Coverage Period: 01/01/2025-12/31/2025 Coverage for: Individual & Family | Plan Type: PPO

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/benefit2025. 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 1-877-475-8440 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$7,000/individual or \$14,000/family Out-of-network: \$7,500/individual or \$15,000/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 30% <u>in-network</u> and 50% <u>out-of-network</u> .
Are there services covered before you meet your deductible?	Yes. In-network: primary care and specialist office visits, preventive services, tier 1 prescription drugs, specialty drugs, urgent care visits, children's eye exams, children's eyeglasses, and children's dental check-ups are covered before you meet your deductible. In-network and out-of-network: emergency medical transportation, and hospice services are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the annual <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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$750/member for Tier 2 and 3 prescription medications.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network: \$8,700/individual or \$17,400/family Out-of-network: \$17,400/individual or \$34,800/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.
What is not included in the out-of-pocket limit?	Premiums, out-of-network prior authorization penalty 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 <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 1-877-475-8440 for a list of in-network providers.	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 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.

Common Medical Services You May		What You Will Pay		Limitations, Exceptions, & Other
Event	Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	\$55 <u>copay/provider</u> /day, <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	\$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. No charge for medical telehealth consultations through BlueCare Anywhere SM .
If you visit a health care provider's office	Specialist visit	\$125 <u>copay/provider/</u> day, <u>deductible</u> does not apply	50% coinsurance & balance bill	Specialist copay for most chiropractic services. \$500 charge if no prior authorization for out-of-network services.
or clinic	Preventive care/screening/immunization	No charge	50% coinsurance & balance bill	Preventive services not required to be covered by state or federal law are not covered. 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.
If you have a toot	Diagnostic test (x-ray, blood work)	Office visit <u>copay</u> (<u>deductible</u> does not apply) or 30% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u> may apply	Cost share varies based on place of service and provider's network status & type. \$500 charge if no prior authorization for out-of-network services.
If you have a test	Imaging (CT/PET scans, MRIs)	Office visit copay (deductible does not apply) or 30% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u> may apply	Cost share varies based on place of service and provider's network status & type. \$500 charge if no prior authorization for out-of-network services.

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* For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025.

Common Medical Event	Services You May Need	What You Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Tier 1a / 1b	Tier 1a: \$3 copay/30 day supply, deductible does not apply Tier 1b: \$35 copay/30 day supply, deductible does not apply	Tier 1a: \$3 copay/30 day supply & balance bill, deductible does not apply Tier 1b: \$35 copay/30 day supply & balance bill, deductible does not apply	90-day supply is 2.5 <u>copays</u> (retail) or 2 <u>copays</u> (mail order). Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it. View the Tier 1a Drug List at https://azblue.com/pharmacy-management/Tier1a-Drug-List .
If you need drugs to treat your illness or condition More information about prescription drug coverage is	Tier 2	\$115 <u>copay</u> /30 day supply	\$115 <u>copay</u> /30 day supply & <u>balance bill</u>	\$750/member deductible for Tier 2 and 3 prescription drugs before copays or coinsurance apply. 90-day supply is 2.5 copays (retail) or 2 copays (mail order). If a generic drug is available, pay the generic cost share + the price difference between the allowed amount for the brand and generic drugs. Some drugs require prior authorization or a formulary exception and won't be covered without it.
available at www.azblue.com	Tier 3	\$205 <u>copay</u> /30 day supply	\$205 <u>copay</u> /30 day supply & <u>balance bill</u>	\$750/member deductible for Tier 2 and 3 prescription drugs before copays or coinsurance apply. 90-day supply is 2.5 copays (retail) or 2 copays (mail order). If a generic drug is available, pay the generic cost share + the price difference between the allowed amount for the brand and generic drugs. Some drugs require prior authorization or a formulary exception and won't be covered without it.
	Specialty drugs	50% <u>coinsurance</u> , <u>deductible</u> does not apply	Not covered	Some drugs require <u>prior authorization</u> or a <u>formulary</u> exception and won't be covered without it.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	\$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	Physician/surgeon fees	30% coinsurance	50% coinsurance & balance bill may apply	Additional \$1,000 access fee for all bariatric surgeries. \$500 charge if no prior authorization for out-of-network services.

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* For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025.

Common Medical Event	Services You May Need	What You Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need	Emergency room care	30% coinsurance		Out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge.
immediate medical attention	Emergency medical transportation	30% <u>coinsurance, dec</u>	ductible does not apply	None.
	Urgent care	\$125 <u>copay/provider/day,</u> <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	None.
If you have a	Facility fee (e.g., hospital room)	30% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	\$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
hospital stay	Physician/surgeon fees	30% coinsurance	50% coinsurance & balance bill may apply	Additional \$1,000 access fee for all bariatric surgeries. \$500 charge if no prior authorization for out-of-network services.
If you need mental health, behavioral health, or substance abuse	Outpatient services	Copay applies to office, home, walk-in clinic visits (deductible does not apply). Amount varies based on PCP/Specialist. 30% coinsurance applies to all other locations.	50% <u>coinsurance</u> & <u>balance bill</u> may apply	Cost share varies based on place of service and provider's network status & type. \$500 charge if no prior authorization for out-of-network services. \$20 copay for counseling or \$45 copay for psychiatric telehealth consultations through BlueCare Anywhere SM .
Inpatient services 30% coinsura		30% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u> may apply	\$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
If you are pregnant	Office Visits	Office visit copay (deductible does not apply) or 30% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Depending on type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in SBC (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>in-network preventive services</u> .
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance & balance bill may apply	Only 1 <u>copay</u> is collected for services included in delivering physician's global charge. Depending on type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	30% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Depending on type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.

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* For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025.

Common Medical Event	Services You May Need	What You Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care/ Home infusion therapy	30% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	\$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Limit of 42 visits (of up to 4 hours)/calendar year.
	Rehabilitation services • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy	30% coinsurance	50% coinsurance & balance bill	\$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Annual limits: 90 <u>inpatient</u> days for Extended Active Rehabilitation Facility (EAR) and Skilled Nursing Facility (SNF) combined, and a 60-visit limit each for outpatient <u>rehabilitative</u> and <u>habilitative</u> services.
If you need help recovering or have other	Habilitation services	30% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	\$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Annual limits: 90 <u>inpatient</u> days for EAR and SNF combined, and a 60-visit limit each for outpatient <u>rehabilitative</u> and <u>habilitative</u> services.
special health needs	Skilled nursing care	30% coinsurance	50% coinsurance & balance bill	\$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services. Annual limits: 90 <u>inpatient</u> days for EAR and SNF combined, and a 60-visit limit each for outpatient <u>rehabilitative</u> and <u>habilitative</u> services.
	Durable medical equipment	Office visit copay (deductible does not apply) or 30% coinsurance	50% coinsurance & balance bill	Cost share varies based on place of service and provider's network status & type. \$500 charge if no prior authorization for out-of-network services.
	Hospice services	No charge	No charge except <u>balance</u> <u>bill</u> , <u>deductible</u> does not apply	\$500 charge if no <u>prior authorization</u> for <u>out-of-network</u> services.
	Children's eye exam	No charge	50% coinsurance & balance bill	Limit of 1 routine vision exam/calendar year.
If your child needs dental or eye care	Children's glasses	No charge	Not covered	Limit of 1 pair of glasses or contact lenses/calendar year.
	Children's dental check-up	No charge	No charge except <u>balance</u> <u>bill</u> , <u>deductible</u> does not apply	Limit of 2 dental check-ups & cleanings/calendar year.

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* For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025.

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.)

- Acupuncture
- Adult routine vision exam
- Alternative medicine
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care and orthodontic services (Adult) except as stated in <u>plan</u>
- <u>DME</u> rental/repair charges that exceed <u>DME</u> allowed amount

- Experimental and investigational treatments except as stated in <u>plan</u>
- Eyewear except as stated in plan
- Fertility and infertility medication and treatment
- Flat feet treatment and services
- Genetic and chromosomal testing, except as stated in plan
- Home health care and infusion therapy exceeding 42 visits (of up to 4 hours)/calendar year
- Long-term care, except long-term acute care
- Massage therapy other than allowed under evidence-based criteria

- Orthodontic services (Pediatric) that are not dentally necessary
- Out-of-network Mail Order and out-of-network Specialty
- Private-duty nursing, except when <u>medically</u> necessary or when <u>skilled nursing</u> not available
- Respite care
- Routine foot care
- 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 plan document.)

- Bariatric surgery
- Chiropractic care

- Hearing aids, up to 1 per ear, per calendar year
- Non-emergency care when travelling outside the U.S.

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^{*} For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025.

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 <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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> 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 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 or https://difi.az.gov/consumer/i/health.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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.

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^{*} For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025.

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 hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínígóó. Ata' halne'ígíí kojí' bich'j' 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 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 로전화하십시오.

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:

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 คณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมลในภาษาของคณได้โดยไม่มีค่าใช้จ่าย พดคยกับล่าม 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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 <u>plan's</u> overall <u>deductible</u>	\$7,000
■ Specialist copayment	\$125
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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)

|--|

In this example, Peg would pay:

Cost Sharing		
<u>Deductibles</u> *	\$7,000	
Copayments	\$140	
<u>Coinsurance</u>	\$890	
What isn't covered		
Limits or exclusions	\$50	
The total Peg would pay is	\$8,080	

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$7,000
■ Specialist copayment	\$125
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing		
<u>Deductibles</u> *	\$330	
Copayments	\$1,650	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$2,000	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$7,000
■ <u>Specialist</u> <u>copayment</u>	\$125
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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> *	\$1,350
Copayments	\$210
Coinsurance	\$280
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,840

^{*}Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

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