# EverydayHealth 4000

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

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

Coverage Period: On and after 02/16/14
**Coverage for:** Individual | **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** or by calling **1-877-475-8440**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network: **$4,000**/member<br>Out-of-network: **$4,500**/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**. Unless a copay, fee, or other percent is shown, the coinsurance percent of the allowed amount that you pay for most services is 20% in-network and 50% out-of-network. Copays, access fees, balance bills, **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<br>Out-of-network: **$12,700**/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, 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. 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 An | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-network Provider | Out-of-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 | 50% coinsurance & balance bill | Limit of 1 routine vision exam/ calendar year at PCP copay. Specialist copay for most chiropractic services. Plan excludes services by acupuncturists, naturopaths & homeopaths. |
| | Specialist visit | $60 copay/ provider/day | | |
| | Other practitioner office visit | 20% coinsurance | | |
| | Preventive care/screening/immunization | No charge | 50% coinsurance & balance bill | Only services covered out-of-network are preventive mammography and foreign travel immunizations. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Office visit copay or 20% coinsurance | 50% coinsurance & balance bill | Cost share varies based on place of service and provider's network status & type. |
| | 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 | Deductible waived. Mail order, Specialty, and 90-day retail supplies of drugs are not covered out-of-network. Cost for 90-day supply is 3 copays at retail pharmacy and 2 copays at mail order pharmacy. 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 | $50 copay/30 day supply | $50 copay/30 day supply & balance bill | |
| | Level 3 prescription drugs | $100 copay/30 day supply | $100 copay/30 day supply & balance bill | |
| | Specialty drugs | 50% coinsurance | Not covered | |

| Common Medical Event | Services You May Need | Your Cost If You Use An | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-network Provider | Out-of-network Provider | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% 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 | $350 copay/facility/day | $350 copay & balance bill | Copay waived if patient is admitted to hospital. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Deductible waived. |
| | 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) | 20% coinsurance | 50% coinsurance & balance bill | Precertification required. $500 charge if no precertification for out-of-network stay. Additional $1,000 access fee for all bariatric surgeries. |
| | Physician/surgeon fee | | | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Office visit copay or 20% coinsurance | 50% coinsurance & balance bill | Cost share varies based on place of service and provider's network status & type. |
| | Mental/Behavioral health inpatient services | 20% coinsurance | | Precertification required. $500 charge if no precertification for out-of-network facility stay. |
| | Substance use disorder outpatient services | Office visit copay or 20% coinsurance | | Cost share varies based on place of service and provider's network status & type. |
| | Substance use disorder inpatient services | 20% coinsurance | | Precertification required. $500 charge if no precertification for out-of-network facility stay. |
| **If you are pregnant** | Prenatal and postnatal care | Physician: Office visit copay | 50% coinsurance & balance bill | Only 1 copay is collected for services included in delivering physician's global charge. Other cost share may apply to services not included in the global charge. |
| | Delivery and all inpatient services | 20% coinsurance | 50% coinsurance & 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 help recovering or have other special health needs** | Home health care/Home infusion therapy | 20% coinsurance | 50% coinsurance & balance bill | Precertification required. $500 charge if no precertification for out-of-network services. Limit of 42 visits (of up to 4 hours)/calendar year. Custodial care is excluded. |
| | Rehabilitation services<br>• EAR = Extended Active Rehabilitation Facility<br>• SNF = Skilled Nursing Facility<br>• PT/OT/ST = Physical therapy, occupational therapy, speech therapy<br>• C&PR = Cardiac and Pulmonary Rehabilitation | 20% coinsurance | 50% coinsurance & balance bill | Precertification required for facility admission. $500 charge if not obtained for out-of-network admission. Limit of 90 days/calendar year for EAR and SNF services combined. Limit of 60 visits/calendar year for rehabilitative and habilitative services (PT, OT, ST and C&PR) combined. No coverage for group PT or OT, private duty nursing, or custodial care. Skilled nursing care covered only through home health and SNF benefits. |
| | Habilitation services | 20% coinsurance | 50% coinsurance & balance bill | |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance & balance bill | |
| | Durable medical equipment | Office visit copay or 20% coinsurance | 50% coinsurance & balance bill | Cost share varies based on place of service and provider's network status & type. No coverage for rental or repair charges that exceed purchase price or for deluxe models that are not medically necessary. |
| | Hospice service | No charge | No charge except balance bill | Custodial & respite care and private duty nursing are not covered. |
| **If your child needs dental or eye care** | Eye exam | $30 copay/visit | 50% coinsurance & balance bill | Limit of 1 routine vision exam/ calendar year. In-network copay waived for members under age 5. |
| | Glasses/Contact lenses | No charge | 50% coinsurance & balance bill, deductible waived | Excluded for members age 19 & older. Limit of 1 pair of glasses or contact lenses/calendar year. |
| | Dental check-up | No charge | No charge except balance bill | 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
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care (Adult) except as stated in plan
- DME rental/repair charges that exceed DME purchase price
- Experimental and investigational treatments
- Eye wear except as stated in plan
- Flat feet treatment and services
- Genetic and chromosomal testing
- Home health care and infusion therapy exceeding 42 visits (of up to 4 hours) per calendar year
- Infertility medication and treatment
- Inpatient EAR & SNF treatment exceeding 90 days per calendar year, and services in most residential treatment facilities except as stated in the plan
- Long-term care, except long-term acute care
- Massage therapy other than allowed under medical coverage guidelines
- Out-of-network Mail Order, Specialty, and 90 day supplies of drugs
- Out-of-network preventive care except mammography and foreign travel immunizations
- Private-duty nursing
- PT, OT, ST, C&PR exceeding 60 visits per calendar year
- Respite care
- Routine vision exam exceeding 1 visit per calendar year
- Services from naturopathic and homeopathic physicians
- 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
- Non-emergency care when travelling outside the U.S.
- Routine foot care

## 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** $3,080
- **Patient pays** $4,460

**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 | $4,000 |
| Copays | $80 |
| Coinsurance | $230 |
| Limits or exclusions | $150 |
| **Total** | **$4,460** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,580
- **Patient pays** $1,820

**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 | $140 |
| Copays | $1,600 |
| Coinsurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$1,820** |

# 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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