The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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 <u>azblue.com/member</u> or call 1-928-526-7211 or 1-855-845-1875. 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 <u>healthcare.gov/sbc-glossary</u> or by calling 1-928-526-7211 or 1-855-845-1875 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network and out-of-network providers combined: \$1,750/member and \$3,500/family <u>Deductible</u> is based on calendar year and starts over each January 1 <sup>st</sup> .	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. 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 20% <u>in-network</u> and 40% <u>out-of-network</u> .
Are there services covered before you meet your <u>deductible?</u>	Yes. Certain <u>in-network</u> <u>preventive</u> services are covered before you meet your <u>deductible</u> .	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 providers: \$5,000/member and \$10,000/family Out-of-network providers: \$7,000/member and \$14,000/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</u> <u>limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, out-of-network 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 <u>out–of–pocket</u> limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use an <u>in-network</u> <u>provider</u> ?	Yes. See www.azblue.com or call 1-928-526-7211 or 1-855-845-1875 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 specialist you choose without a referral.

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	
Common Medical Event	Services You May Need	In-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	20% <u>coinsurance</u>		Precertification may be required. \$500 charge if no precertification for out-of-network services.
lf you visit a health	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	Maximum of twelve (12) chiropractic visits per calendar year. Limit of 1 hearing exam per calendar year. Limit of \$500 per calendar year for acupuncture. Medical telehealth consultations covered through BlueCare Anywhere.
care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No charge, <u>deductible</u> does not apply	40% <u>coinsurance</u> & <u>balance 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>Deductible</u> is waived for <u>out-of-network</u> mammography. Routine physical exam excluded <u>out-of-network</u> .
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance &	Precertification may be required. \$500 charge if
	Imaging (CT/PET scans, MRIs)		balance bill	no precertification for out-of-network services.

Common Medical Event	Services You May Need	What Yo In-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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or 1-877-456-0109.	Prescription drugs	20% <u>coinsurance</u> (\$8 minimum) after <u>deductible</u> is met	40% <u>coinsurance</u> (\$8 minimum) after <u>deductible</u> is met	Retail limited to 30 day supply Retail90 limited to 90 day supply Mail Order limited to 90 day supply Specialty Drug: 30 day maximum on Injectables only 90 day supply through specialty mail Calendar year <u>deductible/out-of-pocket</u> combined with medical
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	Precertification may be required. \$500 charge if no precertification for out-of-network services. Additional \$1,000 access fee for all bariatric surgeries.
If you need immediate	Emergency room care Emergency medical transportation	\$150 access fee per member/facility/day <u>,</u> then 20% <u>coinsurance</u> 20% <u>coinsurance</u>		Access fee is waived if you are admitted to the hospital.
medical attention	Urgent care	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	None
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u> & balance bill	<u>Precertification</u> may be required. \$500 charge if no <u>precertification</u> for <u>out-of-network</u> services. Additional \$1,000 access fee for all bariatric
If you have a hospital	Physician/surgeon fee			surgeries.
stay	Long-term acute care (LTAC)	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	<u>Precertification</u> may be required. \$500 charge if no <u>precertification</u> for <u>out-of-network</u> services. Limit of 365 total LTAC days per member.
If you need mental health, behavioral health, or substance	Outpatient Services	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	Counseling telehealth consultations and Psychiatric telehealth consultations covered through BlueCare Anywhere.
abuse services	Inpatient Services	20% coinsurance	40% <u>coinsurance</u> & <u>balance bill</u>	Precertification may be required. \$500 charge if no precertification for out-of-network services.

		What Yo	u Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Office visits			Maternity care may include tests and services
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% <u>coinsurance</u> & <u>balance bill</u>	described elsewhere in the SBC (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>in-network</u>
	Childbirth/delivery facility services			preventive services.
	Home health care/Home infusion therapy	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	Precertification may be required. \$500 charge if no precertification for out-of-network services. Limited to 6 hours of care per member per day.
<u>Reh</u> ● E/ Fa ● P	<ul> <li><u>Rehabilitation services</u></li> <li>EAR = Extended Active <u>Rehabilitation</u> Facility</li> <li>PT/OT/ST = Physical therapy, occupational therapy, speech therapy</li> </ul>	20% <u>coinsurance</u> except 50% <u>coinsurance</u> for days 61-120 of EAR	40% <u>coinsurance</u> & <u>balance bill</u> except 50% <u>coinsurance</u> & <u>balance bill</u> for days 61-120 of EAR	Precertification may be required. \$500 charge if no precertification for out-of-network services.
If you need help	Habilitation services	Not covered	Not covered	Limit of 120 days/calendar year for EAR and 180 days/calendar year for SNF. Physical medicine
If you need help recovering or have other special health needs	<u>Skilled nursing care</u> in skilled nursing facility (SNF)	20% <u>coinsurance</u> except 50% <u>coinsurance</u> for days 91-180	40% <u>coinsurance</u> & <u>balance bill</u> except 50% <u>coinsurance</u> & <u>balance bill</u> for days 91-180	performed by a chiropractor applies toward the chiropractic limit.
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	Precertification may be required. \$500 charge if no precertification for out-of-network services. Hearing aids limited to \$2,500 per person, every 3 calendar years.
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u> & <u>balance bill</u>	Precertification may be required. \$500 charge if no precertification for out-of-network services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded. Screening for members under age 5 covered under "Preventive care / screening / immunization."
ueritar or eye care	Children's glasses	Not covered	Not covered	Excluded
	Children's dental check-up	Not covered	Not covered	Excluded

## Excluded Services & Other Covered Services:

<ul> <li>Alternative medicine</li> <li>Care that is not <u>medically necessary</u></li> <li>Cosmetic surgery, cosmetic services &amp; supplies</li> <li>Custodial care</li> <li>Dental care except as stated in <u>plan</u></li> <li><u>DME</u> rental/repair charges that exceed <u>DME</u> purchase price</li> <li>Experimental and investigational treatments except as stated in <u>plan</u></li> <li>Eyewear except as stated in <u>plan</u></li> <li>Flat feet treatment and services</li> <li>Fertility and infertility medication and treatment</li> <li>Genetic and chromosomal testing, except as stated in plan</li> </ul>	<ul> <li><u>Habilitation</u> services</li> <li>Hearing aids</li> <li><u>Home health care</u> and infusion therapy exceeding 6 hours of care per member per day</li> <li><u>Inpatient</u> EAR treatment exceeding 120 days per calendar year and <u>inpatient</u> SNF treatment exceeding 180 days per calendar year</li> <li><u>Long-term care</u>, except long-term acute care up to a 365 days benefit <u>plan</u> maximum</li> <li>Massage therapy other than allowed under medical coverage guidelines</li> </ul>	<ul> <li><u>Out-of-network</u> routine physicals</li> <li><u>Preventive services</u> not required to be covered by state or federal law</li> <li>Private-duty nursing</li> <li>Respite care, except as stated in <u>plan</u></li> <li>Routine foot care</li> <li>Routine eye care for members over age 5</li> <li>Services, tests and procedures that are excluded under medical coverage guidelines</li> <li>Sexual dysfunction treatment and services</li> <li>Weight loss programs</li> </ul>
---	---	--

Bariatric surgery	•	Hearing aids limited to \$2,500 per person, every	٠	Non-emergency care when traveling outside the
Chiropractic services (up to 12 visits)		3 calendar years.		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 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 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 Grievance and Appeals 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 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 1-928-526-7211 or 1-855-845-1875. 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 1-928-526-7211 or 1-855-845-1875. 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.

## Does this plan provide Minimum Essential Coverage? Yes

If you don't have <u>Minimum Essential Coverage</u> 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.

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



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 Bab (9 months of in-network pre-natal of hospital delivery)		Managing Joe's Type 2 Diak (a year of routine in-network care of controlled condition)		Mia's Simple Fractu (in-network emergency room visit a care)	
<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist coinsurance</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	\$1,750 20% 20% 20%	<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist</u> <u>coinsurance</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	\$1,750 20% 20% 20%	<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist coinsurance</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	\$1,750 20% 20% 20%
his EXAMPLE event includes service		This EXAMPLE event includes service <u>Primary care physician</u> office visits ( <i>inclu</i> <u>disease aducation</u> )		This EXAMPLE event includes set Emergency room care (including me	
Childbirth/Delivery Professional Service Childbirth/Delivery Facility Services <u>Diagnostic tests</u> ( <i>ultrasounds and blood</i> Specialist visit <i>(anesthesia)</i>		<i>disease education)</i> <u>Diagnostic tests</u> <i>(blood work)</i> <u>Prescription drugs</u> <u>Durable medical equipment</u> <i>(glucose me</i>	ter)	supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutche <u>Rehabilitation services</u> (physical the	,
Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood		Diagnostic tests (blood work) Prescription drugs	ter) \$7,400	Diagnostic test (x-ray) Durable medical equipment (crutche	,
Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Specialist visit (anesthesia)	d work)	<u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose me		Diagnostic test (x-ray) Durable medical equipment (crutche Rehabilitation services (physical the	rapy)
Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Specialist visit (anesthesia) Total Example Cost	d work)	<u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose me Total Example Cost		<u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutche <u>Rehabilitation services</u> (physical the Total Example Cost	rapy)
Childbirth/Delivery Facility Services <u>Diagnostic tests</u> ( <i>ultrasounds and blood</i> <u>Specialist</u> visit <i>(anesthesia)</i> Total Example Cost n this example, Peg would pay:	d work)	<u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose me <b>Total Example Cost</b> In this example, Joe would pay:		Diagnostic test (x-ray) Durable medical equipment (crutche Rehabilitation services (physical the Total Example Cost In this example, Mia would pay:	rapy)
Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Opecialist visit (anesthesia) Total Example Cost In this example, Peg would pay: Cost Sharing	d work) \$12,700	Diagnostic tests (blood work)         Prescription drugs         Durable medical equipment (glucose me         Total Example Cost         In this example, Joe would pay:         Cost Sharing	\$7,400	Diagnostic test (x-ray) Durable medical equipment (crutche Rehabilitation services (physical the Total Example Cost In this example, Mia would pay: Cost Sharing	(1,900 \$1,900
Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Opecialist visit (anesthesia) Total Example Cost n this example, Peg would pay: Cost Sharing Deductibles	d work) \$12,700 \$1,750	Diagnostic tests       (blood work)         Prescription drugs       Durable medical equipment (glucose medical equipment)         Total Example Cost       In this example, Joe would pay:         Cost Sharing         Deductibles	\$7,400 \$1,750	Diagnostic test (x-ray)         Durable medical equipment (crutche         Rehabilitation services (physical the         Total Example Cost         In this example, Mia would pay:         Cost Sharing         Deductibles	(\$1,900) \$1,750
Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Specialist visit (anesthesia) Total Example Cost n this example, Peg would pay: Cost Sharing Deductibles Copayments	d work) \$12,700 \$1,750 \$0	Diagnostic tests (blood work)         Prescription drugs         Durable medical equipment (glucose me         Total Example Cost         In this example, Joe would pay:         Cost Sharing         Deductibles         Copayments	\$7,400 \$1,750 \$0	Diagnostic test (x-ray)         Durable medical equipment (crutche Rehabilitation services (physical the         Total Example Cost         In this example, Mia would pay:         Cost Sharing         Deductibles         Copayments	xrapy) \$1,900 \$1,750 \$0 \$40
Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Opecialist visit (anesthesia) Total Example Cost n this example, Peg would pay: Cost Sharing Deductibles Copayments Coinsurance	d work) \$12,700 \$1,750 \$0	Diagnostic tests       (blood work)         Prescription drugs       Durable medical equipment (glucose medical equipment)         Total Example Cost       In this example, Joe would pay:         Cost Sharing         Deductibles       Copayments         Coinsurance       Coinsurance	\$7,400 \$1,750 \$0	Diagnostic test (x-ray)         Durable medical equipment (crutche         Rehabilitation services (physical the         Total Example Cost         In this example, Mia would pay:         Cost Sharing         Deductibles         Copayments         Coinsurance	xrapy) \$1,900 \$1,750 \$0 \$40

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

## **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 kojį' bich'į' 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 اللتحدث مع مترجم اتصل ب 4799-475-479.

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 .4799-475-479 تماس حاصل نمایید.

Assyrian:

یہ ټسمف، بې ښټ فخېوفې ډښمودومۍ ټمف، دېمگمجف، دوفتو دوم Blue Cross Blue Shield of Arizona، ټسمف، دېمگمجف، فسومډ دفته وخمد مخمو تحکثمونه، خکّته کېموونې ښټ ښټ مخدکېنه، مود تسمه، ښک چکبهه، چدننه 1979-475-479.

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 Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and 1 (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance, BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <a href="https://orrportal.hhs.gov/ocr/">https://orrportal.hhs.gov/ocr/</a> portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1 (800) 368-1019, 1 (800) 537-7697 (TDD). Complaint forms are available at <a href="https://www.hhs.gov/ocr/office/file/index.html">https://www.hhs.gov/ocr/office/file/index.html</a>.