## Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-network and out-of-network: $5,000/individual or $10,000/family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Unless a copay, fee, or other percent is shown, the coinsurance percent of the allowed amount that you pay for most services is 0% in-network (“no charge after deductible”) and 50% out-of-network.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Certain in-network preventive services: in-network primary care and specialist visits; prescription drugs; emergency room care; in-network urgent care visits; hospice services.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
</tbody>
</table>
| What is the out-of-pocket limit for this plan? | In-network: $6,500/individual or $13,000/family
Out-of-network: $13,000/individual or $26,000/family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, out-of-network 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. |
### Important Questions

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<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.azblue.com">www.azblue.com</a> 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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No. You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

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**Important Information:**

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

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): $30 copay, deductible does not apply</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$60 copay, deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge, deductible does not apply</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td></td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
</tbody>
</table>

- Precertification may be required. $500 charge if no precertification for out-of-network services. Specialist copay for most chiropractic. No charge for medical telehealth consultations through BlueCare AnywhereSM.
- 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.
- Precertification may be required. $500 charge if no precertification for out-of-network services. Cost share waived if lab is only service received during physician office visit. Cost share varies based on place of service and provider’s network status & type.

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* For more information about limitations and exceptions, see the plan or policy document at www.azblue.com/member.
### Common Medical Event

#### Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>What You Will Pay</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Network Provider (You will pay the least)</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td><em>If you need drugs to treat your illness or condition</em></td>
<td></td>
</tr>
<tr>
<td>More information about <a href="www.azblue.com">prescription drug coverage</a> is available at <a href="http://www.azblue.com">www.azblue.com</a></td>
<td></td>
</tr>
<tr>
<td>Level 1 (Generic drugs)</td>
<td>$20 copay/30 day supply, deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>$20 copay/30 day supply &amp; balance bill, deductible</td>
</tr>
<tr>
<td></td>
<td>does not apply</td>
</tr>
<tr>
<td>Level 2 (Preferred brand drugs)</td>
<td>$50 copay/30 day supply, deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>$50 copay/30 day supply &amp; balance bill, deductible</td>
</tr>
<tr>
<td></td>
<td>does not apply</td>
</tr>
<tr>
<td>Level 3 (Non-preferred brand drugs)</td>
<td>$80 copay/30 day supply, deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>$80 copay/30 day supply &amp; balance bill, deductible</td>
</tr>
<tr>
<td></td>
<td>does not apply</td>
</tr>
<tr>
<td>Level 4</td>
<td>$140 copay/30 day supply, deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>$140 copay/30 day supply &amp; balance bill, deductible</td>
</tr>
<tr>
<td></td>
<td>does not apply</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Copays (deductible does not apply):</td>
</tr>
<tr>
<td></td>
<td>Level A: $60</td>
</tr>
<tr>
<td></td>
<td>Level B: $110</td>
</tr>
<tr>
<td></td>
<td>Level C: $160</td>
</tr>
<tr>
<td></td>
<td>Level D: $210</td>
</tr>
<tr>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialty copay covers up to a 30-day supply. No</td>
<td></td>
</tr>
<tr>
<td>coverage without precertification.</td>
<td></td>
</tr>
<tr>
<td><em>If you have outpatient surgery</em></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td></td>
<td>Precertification may be required. $500 charge if no</td>
</tr>
<tr>
<td></td>
<td>precertification for out-of-network services.</td>
</tr>
<tr>
<td></td>
<td>Additional $1,000 access fee for all bariatric</td>
</tr>
<tr>
<td></td>
<td>surgeries.</td>
</tr>
<tr>
<td><em>If you need immediate medical attention</em></td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td></td>
<td>No charge after deductible &amp; balance bill</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$50 copay, deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td></td>
<td>Copay applies only to facilities specifically</td>
</tr>
<tr>
<td></td>
<td>contracted for urgent care.</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at www.azblue.com/member.*
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<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge after deductible</td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td></td>
<td>Long-term acute care</td>
<td>No charge after deductible except 50% coinsurance days 101-365</td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office visit copay, deductible does not apply or no charge after deductible. Copay amount varies based on PCP/Specialist</td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge after deductible</td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office Visits</td>
<td>Office visit copay, deductible does not apply or no charge after deductible</td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge after deductible</td>
<td></td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care/Home infusion therapy</td>
<td>No charge after deductible</td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge after deductible except 50% coinsurance for days 61-120 of EAR</td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge after deductible except 50% coinsurance for days 91-180</td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td></td>
<td>In skilled nursing facility (SNF)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Office visit copay, deductible does not apply or no charge after deductible</td>
<td>50% coinsurance &amp; balance bill</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge, deductible does not apply</td>
<td>No charge except balance bill, deductible does not apply</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### 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.)

<table>
<thead>
<tr>
<th>Service</th>
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<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Genetic and chromosomal testing except as stated in plan</td>
<td>Out-of-network Mail Order drugs, out-of-network Specialty drugs, and out-of-network 90-day retail supply of drugs</td>
</tr>
<tr>
<td>Alternative medicine</td>
<td>Habilitation services</td>
<td>Preventive services not required to be covered by state or federal law</td>
</tr>
<tr>
<td>Care that is not medically necessary</td>
<td>Hearing aids</td>
<td>Private-duty nursing</td>
</tr>
<tr>
<td>Cosmetic surgery, cosmetic services &amp; supplies</td>
<td>Home health care and infusion therapy exceeding 6 hours of care per member per day</td>
<td>Respite care except as stated in plan</td>
</tr>
<tr>
<td>Custodial care</td>
<td>Inpatient EAR treatment exceeding 120 days per calendar year and inpatient SNF treatment exceeding 180 days per calendar year</td>
<td>Routine foot care</td>
</tr>
<tr>
<td>Dental care except dental accidents</td>
<td>Long-term care, except long-term acute care up to a 365 days benefit plan maximum</td>
<td>Routine eye care</td>
</tr>
<tr>
<td>DME rental/repair charges that exceed DME purchase price</td>
<td>Massage therapy other than allowed under medical coverage guidelines</td>
<td>Services, tests and procedures that are excluded under medical coverage guidelines</td>
</tr>
<tr>
<td>Experimental and investigational treatments except as stated in plan</td>
<td></td>
<td>Sexual dysfunction treatment and services</td>
</tr>
<tr>
<td>Eyewear except after cataract surgery</td>
<td></td>
<td>Weight loss programs</td>
</tr>
<tr>
<td>Fertility except after cataract surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flat feet treatment and services except as stated in plan</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

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<thead>
<tr>
<th>Service</th>
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<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric surgery</td>
<td>Chiropractic</td>
<td>Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
* For more information about limitations and exceptions, see the plan or policy document at [www.azblue.com/member](http://www.azblue.com/member).
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.

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: Díi kwé’ éeath niilnigií Blue Cross Blue Shield of Arizona haada yit’éégo bina’íidkídgo éí doodago Háidá bijá aniyeedigií t’aaðoo le’é yina’íidkídgo beežah ááníi hóló díi t’á hazaadé’ehjí háká á doowolgo bee haz’á doo bajh ilínggoó. Áta’ halné’íígí kójí bichí’í” hodííhií 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 تساعد له بخصوص Blue Cross Blue Shield of Arizona أي تكلفة للتحدث مع مترجم إعلى ب 877-475-4799.

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

Korean: 만약 당신이 또는 귀하가 대하는 어떤 사람이 Blue Cross Blue Shield of Arizona에 관해 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 이용 부분없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799로 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: آگر شما، یا کسی که شما به‌همراه کمک می‌کنید، سوال در مورد Blue Cross Blue Shield of Arizona داشته باشید، حق دارید که به‌عنوان پاسخگو در مورد سوال خود تماس حاصل نمایید. 877-475-4799 تماس حاصل نمایید.

Assyrian: Blue Cross Blue Shield of Arizona نى، نیسیش، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دinya، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینا، نین دینa

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 หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Blue Cross Blue Shield of Arizonaคุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในการขอสิทธิด้วยไม่มีค่าใช้จ่าย พูดคุยฟรี โทร 877-475-4799

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
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 plan's overall deductible: $5,000
- Specialist copayment: $60
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$5,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$70</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$50</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$5,120</td>
</tr>
</tbody>
</table>

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

- The plan's overall deductible: $5,000
- Specialist copayment: $60
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$50</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,150</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$20</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td>$1,220</td>
</tr>
</tbody>
</table>

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

- The plan's overall deductible: $5,000
- Specialist copayment: $60
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$130</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td>$2,430</td>
</tr>
</tbody>
</table>

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