City of Surprise HMO

Coverage Period: 07/01/2016-06/30/2017

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

Coverage for: Individual & Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.azblue.com** or by calling **1-877-475-8440**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$0**/member	See the chart starting on page 2 for your costs for services this plan covers. Unless a copay, fee or different percentage is shown, the coinsurance percentage of the allowed amount that you will pay for most services is 0%.
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: **$2,000**/member and **$4,000**/family	The **out-of-pocket limit** is the most you could pay during a plan 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**.

- **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**.

Questions: Call **1-877-475-8440** or visit us at **www.azblue.com**.
If you aren't clear about any of the underlined 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.

- 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 a lower cost-share for their services. A noncontracted provider can charge full billed charges, and the plan will reimburse you based only on the plan **allowed amount**, minus your cost share.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per member/provider/day	Not covered	Specialist copay applies to most chiropractic services. Maximum of 12 visits per member, per calendar year. Plan doesn't cover acupuncture & services by naturopaths & homeopaths. In-network routine vision exam limited to 1 exam per calendar year; subject to $15 copay.
	Specialist visit	$30 copay per member/provider/day		
	Other practitioner office visit	No charge		
	Preventive care/ screening/immunization	No charge	Not covered	Provider's diagnosis and procedure codes determine whether service is preventive.
If you have a test	Diagnostic test (x-ray, blood work)	Office visit copay &/or no charge for most professional services	Not covered	Cost share waived at contracted, freestanding, independent clinical labs. Cost share varies based on place of service and type of provider(s). Professional services by a radiologist, pathologist, and dermapathologist always subject to deductible and coinsurance.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.azblue.com/Rx.	Level 1 prescription drugs	Retail: $7 copay Mail Order: $14 copay	Not covered	Some drugs require precertification and won't be covered without it. Copays apply each time you fill a prescription supply. Retail copay covers up to a 30-day supply. Mail order copay covers up to 90-day supply. 90 day supply available at retail for 3x copays. Mail order and specialty are not covered out of network.
	Level 2 prescription drugs	Retail: $25 copay Mail Order: $50 copay	Not covered	
	Level 3 prescription drugs	Retail: $45 copay Mail Order: $90 copay	Not covered	
	Specialty Drugs	Level A: $30 copay Level B: $60 copay Level C: $90 copay Level D: $120 copay	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$75 copay per member/facility/day, then no charge		Copay is waived if you are admitted to the hospital.
	Emergency medical transportation	No charge		None
	Urgent care	$35 copay per member/provider/day	Not covered	Copay applies only to facilities specifically contracted for urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay per member/admission	Not covered	Precertification required.
	Physician/surgeon fee			
	Long-term acute care	$250 copay per member/admission	Not covered	Precertification required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	Not covered	None
	Mental/Behavioral health inpatient services	$250 copay per member/admission		Precertification required for non-emergency admissions.
	Substance use disorder outpatient services	No charge		None
	Substance use disorder inpatient services	$250 copay per member/admission		Precertification required for non-emergency admissions.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	Physician: Office visit copay Hospital: $250 copay per member/admission	Not covered	In-network: Other than initial copay, cost-sharing is waived on physician's global delivery fee.
	Delivery and all inpatient services			
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	No charge	Not covered	Limited to 6 hours of care per member per day. Custodial care excluded. Certain drugs not covered without precertification.
	EAR = Extended Active Rehabilitation Facility	No charge except 50% coinsurance days 61-120 of EAR inpatient stay	Not covered	Precertification required for inpatient stay in EAR facility. Benefit limit of 120 days/member/plan year for EAR inpatient stay.
	PT/OT/ST = Physical therapy, occupational therapy, speech therapy	No charge up to certain number of modalities and treatments.	Not covered	PT/OT: 50% coinsurance after 80 modalities per plan year. ST: 50% coinsurance after 20 visits per plan year. Plan doesn't cover group physical and occupational therapy.
	Habilitation services	Not covered		Excluded
	Skilled nursing care In skilled nursing facility (SNF)	No charge except 50% coinsurance days 91-180	Not covered	Precertification required. Benefit limit of 180 days per member per plan year. Private duty nursing not covered.
	Durable medical equipment	Office visit copay or no charge	Not covered	No coverage for rental or repair charges that exceed purchase price or for deluxe models that aren't medically necessary.
	Hospice service	No charge	Not covered	None
If your child needs dental or eye care	Eye exam	$15 copay/visit. No charge for members under age 5.	Not covered	Routine vision exam limited to 1 exam per calendar year.
	Glasses	Not covered		Excluded
	Dental check-up	Not covered		Excluded

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
- Chiropractic services exceeding 12 visits
- Cosmetic surgery
- Dental care except dental accidents
- Experimental and investigational treatments
- Eye wear except after cataract surgery
- Habilitation care
- Hearing aids
- Infertility treatment
- Inpatient extended active rehabilitation treatment over 120 days per plan year
- Long-term care (except long-term acute care)
- Massage therapy other than allowed under medical coverage guidelines
- Out-of-network mail order prescriptions and specialty medications
- Out-of-network preventive care
- Private-duty nursing
- Routine eye care except one exam per calendar year
- Routine foot care
- Services from naturopathic and homeopathic physicians
- Services from non-contracted providers, except for emergencies and when is use preauthorized
- Sexual dysfunction
- Skilled nursing facility treatment over 180 days per plan year
- Smoking cessation programs, medications, aids and devices
- Weight loss programs except as stated in the benefit plan

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
- Non-emergency care when travelling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-475-8440. You may also contact your state insurance department at (602) 364-2499 or (800) 325-2548, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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** $7,350
- **Patient pays** $190

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	$0
Copays	$40
Coinsurance	$0
Limits or exclusions	$150
Total	**$190**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,450
- **Patient pays** $950

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	$0
Copays	$870
Coinsurance	$0
Limits or exclusions	$80
Total	**$950**

This example shows the cost share for a policy covering only one person. If the policy covers a spouse and/or children, a member's cost share may be less than the amount shown if other members contribute to or satisfy the family deductible before the Plan receives claims for that one member.

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.

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