EverydayHealth 6500 Neighborhood

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: Individual | **Plan Type:** HMO

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/2017INDBooks** or by calling **1-877-475-8440**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,500**/member	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**. Access fees, balance bills, and payments for **excluded services** don't count to the **deductible**.
Are there other deductibles for specific services?	Yes. **$650**/member for Level 2 and 3 prescription medications.	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. **$7,150**/member	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 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 **network providers**.	If you use a **network** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use an out-of-network **provider** for some services. This plan does not cover services by out-of-network **providers** except in very limited circumstances. 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?	Yes. You need a **referral** to see most **specialists**.	This plan will pay some or all of the costs to see a **specialist** for covered services, but only if you have the plan's permission before you see the **specialist**.
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 requires you to use **network providers** who usually accept the plan's allowed amount. This plan doesn't cover services by out-of-network providers except for emergencies and when use is preapproved. For eligible Indian members enrolled in a qualified health plan purchased through the Health Insurance Marketplace, cost share is waived for covered services from the Indian Health Service, Tribe, or a Tribal or Urban Indian Organization, or through referral under contract health services, regardless of the provider's contract status.

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care (PCP) visit to treat an injury or illness	$30 copay/provider/day	Not covered	Specialist copay for most chiropractic services. Limit of 20 chiropractic services per member/calendar year.
	Specialist visit	$100 copay/provider/day		
	Other practitioner office visit	10% coinsurance		
	Preventive care/screening /immunization	No charge	Not covered	Preventive services not required to be covered by state or federal law.
If you have a test	Diagnostic test (x-ray, blood work)	Office visit copay or 10% coinsurance	Not covered	Cost share varies based on place of service and type of provider. Some tests require precertification.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Network Provider	Non-Network Provider	
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	$35 copay/30 day supply	Not covered	$650/member deductible for Level 2 and 3 prescription drugs before copays or coinsurance apply. 90-day supply costs 3 copays (retail pharmacy) and 2 copays (mail order) for Level 1 and 2 prescription drugs. If generic available, member pays level 1 copay + price difference for brand drug. Some drugs require precertification and won't be covered without it. Only formulary drugs are covered unless a formulary exception is approved.
	Level 2 prescription drugs	$100 copay/30 day supply	Not covered	
	Level 3 prescription drugs	30-day supply at retail or mail order: Higher of 40% coinsurance or $200 minimum. 90-day supply at retail: Higher of 40% coinsurance or $600 minimum. 90-day supply at mail order: Higher of 40% coinsurance or $400 minimum.	Not covered	
	Specialty drugs	50% coinsurance, deductible waived	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Precertification required. Additional $1,000 access fee for all bariatric surgeries.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$750 copay/facility/day		If admitted to hospital, copay is waived and you pay deductible and coinsurance for facility and ancillary services in the ER.
	Emergency medical transportation	10% coinsurance		Deductible waived.
	Urgent care	$100 copay/provider/day	Not covered	Copay applies only to facilities specifically contracted for urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Precertification required. Additional $1,000 access fee for all bariatric surgeries.
	Physician/surgeon fee			

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Copay applies to office, home, walk-in clinic visits. Amount varies based on PCP/Specialist. 10% Coinsurance applies to all other locations.	Not covered	Cost share varies based on place of service and type of provider.
	Mental/Behavioral health inpatient services	10% coinsurance	Not covered	Precertification required.
	Substance use disorder outpatient services	Copay applies to office, home, walk-in clinic visits. Amount varies based on PCP/Specialist. 10% Coinsurance applies to all other locations.	Not covered	Cost share varies based on place of service and type of provider.
	Substance use disorder inpatient services	10% coinsurance	Not covered	Precertification required.
If you are pregnant	Prenatal and postnatal care	Physician: Office visit copay	Not covered	Only 1 copay applies for services included in delivering physician's global charge.
	Delivery and all inpatient services	10% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	10% coinsurance	Not covered	Precertification required. Limit of 42 visits (of up to 4 hours)/calendar year.
	Rehabilitation services • EAR= Extended Active Rehabilitation Facility • SNF = Skilled Nursing Facility	10% coinsurance	Not covered	Precertification required for facility admission. Annual limits: 90 inpatient days for EAR and SNF combined, and 60 outpatient visits each for rehabilitative and habilitative services.
	Habilitation services	10% coinsurance	Not covered	
	Skilled nursing care	10% coinsurance	Not covered	
	Durable medical equipment	Office visit copay or 10% coinsurance	Not covered	Cost share varies based on place of service and type of provider. Precertification required for some durable medical equipment.
	Hospice service	No charge	Not covered	None.
If your child needs dental or eye care	Eye exam	$30 copay/visit	Not covered	Excluded for members age 19 & older. Limit of 1 routine vision exam/calendar year. Copay waived for members under age 5.

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If your child needs dental or eye care	Glasses/Contact lenses	No charge	Not covered	Excluded for members age 19 & older. Limit of 1 pair of glasses or contact lenses/calendar year.
	Dental check-up	No charge	Not covered	Excluded for members age 19 & older. Limit of 2 dental check-ups & cleanings/calendar year.

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
- Adult routine vision exam
- Care that is not medically necessary
- Chiropractic services exceeding 20 visits per calendar year
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care and orthodontic services (Adult) 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 outpatient services exceeding 60 visits per calendar year
- Home health care and infusion therapy exceeding 42 visits (of up to 4 hours) per calendar year
- Homeopathic services
- Infertility medication and treatment
- Inpatient EAR & SNF treatment exceeding 90 days per calendar year
- Long-term care, except long-term acute care
- Massage therapy other than allowed under medical coverage guidelines
- Naturopathic services
- Non-emergency care when traveling outside the U.S.
- Orthodontic services (Pediatric) that are not dentally necessary
- Pediatric dental check-ups exceeding 2 check-ups and cleanings per calendar year
- Pediatric glasses or contact lenses exceeding 1 pair of glasses or contact lenses per calendar year
- Private-duty nursing, except when medically necessary or when skilled nursing not available
- Rehabilitation outpatient services exceeding 60 visits per calendar year
- Respite care
- Routine foot care
- Routine vision exam (child) exceeding 1 visit per calendar year
- Services from providers outside the network, except in emergencies and other limited situations when use preauthorized
- 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	• Hearing aids, up to 1 per ear, per calendar year

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.**

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.

Blue Cross Blue Shield of Arizona does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment in benefit determinations.

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** $2,100
- **Patient pays** $5,440

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	$5,170
Copays	$120
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,440**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,340
- **Patient pays** $3,060

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	$310
Copays	$2,670
Coinsurance	$0
Limits or exclusions	$80
Total	**$3,060**

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 **network providers**. If the patient had received care from out-of-network **providers**, services would not have been covered.

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.

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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' 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 .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:
[illegible] Blue Cross Blue Shield of Arizona، [illegible]
[illegible] 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.