copay/visit	50% coinsurance & balance bill	Limit of 1 routine vision exam/ calendar year. Copay doesn't count toward 3 visit limit. In-network copay waived for members under age 5.
	Glasses/Contact lenses	Not covered	Not covered	Excluded
	Dental check-up	Not covered	Not covered	Excluded

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your benefit book for other excluded services.)

- Acupuncture
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care except as stated in plan
- DME rental/repair charges that exceed DME purchase price
- Experimental and investigational treatments
- Eyewear except as stated in plan
- Flat feet treatment and services
- Genetic and chromosomal testing
- Habilitation services, except certain autism services.
- Hearing aids
- Home health care and infusion therapy exceeding 6 hours of care per member per day
- Homeopathic services
- Infertility medication and treatment
- Inpatient EAR treatment exceeding 120 days per calendar year and inpatient SNF treatment exceeding 180 days per calendar year
- Long-term care, except long-term acute care up to a 365 days benefit plan maximum
- Massage therapy other than allowed under medical coverage guidelines
- Naturopathic services
- Out-of-network Mail Order, out-of-patient Specialty, and out-of-patient 90 day supplies of drugs
- Preventive services not required to be covered by state or federal law
- Private-duty nursing
- Respite care, except as stated in plan
- Routine foot care
- Routine vision exam exceeding 1 visit per calendar year
- Services, tests and procedures that are excluded under medical coverage guidelines.
- Sexual dysfunction treatment and services
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your benefit book for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Non-emergency care when travelling outside the U.S.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-877-475-8440. You may also contact your state insurance department at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-877-475-8440.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 602-864-4884.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 602-864-4884.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**602-864-4884.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-864-4884.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*———————————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,030
- **Patient pays** $3,510

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$60
Coinsurance	$800
Limits or exclusions	$150
Total	**$3,510**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,300
- **Patient pays** $2,100

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$900
Copays	$1,120
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,100**

These examples show the cost share for a policy covering only one person. If the policy covers a spouse and/or children, a member's cost share may be less than the amount shown if other members contribute to or satisfy the family deductible before the Plan receives claims for that one member.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from **in-network providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-877-475-8440 or visit us at www.azblue.com.
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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 yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hólǫ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíílnih 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 .للتحدث مع مترجم اتصل ب .877-475-4799

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 .[877-475-4799 تماس حاصل نمایید.

Assyrian:
ܐܢ ܐܢܬܘܢ، ܝܢ ܚܕ ܦܪܨܘܦܐ ܕܝܬܘܢ ܥܕܘܪܐ ܠܗ، ܐܝܬ ܠܗ ܫܘܐܠܐ ܒܘܬ Blue Cross Blue Shield of Arizona، ܐܝܬ ܠܘܟܘܢ ܙܕܩܐ ܕܩܒܠܝܬܘܢ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘ ܠ 877-475-4799.

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: หากคณ หรอคนทคณกาลงชวยเหลอมคาถามเกยวกบ Blue Cross Blue Shield of Arizona คณมสทธทจะไดรบความชวยเหลอและขอมลในภาษา ของคณไดโดยไมมคาใชจาย พดคยกบลาม โทร 877-475-4799

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these 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 BCBSAZ 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: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance, BCBSAZ's Civil Rights 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, DC 20201, 1 (800) 368-1019, 1 (800) 537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.