Health Choice Value Silver 94%

Coverage Period: 01/01/2016 - 12/31/2016

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 Evidence of Coverage at www.healthchoiceessential.com/members/member_benefits.aspx or by calling 1-855-452-4242.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** per person / **$200** per family. Does not apply to preventive care.	The deductible applies to every covered benefit unless the Schedule of Benefits of this plan says it does not apply. Check your Evidence of Coverage for more information on individual, family and calendar year **deductible**. See the chart starting on page 2 for how much you pay for covered services after you meet 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, **$1,100** person / **$2,200** family	The **out-of-pocket limit** is the most you could pay during a coverage period 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, amounts for non-covered benefits, preventative service with no cost share, charges for lack of prior authorizations	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see www.healthchoiceessential.com/MyProvider or call 855-452-4242.	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. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. 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?	Yes, written referral, prior authorization, is required for specialists.	See your Evidence of Coverage for additional information.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 of this document. See your Evidence of Coverage for additional information about **excluded services**.

Questions: Call 1-855-452-4242 or visit us at www.healthchoiceessential.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.healthchoiceessential.com/glossary or call 1-855-452-4242 to request a copy.

- **Copayments** 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 may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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, whether medical, mental health or substance use.	$7 Copay per visit	Not Covered	
	Specialist visit, whether medical, mental health or substance use.	$ 35 Copay per visit, after deductible	Not Covered	Prior authorization required.
	Other practitioner office visit	$7 Copay per visit	Not Covered	Prior authorization required.
	Preventive care/screening/immunization	No charge	Not Covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance per visit after deductible	Not Covered	Prior authorization required except if covered under primary care office visit.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance per visit after deductible	Not Covered	Prior authorization required.
	Generic drugs	$5 copay retail,	Not Covered	Covers up to a 30-day supply

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthchoiceessential.com/members/rxdrugs.aspx		$25 copay before deductible mail order		(retail prescription); 31-90 day supply (mail order prescription – excluding specialty & oncology drugs). No charge for preventive health medications and supplies. Prior authorization may be required for certain prescriptions, consult formulary for details at www.healthchoiceessential.com/docs/providers/formulary/formulary.pdf
	Preferred brand drugs	$25 copay retail, $112.50 copay after deductible mail order	Not Covered	
	Non-preferred brand drugs	50% coinsurance after deductible retail and mail order	Not Covered	
	Specialty drugs	50% coinsurance retail, mail order not applicable	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance per visit, after deductible	Not Covered	Prior authorization required for outpatient surgery.
	Physician/surgeon fees	10% coinsurance per visit, after deductible	Not Covered	Prior authorization required for outpatient surgery.
If you need immediate medical attention	Emergency room services	20% coinsurance per visit after deductible	30% coinsurance per visit after deductible	Out-of-Network cost share same as in-network.
	Emergency medical transportation	10% coinsurance per visit, after deductible	20% coinsurance per visit after deductible	Out-of-Network cost share same as in-network.
	Urgent care	10% coinsurance per visit, after deductible	Not Covered	If traveling outside the plan service area, contact your primary care provider and the Health Choice Insurance Co. Prior Authorization Department prior to receiving services.

If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance per visit after deductible	Not Covered	Prior authorization required for hospital admissions.
	Physician/surgeon fee	10% coinsurance per visit after deductible	Not Covered	Prior authorization required for inpatient surgery.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$7 copay per primary care provider visit / $35 Copay per visit for specialist, after deductible	Not Covered	Please see "If you visit a health care provider's office or clinic" section above.
	Mental/Behavioral health inpatient services	10% coinsurance per visit after deductible	Not Covered	Prior authorization required for inpatient services.
	Substance use disorder outpatient services	$7 copay per primary care provider visit / $35 Copay per visit for specialist, after deductible	Not Covered	Please see "If you visit a health care provider's office or clinic" section above.
	Substance use disorder inpatient services	10% coinsurance per visit, after deductible	Not Covered	Prior authorization required. Two treatments per year.
If you are pregnant	Prenatal and postnatal care	10% coinsurance per visit after deductible	Not Covered	Prior authorization required.
	Delivery and all inpatient services	10% coinsurance per visit after deductible	Not Covered	Prior authorization required if a decision is made to lengthen the time of inpatient stay to more than forty-eight (48) hrs. (Vaginal delivery) or

				ninety-six (96) hrs. (Cesarean delivery).
If you need help recovering or have other special health needs	Home health care	10% coinsurance per visit after deductible	Not Covered	42 visits per year, prior authorization required.
	Rehabilitation services	10% coinsurance per visit, after deductible	Not Covered	Coverage is limited to 60 visits PT/OT/ST combined, prior authorization required.
	Habilitation services	10% coinsurance per visit after deductible	Not Covered	Coverage is limited to 60 visits, prior authorization required.
	Skilled nursing care	10% coinsurance per visit after deductible	Not Covered	Coverage is limited to 90 visits, prior authorization required.
	Durable medical equipment	10% coinsurance after deductible	Not Covered	Prior authorization required for charges over $300.
	Hospice service	10% coinsurance after deductible	Not Covered	Prior authorization required.
If your child needs dental or eye care (Children under 19 years)	Eye exam	No Charge	Not Covered	Coverage is limited to 1 routine exam per year.
	Glasses	No Charge	Not Covered	Coverage is limited to 1 pair of glasses (lenses and frames) or contact lenses per year.
	Dental check-up	No Charge	Not Covered	Coverage is limited to 1 visit every 6 months.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your Evidence of Coverage for other excluded services.)

- Abortions for which public funding is prohibited
- Cosmetic Surgery
- Infertility treatment
- Long-term care
- Cost for services while traveling outside the United States.
- Routine foot care
- Weight loss programs
- Homeopathy

Other Covered Services (This isn't a complete list. Check your Evidence of Coverage for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Hearing aids – limited to 1 hearing aid per ear per year
- Routine eye care (Adult) – limited to 1 routine exam per year

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep 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 855-452-4242. You may also contact your state insurance department at (602) 364-3100, www.id.state.az.us/

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 us by calling our toll free number 855-452-4242. You may also contact your State Department of Insurance at (602) 364-3100, www.id.state.az.us/

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855-452-4242.

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** $6,696
- **Patient pays** $844

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	$100
Copays	$0
Coinsurance	$744
Limits or exclusions	$0
Total	**$844**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,092
- **Patient pays** $308

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	$100
Copays	$208
Coinsurance	$0
Limits or exclusions	$0
Total	**$308**

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.