Summary of Benefits and Coverage: What this <u>Plan</u> Covers & What You Pay for Covered Services Town of Marana Copper PPO \$400

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit azblue.com/member. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-818-0237 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-network</u> : \$400 /individual and \$800 /family <u>Out-of-network</u> : \$800 /individual and \$1,600 /family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <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 10% <u>in-network</u> and 40% <u>out-of-network</u> . Claims applied to the <u>in-network</u> <u>deductible</u> will also apply to the <u>out-of-network</u> <u>deductible</u> and claims applied to the <u>out-of- network</u> <u>deductible</u> will also apply to the <u>in-network</u> <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>in-network preventive</u> services; <u>in-network primary care</u> and <u>specialist</u> visits; <u>prescription drugs;</u> <u>emergency room care</u> ; <u>in-network urgent</u> <u>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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network: \$2,000 /individual and \$5,000 /family <u>Out-of-network</u> : \$4,000 /individual and \$10,000 /family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. Claims applied to the <u>in-network out-of-pocket limit</u> will also apply to the <u>out-of-network out-of-pocket limit</u> and claims applied to the <u>out-of-network out-of-pocket limit</u> will also apply to the <u>in-network out-of-pocket limit</u> .
What is not included in the out-of-pocket limit?	Premiums, out-of-network prior authorization charges, balance-bills, 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 <u>network provider</u> ?	Yes. See www.azblue.com or call 1-855- 818-0237 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

		What Yo	u Will Pay	Limitationa Exacutiona 8 Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$15 <u>copay</u> , <u>deductible</u> does not apply	40% <u>coinsurance</u> & <u>balance</u>	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. <u>Specialist copay</u> for most
If you visit a health care <u>provider's</u> office	<u>Specialist</u> visit	\$35 <u>copay, deductible</u> does not apply	bill	chiropractic services. \$10 <u>copay</u> for Medical telehealth consultations through BlueCare Anywhere SM .
or clinic	Preventive care/screening/ immunization	No charge, <u>deductible</u> does not apply	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	<u>Preventive services</u> not required to be covered by state or federal law are not covered. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)			<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. <u>Cost share</u> waived if lab is
If you have a test	Imaging (CT/PET scans, MRIs)	Office visit <u>copay</u> , <u>deductible</u> does not apply or 10% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply	only service received during physician office visit and at contracted, freestanding, independent clinical labs. <u>Cost share</u> varies based on place of service and provider's network status and type.

		What Yo	u Will Pay	Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
If you need drugs to	Tier 1	\$10 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	Not covered	Some drugs require <u>prior authorization</u> and won't be covered without it. 90-day supply costs 2.5
treat your illness or condition More information about	Tier 2	\$50 <u>copay</u> /30 day supply, <u>deductible</u> does not apply 10% <u>coinsurance</u>	Not covered	<u>copays</u> for retail pharmacy and 2.5 <u>copays</u> for mail order. Retail, Mail order and 90-day retail supply not covered <u>out-of-network</u> . If generic available,
prescription drug coverage is available at	Tier 3	\$100 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	Not covered	member pays Tier 1 <u>copay</u> + price difference for brand drugs.
www.azblue.com	Specialty drugs	\$150 <u>copay, deductible</u> does not apply	Not covered	Specialty <u>copay</u> covers up to a 30-day supply. No coverage without <u>prior authorization</u> .
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for
surgery	Physician/surgeon fees		40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply	out-of-network services.
If you need immediate medical attention	Emergency room care	\$150 <u>copay,</u> <u>deduc</u>	<u>stible</u> does not apply	<u>Copay</u> is waived if you are admitted as an inpatient to the hospital. Admittance for observation is not inpatient. <u>Out-of-network</u> <u>providers</u> can't <u>balance bill</u> for the difference between the <u>allowed amount</u> and the billed charge.
	Emergency medical transportation	10% <u>coinsurance</u>		None
	<u>Urgent care</u>	\$50 <u>copay</u> , <u>deductible</u> does not apply	\$50 <u>copay</u> & <u>balance bill,</u> <u>deductible</u> does not apply	<u>Copay</u> applies only to facilities specifically contracted for <u>urgent care</u> .
	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> 40% <u>coinsurance</u> & <u>balance</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.
If you have a hospital stay	Long-term acute care	10% coinsurance	<u>bill</u> may apply 40% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services. Limit of 365 total LTAC days per member.

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit <u>copay</u> , <u>deductible</u> does not apply or 10% <u>coinsurance</u> . <u>Copay</u> amount varies based on <u>PCP/Specialist</u> .	40% <u>coinsurance</u> & <u>balance</u> bill may apply	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. <u>Copay</u> applies to office, home, walk-in clinic visits. <u>Coinsurance</u> applies to all other locations. \$20 <u>copay</u> for Counseling telehealth consultations and Psychiatric telehealth consultations through BlueCare Anywhere SM .
	Inpatient services	10% coinsurance	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.
	Office Visits	Office visit <u>copay,</u> deductible does not apply	40% <u>coinsurance</u> & <u>balance</u> bill	Other than initial <u>copay</u> , <u>in-network</u> <u>cost-sharing</u> is waived for the physician's global charge and
If you are pregnant	Childbirth/delivery professional services	or 10% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply	physician home/office visits. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or
	Childbirth/delivery facility services	10% coinsurance	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	<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> .

What You Will Pay		u Will Pay	Limitations, Exceptions, & Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	<u>Home health care</u> /Home infusion therapy	10% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	<u>Prior authorization</u> may be required. Claim may be denied or \$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limited to 6 hours of care per member per day. 6 hour limit applies unless medically necessary. Custodial care excluded.
If you need help recovering or	Rehabilitation services• EAR = Extended ActiveRehabilitation Facility• PT/OT/ST = PhysicalTherapy, OccupationalTherapy, Speech Therapy	10% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services. Limit of 180 days/plan year
have other special health needs	Habilitation services	Not covered	Not covered	for EAR and SNF combined. <u>Plan</u> does not cover group physical and occupational therapy.
	Skilled nursing care In skilled nursing facility (SNF)	10% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	
	Durable medical equipment	Office visit <u>copay,</u> <u>deductible</u> does not apply or 10% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for <u>out-of-network</u> services. Cost share varies based on place of service and provider's network status and type.
	Hospice services	10% coinsurance	40% <u>coinsurance</u> & <u>balance</u> <u>bill</u>	Prior authorization may be required. Claim may be denied or \$500 charge if no prior authorization for out-of-network services.
If your child needs	Children's eye exam	Not covered	Not covered	Excluded. <u>Screening</u> for members under age 5 covered under " <u>Preventive care</u> / <u>screening</u> / immunization."
dental or eye care	Children's glasses	Not covered	Not covered	Excluded
	Children's dental check-up	Not covered	Not covered	Excluded

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

- Genetic and chromosomal testing except as stated in <u>plan</u>
- Habilitation services
- Hearing aids
- <u>Home health care</u> and infusion therapy exceeding 6 hours of care per member per day, 6 hour limit applies unless medically necessary.
- Inpatient EAR and Inpatient SNF treatment exceeding a combined 180 days per plan year
- <u>Long-term care</u>, except long-term acute care up to a 365 days benefit <u>plan</u> maximum
- Massage therapy other than allowed under evidence-based criteria

- <u>Out-of-network</u> Retail, Mail Order drugs, <u>out-of-network</u> Specialty drugs, and <u>out-of-network</u> 90-day retail supply of drugs
- <u>Preventive services</u> not required to be covered by state or federal law
- Private-duty nursing
- Respite care except as stated in plan
- Routine eye care
- 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

Chiropractic care

• Non-emergency care when traveling outside the U.S

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

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

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

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

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-855-818-0237. 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 1-855-818-0237. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area or https://difi.az.gov/consumer/i/health.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Multi-language Interpreter Services

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

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

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

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

Arabic:

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

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

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

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

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

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

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

Farsi:

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

Assyrian:

یہ نم مذہ بی مذم دونوں تحمق، دیمگمجفہ حوشق حوم Blue Cross Blue Shield of Arizona، نم مذم دیمگمجف، استماد بوحکیمف، اونداد مخمور تحکیم م تحکیم محمد تحکیم تحکیم

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

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

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

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About These Coverage Examples

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	\$400
Specialist copayment	\$35
Hospital (facility) <u>coinsurance</u>	10%
■ Other coinsurance	10%

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

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In this example, Peg would pay:

Cost Sharing		
<u>Deductibles</u>	\$400	
Copayments	\$50	
Coinsurance	\$960	
What isn't covered		
Limits or exclusions	\$50	
The total Peg would pay is	\$1,460	

■ The plan's overall deductible \$4	ſ
controlled condition)	
(a year of routine in-network care of a well-	
Managing Joe's Type 2 Diabetes	

The <u>plan's</u> overall <u>deductible</u>	\$400
Specialist copayment	\$35
Hospital (facility) <u>coinsurance</u>	10%
Other <u>coinsurance</u>	10%

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

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

Cost Sharing		
Deductibles	\$50	
Copayments	\$690	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$760	

Mia's Simple Fracture

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

The <u>plan's</u> overall <u>deductible</u>	\$400
Specialist copayment	\$35
Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%
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This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

In this example, Mia would pay:

Cost Sharing		
<u>Deductibles</u>	\$400	
<u>Copayments</u>	\$230	
Coinsurance	\$150	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$780	

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

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