Arizona State Retirement System

2015

The Affordable Care Act & The Arizona Health Insurance Marketplace

A Guide for Non-Medicare Members

There are four main points for ASRS retirees to keep in mind:

1) The ASRS retiree health insurance program meets the health care requirements outlined by the Affordable Care Act (ACA).
2) If you are not eligible for Medicare and have health insurance through the ASRS or your ASRS employer, you now have additional health insurance options through the Arizona Health Insurance Marketplace.
3) If you are not eligible for Medicare and do not now participate in ASRS retiree health insurance or otherwise have health insurance, in most cases you will be required to obtain coverage or pay a penalty.
4) If you are eligible for Medicare and participate in a Medicare plan, either through the ASRS or some other option, the Affordable Care Act and the plans available in the Arizona Health Insurance Marketplace do not apply to you.

The Affordable Care Act

The federal Patient Protection and Affordable Care Act (ACA) was signed into law by President Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, which was signed into law on March 30, 2010, they represent the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

The ACA aims to increase the quality and affordability of health insurance, lower the number of uninsured by expanding public and private insurance coverage, and reduce the overall costs of healthcare. It provides a number of mechanisms, including mandates, subsidies and an insurance exchange, with the goal of improving coverage and affordability. The law also requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or gender.

The ACA requires each state to operate or participate in a web-based Health Insurance Marketplace, also known as an exchange, where people may purchase private insurance coverage. Coverage began on January 1, 2014. Open enrollment periods are conducted annually.

Through the online Health Insurance Marketplace, consumers will be able to compare plans, prices and healthcare providers. The primary goal of the ACA is to provide access to the uninsured and to provide a competitive marketplace for plan premiums and coverage.

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Disclaimer

Every attempt to present accurate information in this brochure has been taken. Information has been gleaned from the HealthCare.gov website, the text of the Affordable Care Act, benefits consultants, media sources and the individual insurance companies that offer plans through the Health Insurance Marketplace. All information presented in this brochure was collected and analyzed in the fall of 2014 when Marketplace information was released to the general public.

While it is our belief that the information provided is accurate, the ASRS makes no guarantees. Information in this brochure should not be construed as advice or recommendation for any healthcare plan. The reader accepts full responsibility for his or her understanding of any aspect of this brochure and is encouraged to do further personal research on any topic presented.

Insurance plan documents will always govern pricing and coverage of any plan selected by an individual.

A little advice . . .

This brochure was designed primarily for non-Medicare ASRS retirees as a guide to the health care plans available through the Arizona Health Insurance Marketplace. Knowledge of the available plans will be essential as non-Medicare ASRS retirees consider their health insurance plan options for the future.

In addition to ASRS, employer or other private retiree health insurance, non-Medicare eligible retirees may now take advantage of Marketplace plans as well.

Enrollment in any health insurance plan assumes that the enrollee is sufficiently knowledgeable about the plan selected, that the enrollee conducted some reasonable level of comparative analysis in the selection of the plan, and that the enrollee understands the various costs associated with the selection of a particular plan.

It is our hope that readers of this brochure will have a better understanding of the health care plans available through the Arizona Health Insurance Marketplace as they weigh options in enrolling in an appropriate medical plan, which now is a mandatory requirement of the Affordable Care Act for all eligible persons.

— Paul Matson
Director, Arizona State Retirement System

A Mandate for Health Care

Most people must have health coverage in 2015 or pay a fee. If you do not have coverage in 2015, you'll have to pay a penalty of $325 per adult, $162.50 per child, or 2% of your income, whichever is higher. The fee increases every year. Some people may qualify for an exemption to this fee. If you enroll by February 15, 2014, you won't have to pay the fee for any month before your coverage began.

You are considered covered if you have Medicare, Medicaid, Children's Health Insurance Program (CHIP), any job-based plan, any plan you bought yourself, COBRA, retiree coverage, TRICARE, VA health coverage, or some other types of health coverage.

If you are eligible for job-based insurance, you may consider switching to a Marketplace plan. However, you will not qualify for lower costs based on your income unless the job-based insurance is unaffordable or doesn't meet minimum requirements. You also may lose any contribution your employer makes to your premiums.

If you have Medicare, you are considered covered and do not have to make any changes. You cannot use the Health Insurance Marketplace to buy a supplemental medical or separate dental plan.

Exceptions to the Affordable Care Act Requirement

Certain people may not be required to obtain health care under the Affordable Care Act:

- People enrolled in Medicare
- People who get their health insurance through work
- Native Americans
- Religious objectors
- People who are in jail or prison
- Illegal immigrants
- People who are uninsured for less than 3 months of the year
- Individuals/families who don't earn enough to file a tax return
- People who receive an authorized "hardship" exemption

Important Dates

√ **Jan. 1, 2014:** Coverage through the ACA began
√ **Nov. 15, 2014:** 2015 open enrollment begins
√ **Dec. 15 2014:** Last day to enroll for coverage that begins Jan. 1, 2015
√ **Jan. 1, 2015:** 2015 health coverage begins
√ **Feb. 15, 2015:** 2015 open enrollment ends

The Arizona Health Insurance Marketplace

The Arizona Health Insurance Marketplace is designed to assist Arizona's non-Medicare eligible residents to shop for health insurance that meets the federal mandate of individual health insurance coverage that includes "essential health benefits." (See Pages 5 and 6 for details.)

Each state must create an exchange or allow the federal government to operate an exchange on behalf of the state where individuals may purchase insurance coverage. It is the goal of the Marketplace to offer "one-stop shopping" to find and compare private health insurance options.

Health insurers must abide by new rules that prevent denial of coverage to the sick or from charging older adults significantly more for coverage. Providers are also required to provide benefits in certain categories including hospital care, physician services, medication and emergency, preventive, rehabilitative and mental health services.

No one can be refused the opportunity to buy health coverage based on a pre-existing condition, such as diabetes or asthma. And, your insurance carrier cannot cancel your coverage if you become sick.

The Marketplace will not replace private health insurance. It is simply a new place for qualified individuals and qualified employers to shop for and buy health insurance.

Those who wish may still buy health insurance privately. However, people who do not have a health insurance plan offered at work, or cannot afford it, may be able to enroll in a healthcare plan offered through the Health Insurance Marketplace.

The U.S. Department of Health and Human Services administers the Marketplace in states that choose not to operate one, such as is the case in Arizona.

Details on the Arizona Health Insurance Marketplace can be found beginning on Page 9, followed by plan comparisons.

Participating Arizona Health Insurance Marketplace Carriers

The Arizona Health Insurance Marketplace is administered by the federal government.
The Arizona Health Insurance Marketplace consists of the following carriers that offer eligible insurance plans from which to choose:

- Aetna
- Assurant Health
- Blue Cross/Blue Shield of Arizona
- Cigna Health Care
- Health Choice Insurance Company
- Health Net of Arizona
- Humana Inc.
- Meritus Mutual and Health Partners
- Phoenix Health Plans, Inc.
- United HealthCare
- University of Arizona Health Plans (University Healthcare Marketplace)

(See contact information on Page 9)

www.HealthCare.gov

Plan Structures

The Arizona Health Insurance Marketplace is designed to assist Arizona's non-Medicare eligible residents to shop for health insurance that meets the federal mandate of individual health insurance coverage that includes essential health benefits.

As with all health plans, you'll have to pay a monthly premium. The Marketplace offers a choice of plan types, categorized by the percentage of out-of-pocket costs to you. The plans have been categorized as Bronze, Silver, Gold, Platinum and Catastrophic. Catastrophic only applies to individuals under age 30 or with hardship exemptions. Exemptions may be granted by Health and Human Services on a case-by-case basis, based on capability to obtain coverage.

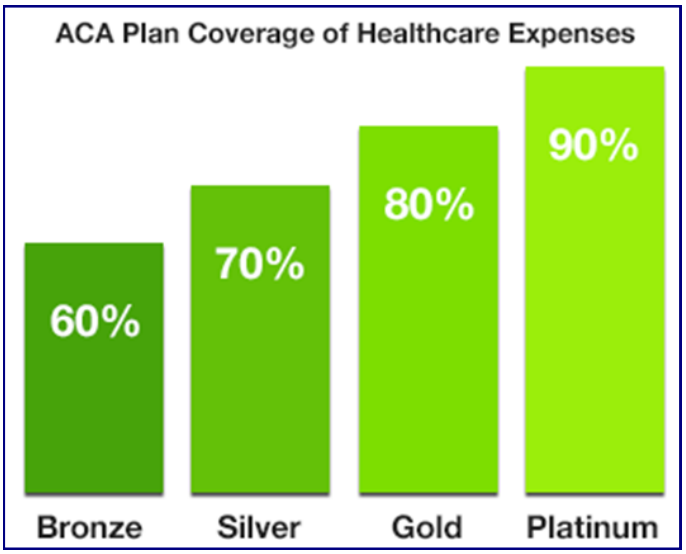
The type of plan you choose affects how much your premium will be each month, and what portion of your health care expense you pay for things like hospital visits or prescription medications. It also affects your total out-of-pocket costs — the total amount you will spend for the year if you need lots of care.

The maximum out-of-pocket cost for any Marketplace plan for 2015 is $6,350 for an individual plan and $12,700 for a family plan.

Premiums are generally higher for plans that pay more of your out-of-pocket medical costs when you get care. For example, if you have a Gold plan, you'll likely pay a higher premium, but may have lower costs when you go to the doctor or use another medical service.

With a Bronze plan, you'll likely pay a lower premium, but you'll pay a higher share of costs when you get care.

Platinum plans will likely have the highest monthly premiums and lowest out-of-pocket costs. In general, when choosing your health plan, keep this in mind: the lower the premium, the higher the out-of-pocket costs when you need care; the higher the premium, the lower the out-of-pocket costs when you need care.



Think about the health care needs of your household when considering which Marketplace insurance plan to buy.

Do you expect to have a lot of doctor visits or need regular prescriptions? If you do, you may want a Gold or Platinum plan. If you don't, you may prefer a Bronze or Silver plan.

But keep in mind that if you experience a serious accident or an unexpected health problem, Bronze and Silver plans will require you to pay more of the costs.

Essential Health Benefits

Essential health benefits are minimum requirements for all plans offered through the Marketplace. Plans may offer additional coverage. Please refer to the comparison tables in this brochure for more information on each plan.

Essential health benefits include:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (such as surgery)
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

For details on essential health benefits, see Page 6.

Essential Health Benefits

The Affordable Care Act (ACA) establishes a minimum standard of benefits that insurance companies must offer in order for insurance plans to be certified and allowed to be offered through the Health Insurance Marketplace. This minimum standard is known as essential health benefits. The ACA further distinguishes between a plan's covered services (essential and additional) and the plan's cost sharing features, such as deductibles, copayments, and coinsurance. The cost sharing features will determine the level of value of the plan, as expressed by its metal tier: Bronze, Silver, Gold or Platinum.

All private individual insurance policies offered through the Marketplace must include, at a minimum, items and services within the following 10 categories:

Preventive and wellness services and chronic disease treatment – such as physicals, immunizations and cancer screenings designed to prevent or detect certain medical conditions. Also care for chronic conditions, such as asthma and diabetes, is covered.
Free preventive care services for adults include: screening for diabetes, colorectal cancer, high blood pressure, HIV, obesity and depression; counseling for weight loss dietary needs and tobacco cessation. Preventative services for men include cholesterol screening for those 35 years and older, and for women preventative services include annual mammograms, cervical cancer screenings, colorectal cancer screenings and osteoporosis counseling. There are also free benefits for pregnant women, infants and children. (Additional details on recommended preventive care can be found on the HealthCare.Gov website.)

Ambulatory patient services – often called outpatient care, it is the care you receive at a doctor's office, clinic, or same-day (outpatient) surgery center. Plan provider networks and access to doctors will vary by insurance carrier depending on geographical area covered and the type of plan offered.

Hospitalization – care you receive as a hospital inpatient, including care from doctors, nurses, and other hospital staff, laboratory and other tests, medications you receive during your hospital stay, and room and board. Hospitalization coverage also includes surgeries, transplants and care received in a skilled nursing facility, such as a nursing home that specializes in the care of the elderly. Note: some plans may limit the number of days of skilled nursing facility coverage.

Emergency services – care you receive for conditions that could lead to serious disability or death if not immediately treated, such as accidents or sudden illness. Typically, this is a trip to the emergency room, and may include transport by ambulance. You cannot be penalized for using out-of-network services or for not having prior authorization.

Rehabilitative services – services and devices to help you gain or recover mental and physical skills lost due to injury, disability or a chronic condition. Plans have to provide 30 visits each year for either physical or occupational therapy, or visits to a chiropractor. Plans must also cover 30 visits for speech therapy as well as 30 visits for cardiac or pulmonary rehabilitation.

Laboratory services – testing provided to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a particular treatment.

Mental health services and addiction treatment – inpatient and outpatient care provided to evaluate, diagnose and treat a mental health condition or substance abuse disorder. Note: some plans may limit coverage to 20 days each year.

Prescription drugs – medications that are prescribed by a doctor to treat an illness or condition. Examples include prescription antibiotics to treat an infection or medication used to treat an ongoing condition, such as high blood pressure or high cholesterol. At least one prescription drug must be covered for each category and classification of federally approved drugs.

Maternity and newborn care – care that women receive during pregnancy (prenatal care), throughout labor, delivery and post-delivery, and care for newborn babies.

Pediatric services – care provided to infants and children, including well child visits and recommended vaccines and immunizations. Dental and vision care must be offered to children younger than 19. This includes two routine dental exams, an eye exam and one pair of corrective lenses each year.

The benefit levels of essential health benefits are addressed in the plans comparison section of this brochure along with other benefits and their costs (deductibles, copayments or coinsurance).

These 10 essential health benefits are mandatory benefits required by the Affordable Care Act that must be included in every insurance plan offered through the Health Insurance Marketplace, unless separate coverage may also be obtained through the Marketplace.

Subsidies and Tax Credits

In the Health Insurance Marketplace you may be able to lower the costs of your health insurance coverage by paying lower monthly premiums and lower out-of-pocket costs, if you qualify based on family size and household income.

You will see the amount of savings you are eligible for when you complete your Marketplace application. Premiums shown for insurance plans you select on the Marketplace website will automatically reflect the lower costs.

These lower premium costs are subsidized by a tax credit called the Advance Premium Tax Credit. These tax credits are applied directly to your monthly premiums, so you get the lower costs immediately.

The amount you save depends on your family size and how much money your family earns. In general, if your income falls within the ranges outlined in the chart below, taken from the HealthCare.gov website, you will qualify to save money on your premiums in 2015. The lower your income within these ranges, the more you'll save.

Likewise, when you obtain coverage through the Health Insurance Marketplace, you may be able to get lower costs on deductibles, copayments, and coinsurance. This will also depend on your family size and household income.

If you qualify for out-of-pocket savings, you must choose a Silver plan to get the savings. If you qualify for these savings, you will receive the out-of-pocket savings benefits of a Gold or Platinum plan for a Silver plan price. You may choose any category of plan; however, you will receive the out-of-pocket savings only if you enroll in a Silver plan.

Factors that Affect Your Costs

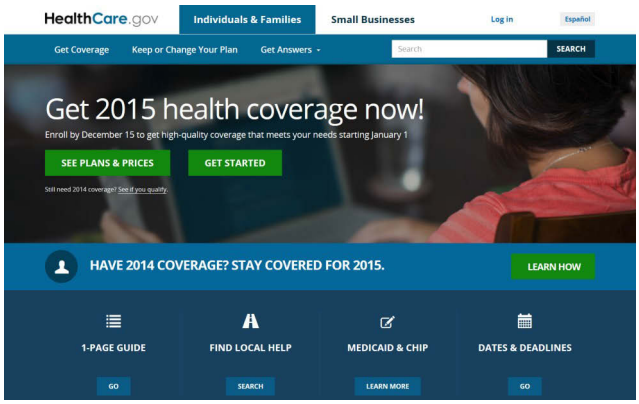
- Family size
- Household income
- Age
- Geographic area
- Tobacco use

Factors that Do Not Affect Your Costs

- Health status or previous healthcare use
- Gender
- Pre-existing conditions

		Number of people in your household					
	2015	**1**	**2**	**3**	**4**	**5**	**6**
Private Marketplace Health Plans	You may qualify for lower premiums on a Marketplace insurance plan if your yearly income is between . . . (See next row if your income is at the lower end of this range)	$11,670 - $46,6800	$15,730 - $62,920	$19,790 - $79,160	$23,850 - $95,400	$27,910 - $111,640	$31,970 - $127,880
Private Marketplace Health Plans	You may qualify for lower premiums and lower out-of-pocket costs for Marketplace insurance if your yearly income is between . . . (See next row if your income is at the lower end of this range)	$11,670 - $29,175	$15,730 - $39,325	$19,790 - $49,475	$23,850 - $59,625	$27,910 - $69,775	$31,970 - $79,925
Medicaid Coverage	You may qualify for Medicaid coverage in Arizona if your yearly income is below . . .	$16,105	$21,707	$27,310	$32, 913	$38,516	$44,119
Medicaid Coverage	If you reside in a state that is not expanding Medicaid in 2014, you may not qualify for any Marketplace savings programs if your yearly income is below . . .	$11,670	$15,730	$19,790	$23,850	$27,910	$31,970

Application & Information



Four ways to apply

Online—www.HealthCare.Gov

There are four steps to the online application:

1) Set up an account.
2) Fill out the online application.
3) Compare options.
4) Enroll.

If you have questions, live and online assistance is available.

By Phone

To apply by phone, call (800) 318-2596, 24 hours a day, 7 days a week (TTY (855) 889-4325). A customer service representative will work with you to complete the application and enrollment process.

Paper Application

You may complete and mail a paper application if you do not apply online. You will find out whether you are eligible for lower costs on private insurance, Medicaid, or the Children's Health Insurance Program (CHIP) after an automatic review of your application is completed.

Once you receive your eligibility notice, you can either go online to compare, choose, and enroll in a plan or contact the Marketplace call center at the numbers listed above. A customer service representative will assist you.

To get a paper application, download the application form and instructions from the HealthCare.gov website.

In Person

In all states, there are people trained and certified to help you understand your health coverage options and enroll in a Marketplace plan. They're known by different names, depending on who provides the service and where they're located. All can provide the help you need with your application and choices:

- Navigators
- Application assisters
- Certified application counselors
- Government agencies, such as State Medicaid and Children's Health Insurance Program (CHIP) Offices
- Insurance agents and brokers can also help you with your application and choices

Visit LocalHelp.HealthCare.gov to find assistance in your area.

Resources

Official website for the Affordable Care Act and Health Insurance Marketplace ..... www.HealthCare.gov

Kaiser Family Foundation website with recommended financial assistance calculator ..... www.kff.org

Organizations providing assistance to Arizona residents (100+ assistance centers) ..... LocalHelp.HealthCare.gov

Arizona State Retirement System Retiree Healthcare Information ..... www.azasrs.gov/web/HealthInsurance.do

Plans Available in the 2015 Arizona Health Insurance Marketplace

The following four sections of this brochure compare the private insurance plans offered through the Arizona Health Insurance Marketplace and are grouped by the metal tier in which they belong: Bronze, Silver, Gold and Platinum. There are two insurance plans specifically for Native Americans. Also, there are seven catastrophic insurance plans offered but these plans are only available to people under age 30 or with a hardship exemption and, as a result, this brochure does not provide information on catastrophic or Native Americans plans.

By removing the seven catastrophic insurance plans and the two plans for Native Americans from the comparison, there remain 127 private insurance plans to consider: 35 Bronze, 44 Silver, 34 Gold, and 14 Platinum plans. The plans are compared in their respective metal tier and comprise their own sections in this brochure.

The ACA requires each plan offered in the Marketplace to have "essential health benefits" which are considered as minimum essential services, treatments and benefits of a qualified medical and prescription drug plan. (See Pages 5 and 6 for additional details.)

The charts that follow compare the 10 essential health benefits (highlighted in bold type) as well as other key medical services, treatments and benefits so that a more comprehensive comparison of each plan may be done. The plans are grouped by insurance carrier and do not represent any specific order of value; only that a particular group of plans belongs in a specific metal tier as determined by the insurance carrier.

Please Note: No reference to premiums is made or provided. Premiums are a function of family size, household income, age, geographic area, and tobacco use. Because these very specific and personal factors are used to determine your premium for a specific plan as well as what, if any, tax credits or subsidies for which you could be eligible, the ASRS does not provide premium information. Instead, you are referred to the healthcare.gov website, a navigator, a certified application counselor, an application assister, or any authorized representative who is familiar with the premium determination for appropriate and qualified assistance for the costs associated with any of the plans offered through the Arizona Health Insurance Marketplace.

Please direct questions regarding an Arizona Health Insurance Marketplace plan directly to the individual insurance carrier representing that plan.

Insurance Company	Website	Phone
Aetna	www.aetna.com	(800) 217-2386
Assurant Health	www.assuaranthealth.com	(800) 647-9106
Blue Cross/Blue Shield of Arizona	www.azblue.com	(877) 864-4899
Cigna Health Care	www.cigna.com	(800) 244-6224
Health Choice Insurance Co.	www.healthchoiceessential.com	(855) 452-4242
Health Net of Arizona	www.healthnet.com	(800) 289-2818
Humana Inc.	www.humana.com	(888) 347-0092
Meritus Mutual and Health Partners	www.meritusaz.com	(602) 957-2113
Phoenix Health Plans, Inc.	www.phxchoice.com	(855)463-7275
UnitedHealthCare	www.xas.welcometouhc.com	(877) 512-9939
University of Arizona Health Plans	www.uamarketplace.com	(855) 231-9236

Arizona Health Insurance Marketplace
Bronze Plans

Referred to as "metal plans," the different tiers are defined by the percentage each plan will pay toward health care expenses, known as the actuarial value, for an average person.

A Bronze plan is designed to provide 60 percent coverage with the enrollee paying approximately 40 percent of eligible expenses.

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Aetna	
	Plan Name	Banner Health Network $20 Copay	Banner Health Network HSA Eligible
	Plan Provisions		
1	Calendar Year Deductible	In Network $5,750/Mbr and $11,500/family Out of Network $11,500/Mbr and $23,000/family	In Network $6,300/Mbr and $12,600/family Out of Network $12,600/Mbr and $25,200/family
2	Out-of-Pocket Limit	In Network $6,600/Mbr and $13,200/family Out of Network $Unlimited/Mbr and $Unlimited/family	In Network $6,300/Mbr and $12,600/family Out of Network $Unlimited/Mbr and $Unlimited/family
3	Provider Network	PPO	PPO
4	Coverage Area	Maricopa	Maricopa
5	Coinsurance	Copay	0%
6	Primary Care Physician	In Network $20 copay per visit, deductible waived Out of Network 50% coinsurance	In Network 0% coinsurance Out of Network 50% coinsurance
7	Specialist	In Network $50 copay per visit Out of Network 50% coinsurance	In Network 0% coinsurance Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee $250 copay per visit Physician, surgeon 0% coinsurance Out of Network 50% coinsurance	In Network 0% coinsurance Out of Network 50% coinsurance
10	Ambulance	In Network $250 copay Out of Network paid as In Network	In Network 0% coinsurance Out of Network 50% coinsurance
11	**HOSPITALIZATION**	In Network surgery facility fee $250 copay per admission Physician, surgeon 0% coinsurance Out of Network 50% coinsurance	In Network 0% coinsurance Out of Network 50% coinsurance
12	Urgent Care Visit	In Network $60 copay per visit, deductible waived Out of Network 50% coinsurance	In Network 0% coinsurance Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network & Out of Network $250 copay Transportation $250 copay per trip	In Network 0% coinsurance Out of Network 50% coinsurance
14	**REHABILITATION SERVICES**	In Network $50 copay per visit Out of Network 50% coinsurance	In Network 0% coinsurance Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network 0% coinsurance Out of Network 50% coinsurance	In Network 0% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network outpatient $50 copay per visit Inpatient $250 per admission Out of Network 50% coinsurance	In Network 0% coinsurance Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $15 copay (retail), $30 copay (mail order), deductible waived Tier 2- $45 copay (retail) $122.50 copay (mail order) Tier 3-$75 copay (retail) $225 (mail order) Specialty- Preferred 40% coinsurance, Non-preferred 50% Out of Network all Tiers 50% coinsurance (retail & mail order)	In Network 0% coinsurance Out of Network 50% coinsurance
18	**MATERNITY**	In Network Prenatal no charge, postnatal 0% coinsurance Delivery/impatient $250 copay per admission Out of Network 50% coinsurance	In Network Prenatal no charge, postnatal 0% coinsurance Delivery/impatient $250 copay per admission Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Not Covered Available as a standalone plan in the Marketplace	Not Covered Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Assurant Health	
	Plan Name	Plan 001	Plan 002
	Plan Provisions		
1	Calendar Year Deductible	In Network $6,000 /Mbr $12,000/family Out of Network $18,000 Mbr $36,000/family	In Network $5,000 Mbr $10,000/family Out of Network $15,000 Mbr $30,000/family
2	Out-of-Pocket Limit	In Network $6,000/Mbr $12,000/family Out of Network $18,000 Mbr 36,000/family	In Network $6,300 Mbr $12,600/family Out of Network $19,500 Mbr $30,000 /family
3	Provider Network	HDHP	HDHP
4	Coverage Area	Statewide	Statewide
5	Coinsurance	0%	25%
6	Primary Care Physician	In Network and Out of Network no charge after deductible	In Network $35 copay Out of Network 45% coinsurance a
7	Specialist	In Network and Out of Network no charge after deductible	In Network $35 copay Out of Network 45% coinsurance
8	**PREVENTIVE SERVICES**	In Network and Out of Network no charge after deductible	In Network 0% coinsurance Out of Network 45% coinsurance
9	**OUTPATIENT CARE**	In Network and Out of Network no charge after deductible	In Network 25% coinsurance Out of Network 45% coinsurance
10	Ambulance	In Network and Out of Network no charge after deductible	In Network and Out of Network 25% coinsurance
11	**HOSPITALIZATION**	In Network and Out of Network no charge after deductible	In Network 25% coinsurance Out of Network 45% coinsurance
12	Urgent Care Visit	In Network and Out of Network no charge after deductible	In Network 25% coinsurance Out of Network 45% coinsurance
13	**EMERGENCY SERVICES**	$100 access fee, then deductible	In Network and Out of Network $100 access fee, then deductible and 25% coinsurance
14	**REHABILITATION SERVICES**	In Network and Out of Network no charge after deductible	In Network 25% coinsurance Out of Network 45% coinsurance
15	**LABORATORY SERVICES**	In Network and Out of Network no charge after deductible	In Network 25% coinsurance Out of Network 45% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network and Out of Network no charge after deductible	In Network inpatient 25% coinsurance Outpatient $35 copay/visit Out of Network 45% coinsurance
17	**PRESCRIPTION DRUGS**	In Network and Out of Network no charge after deductible Out of Network specialty drugs not covered	In Network 25% coinsurance Out of Network 45% coinsurance, specialty drugs not covered
18	**MATERNITY**	In Network and Out of Network no charge after deductible	In Network 25% coinsurance Out of Network 45% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	No charge	No charge

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Blue Cross Blue Shield of Arizona		
	Plan Name	CopayComplete 40 Alliance	Portfolio 6300 Select	Essential 6000 Statewide
	Plan Provisions			
1	Calendar Year Deductible	In Network $0/Mbr and $0/family	In Network $6,300/Mbr and $12,600/family	In Network $6,000/Mbr and $12,000/family Out of Network $6,500/Mbr and $13,000/family
2	Out-of-Pocket Limit	In Network $6,350/Mbr and $12,700/family	In Network $6,350/Mbr and $12,700/family	In Network $6,600/Mbr and $13,2000/family Out of Network $13,200/Mbr and $26,400/family
3	Provider Network	HMO	HSA-qualified HMO	PPO
4	Coverage Area	Statewide	Statewide	Statewide, National
5	Coinsurance	Copay	Copay	In Network 20% after deductible Out of Network 50% coinsurance after deductible
6	Primary Care Physician	In Network $40 copay/provider/day Out of Network not covered	No charge after deductible Out of Network not covered	In Network $35 for first three office visits (combined with specialists visits) then 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill
7	Specialist	In Network $80 copay/provider/day Out of Network not covered	No charge after deductible Out of Network not covered	In Network $75 for first three office visits (combined with PCP visits) then 20% coinsurance after deductible Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network not covered	No charge after deductible Out of Network not covered	In Network no charge Out of Network 50% coinsurance & balance bill
9	**OUTPATIENT CARE**	In Network facility fee, $750 copay/day Physician, surgeon no charge Out of Network not covered	No charge after deductible Out of Network not covered	In Network facility fee, physician, surgeon 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible
10	Ambulance	$250 copay/provider/day	In Network and out of Network no charge after deductible	20% coinsurance deductible waived
11	**HOSPITALIZATION**	In Network facility fee $1,500 copay/day for a max of four copays per admit Physician, surgeon no charge Out of Network not covered	No Charge after deductible Out of Network not covered	In Network facility fee, physician/surgeon 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible
12	Urgent Care Visit	In Network $80 copay/provider/day Out of Network not covered	In Network no charge after deductible Out of Network not covered	In Network $75 copay Out of Network 50% coinsurance & balance bill after deductible
13	**EMERGENCY SERVICES**	In Network and Out of Network $500 copay/facility/day	In Network and out of Network no charge after deductible	In Network and Out of Network 20% coinsurance after deductible, copay waived if admitted Out of Network subject to balance bill
14	**REHABILITATION SERVICES**	Outpatient $80 copay/provider/visit Inpatient $1,500 copay/day for a max of four copays per admit Out of Network not covered	No Charge after deductible Out of Network not covered	In Network copay or 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible Precertification may be required May be subject to visit limits per calendar year that vary by type of therapy
15	**LABORATORY SERVICES**	Outpatient facility $40 copay/provider/day Outpatient not covered	No charge after deductible Out of Network not covered	In Network office visit copay or 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	Outpatient office visit $40 copay Inpatient $1,500 copay/day for a max of four copays Out of Network not covered	No Charge after deductible Out of Network not covered	In Network outpatient no charge if services in office, home, walk-in clinic, 20% coinsurance other locations In patient 20% coinsurance after deducible Out of Network 50% coinsurance & balance bill after deductible
17	**PRESCRIPTION DRUGS**	In Network and Out of Network Tier 1- $25 copay Tier 2- $70 copay Tier 3- $160 copay Specialty 50% coinsurance Out of Network not covered	No charge after deductible Out of Network not covered	In Network and Out of Network Tier 1- $25 copay Tier 2- $70 copay Tier 3- $160 copay Specialty- 50% coinsurance Out of Network not covered for specialty $600/Mbr for 2 and 3 medications
18	**MATERNITY**	In Network Prenatal and postnatal care physician office visit $40 copay Delivery and all inpatient services $1,500 copay/day, for a max of 4 copays per admit Out of Network not covered	No Charge after deductible Out of Network not covered	In Network Prenatal and postnatal care office visit copay or 20% coinsurance Delivery and all inpatient services 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible Out of Network all at 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Dental check-up no charge Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check-up & cleanings, no charge, limit 2 per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check-up & cleanings, no charge, limit 2 per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Blue Cross Blue Shield of Arizona (continued)		
	Plan Name	Portfolio 5500 Alliance / Select 2 networks same plan provisions	Essential 6000 Alliance / Select 2 networks same plan provisions	EverydayHealth 6000 Alliance / Select 2 networks same plan provisions
	Plan Provisions			
1	Calendar Year Deductible	In Network $5,500/Mbr and $11,000/family	In Network $6,000/Mbr and $12,000/family	In Network $6,00/Mbr and $12,000/family
2	Out-of-Pocket Limit	In Network $5,500/Mbr and $11,000/family	In Network $6,000/Mbr and $12,000/family	In Network $6,350/Mbr and $12,700/family
3	Provider Network	HSA-qualified HMO	HMO	HMO
4	Coverage Area	Statewide	Statewide	Statewide
5	Coinsurance	Copay	20%	20%
6	Primary Care Physician	No charge after deductible Out of Network not covered	$35 copay/visit three visits per member (PCP and Specialist visits combined), then 20% coinsurance Out of Network not covered	$40 copay/provider/day
7	Specialist	No charge after deductible Out of Network not covered	$70 copay/visit three visits per member (PCP and Specialist visits combined), then 20% coinsurance Out of Network not covered	$80 copay/provider/day
8	**PREVENTIVE SERVICES**	No charge after deductible Out of Network not covered	No charge after deductible Out of Network not covered	No charge after deductible Out of Network not covered
9	**OUTPATIENT CARE**	No charge after deductible Out of Network not covered	In Network facility fee, physician, surgeon 20% coinsurance after deductible Out of Network not covered	In Network facility fee, physician, surgeon 20% coinsurance after deductible Out of Network not covered
10	Ambulance	No charge after deductible Out of Network not covered	20% coinsurance In Network and Out of Network	20% coinsurance In Network and Out of Network
11	**HOSPITALIZATION**	No Charge after deductible Out of Network not covered	In Network facility fee, physician/surgeon 20% coinsurance after deductible Out of Network not covered	In Network facility fee, physician/surgeon 20% coinsurance after deductible Out of Network not covered
12	Urgent Care Visit	In Network no charge after deductible Out of Network not covered	$75 copay Out of Network not covered	$80 copay/provider/day Out of Network not covered
13	**EMERGENCY SERVICES**	No charge after deductible Out of Network not covered	20% coinsurance In Network and Out of Network	$500 copay/facility/day In Network and Out of Network
14	**REHABILITATION SERVICES**	No charge after deductible Out of Network not covered	20% coinsurance Out of Network not covered	20% coinsurance Out of Network not covered
15	**LABORATORY SERVICES**	No charge after deductible Out of Network not covered	Office visit copay of $35 or 20% coinsurance after copay limit is reached	Office visit copay of $40 or 20% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	No charge after deductible Out of Network not covered	No charge if services in office, home, walk-in clinic 20% coinsurance other location or 20% coinsurance for inpatient Out of Network not covered	Office visit copay of $40 or 20% coinsurance for inpatient Out of Network not covered
17	**PRESCRIPTION DRUGS**	No charge after deductible Out of Network not covered	Tier 1- $25 copay Tier 2- $70 copay Tier 3- $160 copay Specialty- 50% coinsurance Out of Network not covered $600/Mbr for 2 and 3 medications	Tier 1- $25 copay Tier 2- $80 copay Tier 3- $160 copay Specialty- 50% coinsurance Out of Network not covered
18	**MATERNITY**	No charge after deductible Out of Network not covered	Prenatal and postnatal care physician office visit copay of $35 or 20% coinsurance Delivery and inpatient services 20% coinsurance	Prenatal and postnatal care physician office visit copay of $40 or 20% coinsurance Delivery and inpatient services 20% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Dental check-up & cleanings, no charge, limit 2 per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check-up & cleanings, no charge, limit 2 per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Blue Cross Blue Shield of Arizona (continued)		
	Plan Name	Portfolio 5500 Statewide	EverydayHealth 6000 Statewide	Portfolio 6300 Statewide
	Plan Provisions			
1	Calendar Year Deductible	In Network $5,500/Mbr and $11,000/family Out of Network $6,000/Mbr and $12,000/family	In Network $6,000/Mbr and $12,000/family Out of Network $6,500/Mbr and $13,000/family	In Network $6,000/Mbr and $12,000/family Out of Network $6,800/Mbr and $13,600/family
2	Out-of-Pocket Limit	In Network $5,500/Mbr and $11,000/family Out of Network $11,000/Mbr and $22,000/family	In Network $6,600/Mbr and $13,2000/family Out of Network $13,200/Mbr and $26,400/family	In Network $6,300/Mbr and $12,600/family Out of Network $12,600/Mbr and $25,200/family
3	Provider Network	HSA-qualified HMO	PPO	HSA-qualified PPO
4	Coverage Area	Statewide, National	Statewide, National	Statewide, National
5	Coinsurance	In Network 0% after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network 20% after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network 0% after deductible Out of Network 50% coinsurance & balance bill after deductible
6	Primary Care Physician	In Network no charge after deductible Out of Network 50% coinsurance & balance bill	In Network $40 copay/provider/day Out of Network 50% coinsurance & balance bill	In Network no charge after deductible Out of Network 50% coinsurance & balance bill
7	Specialist	In Network no charge after deductible Out of Network 50% coinsurance & balance bill	In Network $80 copay/provider/day Out of Network 50% coinsurance & balance bill	In Network no charge after deductible Out of Network 50% coinsurance & balance bill
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance & balance bill	In Network no charge Out of Network 50% coinsurance & balance bill	In Network no charge Out of Network 50% coinsurance & balance bill
9	**OUTPATIENT CARE**	In Network facility fee, physician, surgeon no charge after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network facility fee, physician, surgeon 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network facility fee, physician, surgeon no charge after deductible Out of Network 50% coinsurance & balance bill after deductible
10	Ambulance	No charge after deductible	In Network and Out of Network 20% coinsurance deductible waived	No charge after deductible
11	**HOSPITALIZATION**	In Network facility fee, physician, surgeon no charge after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network facility fee, physician, surgeon 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network facility fee, physician, surgeon no charge after deductible Out of Network 50% coinsurance & balance bill after deductible
12	Urgent Care Visit	In Network no charge after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network $80 copay/provider/day Out of Network 50% coinsurance & balance bill after deductible	In Network no charge after deductible Out of Network 50% coinsurance & balance bill after deductible
13	**EMERGENCY SERVICES**	In Network and Out of Network no charge after deductible Copay waived if admitted Out of Network subject to balance bill	In Network and Out of Network $500 copay/facility/day Copay waived if admitted Out of Network subject to balance bill	In Network and Out of Network no charge after deductible Copay waived if admitted Out of Network subject to balance bill
14	**REHABILITATION SERVICES**	In Network no charge after deductible after deductible Out of Network 50% coinsurance & balance bill after deductible Precertification may be required May be subject to visit limits per calendar year that vary by type of therapy	In Network 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible Precertification may be required May be subject to visit limits per calendar year that vary by type of therapy	In Network no charge after deductible after deductible Out of Network 50% coinsurance & balance bill after deductible Precertification may be required May be subject to visit limits per calendar year that vary by type of therapy
15	**LABORATORY SERVICES**	In Network no charge after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network office visit copay or 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network no charge after deductible Out of Network 50% coinsurance & balance bill after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network no charge after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network outpatient office visit copay or 20% coinsurance Inpatient 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network no charge after deductible Out of Network 50% coinsurance & balance bill after deductible
17	**PRESCRIPTION DRUGS**	In Network retail and mail order no charge after deductible Out of Network 50% retail coinsurance and not covered for specialty	In Network and Out of Network Tier 1- $25 copay Tier 2- $80 copay Tier 3- $160 copay Specialty In Network- 50% coinsurance Out of Network not covered Out of network not covered for specialty	In Network retail and mail order no charge after deductible Out of Network 50% retail coinsurance and not covered for specialty
18	**MATERNITY**	In Network Prenatal and postnatal care physician office visit no charge Delivery and all inpatient services no charge after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network Prenatal and postnatal care physician office visit copay Delivery and all inpatient services 20% coinsurance Out of Network 50% coinsurance & balance bill after deductible	In Network Prenatal and postnatal care physician office visit no charge Delivery and all inpatient services no charge after deductible Out of Network 50% coinsurance & balance bill after deductible
19	**PEDIATRIC DENTAL SERVICES**	Dental check-up & cleanings, no charge, limit 2 per calendar year Basic/Major dental care 50% after deductible Orthodontia 50 % after deductible	Dental check-up & cleanings no charge limit 2 per calendar year Basic/Major dental care 50% after deductible Orthodontia 50 % after deductible	Dental check-up & cleanings, no charge, limit 2 per calendar year Basic/Major dental care 50% after deductible Orthodontia 50 % after deductible

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Cigna Healthcare		
	Plan Name	Health Flex 5100	Health Flex 5500	Health Savings 6100
	Plan Provisions			
1	Calendar Year Deductible	In Network $5,100/Mbr and $10,200 /family Out of Network $12,500/Mbr and $25,000 /family	In Network $5,500/Mbr and $11,000/family Out of Network $12,500/Mbr and $25,000/family	In Network $6,100/Mbr and $12,200/family Out of Network $12,500/Mbr and $25,000/family
2	Out-of-Pocket Limit	In Network $6,400/Mbr and $12,800/family Out of Network $25,000/Mbr and $50,000/family	In Network $6,350/Mbr and $12,700/family Out of Network $25,000/Mbr and $50,000/family	In Network $6,350/Mbr and $12,700/family Out of Network $25,000/Mbr and $50,000/family
3	Provider Network	LocalPlus Plan	LocalPlus Plan	LocalPlus Plan
4	Coverage Area	Statewide	Statewide	Statewide
5	Coinsurance	In Network 40% Out of Network 50% coinsurance & balance bill after deductible	In Network 40% Out of Network 50% coinsurance & balance bill after deductible	In Network no charge Out of Network 50% coinsurance & balance bill after deductible
6	Primary Care Physician	In Network $45 copay Out of Network 50% coinsurance	In Network $30 copay for first two visits then 40% coinsurance Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
7	Specialist	In Network $85 copay Out of Network 50% coinsurance	In Network $60 copay for first two visits then 40% coinsurance Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee, physician, surgeon 40% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network facility fee, physician, surgeon 40% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible	In Network facility fee, physician, surgeon no charge after deductible Out of Network 50% coinsurance & balance bill after deductible
10	Ambulance	In Network and Out of Network 40% coinsurance	In Network and Out of Network 40% coinsurance	In Network and Out of Network no charge
11	**HOSPITALIZATION**	In Network facility fee, physician, surgeon 40% coinsurance Out of Network 50% Coinsurance	In Network facility fee, physician, surgeon fee 40% coinsurance Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
12	Urgent Care Visit	In Network and out Network $75 copay/visit	In Network and out Network $75 copay/visit	In Network and Out of Network no charge
13	**EMERGENCY SERVICES**	In Network and Out of Network 40% coinsurance	In Network and Out of Network 40% coinsurance	In Network and Out of Network no charge
14	**REHABILITATION SERVICES**	In Network 40% coinsurance Out of Network 50% coinsurance	In Network 40% coinsurance Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network 40% coinsurance Out of Network 50% coinsurance	In Network 40% coinsurance Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network 40% coinsurance Out of Network 50% coinsurance	In Network 40% coinsurance Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1-$4 copay (retail) $10 copay (home delivery) Tier 2-$30 copay (retail) $75 (home delivery) Tier 3- 40% coinsurance (retail) /40% coinsurance (home delivery) Tier 4- 50% coinsurance (retail) /50% coinsurance (home delivery) Specialty- 40% coinsurance (retail) /30% coinsurance (home delivery) Out of Network all Tiers 50% coinsurance (retail) not covered (home delivery)	In Network Tier 1-$4 copay (retail) $10 copay (home delivery) Tier 2 and Tier 3- 40% coinsurance (retail) /40% coinsurance (home delivery) Tier 4- 50% coinsurance (retail) /50% coinsurance (home delivery) Specialty- 40% coinsurance (retail) /30% coinsurance (home delivery) Out of Network all Tiers 50% coinsurance (retail) not covered (home delivery)	In Network Tier 1,2,3- no charge for retail and home delivery Tier 4- 50% coinsurance (retail/home delivery) Specialty- no charge (retail/home delivery) Out of Network all Tiers- 50% coinsurance (retail) not covered (home delivery)
18	**MATERNITY**	In Network 40% coinsurance Out of Network 50% coinsurance	In Network 40% coinsurance Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Available as a standalone plan in the Marketplace	Available as a standalone plan in the Marketplace	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Health Net	
	Plan Name	50%/50%/$5,500	50%/50%/$5,500
	Plan Provisions		
1	Calendar Year Deductible	In Network $5,500/Mbr and $11,000/family Out of Network 11,000/Mbr and $22,000 family	In Network $5,500/Mbr and $11,000/family Out of Network 11,000/Mbr and $22,000 family
2	Out-of-Pocket Limit	In Network $6,300/Mbr and $12,700/family Out of Network $12,700/Mbr and $25,400/family	In Network $6,300/Mbr and $12,700/family Out of Network $12,700/Mbr and $25,400/family
3	Provider Network	PPO	PPO
4	Coverage Area	Statewide	Statewide
5	Coinsurance	50%	50%
6	Primary Care Physician	In Network 50% coinsurance Out of Network 50% coinsurance	In Network 50% coinsurance Out of Network 50% coinsurance
7	Specialist	In Network 50% coinsurance Out of Network 50% coinsurance	In Network 50% coinsurance Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 30% coinsurance
9	**OUTPATIENT CARE**	Facility fee, physician, surgeon 50% coinsurance Out of Network 50% coinsurance	Facility fee, physician, surgeon 50% coinsurance Out of Network 50% coinsurance
10	Ambulance	In Network 50% coinsurance Out of Network 50% coinsurance	In Network 50% coinsurance Out of Network 50% coinsurance
11	**HOSPITALIZATION**	Facility fee, physician, surgeon 50% coinsurance Out of Network 50% coinsurance	In Network 50% coinsurance Out of Network 50% coinsurance
12	Urgent Care Visit	In Network 50% coinsurance Out of Network 50% coinsurance	In Network 50% coinsurance Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network 50% coinsurance Out of Network 50% coinsurance	In Network 50% coinsurance Out of Network 50% coinsurance
14	**REHABILITATION SERVICES**	Facility fee, physician/surgeon fee 50% coinsurance	In Network 50% coinsurance Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network 50% coinsurance Out of Network 50% coinsurance	In Network 50% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network 50% coinsurance Out of Network 50% coinsurance	In Network 50% coinsurance Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	50% coinsurance retail/mail order for all tiers Out of Network not covered	50% coinsurance retail/mail order for all tiers Out of Network not covered
18	**MATERNITY**	In Network 50% coinsurance Out of Network 50% coinsurance	In Network 50% coinsurance Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	No charge after deductible Out of Network available as a standalone plan in the Marketplace	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Health Net (continued)	
	Plan Name	HMO Open Access 40%/40%/$5,000	HMO Open Access 40%/40%/$5,000
	Plan Provisions		
1	Calendar Year Deductible	$5,000/Mbr and $10,000/family	$5,000/Mbr and $10,000/family
2	Out-of-Pocket Limit	$6,000/Mbr and $12,000/family	$6,000/Mbr and $12,000/family
3	Provider Network	CommunityCare HMO Open Access	CommunityCare HMO Open Access
4	Coverage Area	Maricopa, Pinal, Pima	Maricopa, Pinal, Pima
5	Coinsurance	40%	40%
6	Primary Care Physician	40% coinsurance after deductible	40% coinsurance after deductible
7	Specialist	40% coinsurance after deductible	40% coinsurance after deductible
8	**PREVENTIVE SERVICES**	$0	$0
9	**OUTPATIENT CARE**	40% coinsurance after deductible	40% coinsurance after deductible
10	Ambulance	40% coinsurance after deductible	40% coinsurance after deductible
11	**HOSPITALIZATION**	40% coinsurance after deductible	40% coinsurance after deductible
12	Urgent Care Visit	40% coinsurance after deductible	40% coinsurance after deductible
13	**EMERGENCY SERVICES**	40% coinsurance after deductible	40% coinsurance after deductible
14	**REHABILITATION SERVICES**	40% coinsurance after deductible	40% coinsurance after deductible
15	**LABORATORY SERVICES**	40% coinsurance after deductible	40% coinsurance after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	40% coinsurance after deductible	40% coinsurance after deductible
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $20 retail, $60 mail order Tier 2- $40 retail, $120 mail order Tier 3- $60 retail, $180 mail order Specialty- 40% coinsurance Out of Network not covered	In Network Tier 1- $20 retail, $60 mail order Tier 2- $40 retail, $120 mail order Tier 3- $60 retail, $180 mail order Specialty- 40% coinsurance
18	**MATERNITY**	40% coinsurance after deductible	40% coinsurance after deductible
19	**PEDIATRIC DENTAL SERVICES**	No charge after deductible Out of Network available as a standalone plan in the Marketplace	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Health Choice Insurance Co.		Humana Inc.
	Plan Name	Essential	Value	6300/Phoenix HMOx
	Plan Provisions			
1	Calendar Year Deductible	$5,000/Mbr and $10,000/family	$5,000/Mbr and $10,000/family	$6,300/Mbr and $12,600/family
2	Out-of-Pocket Limit	$6,600/Mbr and $13,200/family	$6,600/Mbr and $13,200/family	$6,300/Mbr and $12,600/family
3	Provider Network	HMO	HMO	HMO
4	Coverage Area	Statewide w/exceptions	Statewide w/exceptions	Maricopa, Pima
5	Coinsurance	40%	40%	100%
6	Primary Care Physician	$20 copay per visit after deductible	$20 copayment after deductible	No charge after deductible
7	Specialist	$50 copayper visit after deductible	$50 copayment after deductible	No charge after deductible
8	**PREVENTIVE SERVICES**	No charge	No charge	No charge
9	**OUTPATIENT CARE**	40% coinsurance after deductible	40% coinsurance after deductible	No charge after deductible
10	Ambulance	40% coinsurance after deductible	40% coinsurance after deductible	No charge after deductible
11	**HOSPITALIZATION**	40% coinsurance after deductible	40% coinsurance after deductible.	No charge after deductible
12	Urgent Care Visit	$50 copay per visit after deductible	$50 copay per visit after deductible	No charge after deductible
13	**EMERGENCY SERVICES**	$500 copay visit after deductible	$500 copay visit after deductible	No charge after deductible
14	**REHABILITATION SERVICES**	40% coinsurance after deductible	40% coinsurance after deductible	No charge after deductible
15	**LABORATORY SERVICES**	40% coinsurance after deductible	40% coinsurance after deductible	No charge after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	Inpatient 40% coinsurance/visit after deductible Outpatient $20 copay/visit after deductible	Inpatient 40% coinsurance/visit after deductible Outpatient $20 copay/visit after deductible	No charge after deductible
17	**PRESCRIPTION DRUGS**	Tier- $15 copay after deductible Tier 2- $50 copay after deductible Tier 3- 50% coinsurance after deductible Specialty- 50% coinsurance after deductible	Tier- $15 copay after deductible Tier 2- $50 copay after deductible Tier 3- 50% coinsurance after deductible Specialty- 50% coinsurance after deductible Deductible $5,000	No charge after deductible
18	**MATERNITY**	Prenatal and postnatal care no charge Delivery and all inpatient services 40% coinsurance after deductible	Prenatal and postnatal care no charge Delivery and all inpatient services 40% coinsurance after deductible	No charge after deductible
19	**PEDIATRIC DENTAL SERVICES**	No charge	No charge	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Meritus Health Partners		
	Plan Name	Healthy HMO 6000 Complete/Abrazo/Banner 3 Networks same plan provisions	Healthy Choice PPO Plus 6000	Healthy Saver HSA Plus 6300
	Plan Provisions			
1	Calendar Year Deductible	$6,000/Mbr and $12,000/family	In Network $6,000/Mbr and $12,000/family Out of network $18,000/Mbr and $36,000/family	In Network $6,300/Mbr and $13,200/family and Out of Network $12,600/Mbr and $25,200/family
2	Out-of-Pocket Limit	$6,600/Mbr and $13,200/family	$6,600/Mbr and $13,200/family Out of Network $19,800/Mbr and $38,000	$6,600/Mbr and $13,200/family and Out of Network $25,200 and $50,400
3	Provider Network	HMO	PPO	HSA
4	Coverage Area	Maricopa, Pima, Santa Cruz	Maricopa, Pima, Santa Cruz	Maricopa, Pima, Santa Cruz
5	Coinsurance	50%	50%	0%
6	Primary Care Physician	In Network $40/visit copay per visit Out of Network not covered	In Network $40 /visit copay per visit Out of Network 50% coinsurance	In Network 0% coinsurance after deductible Out of Network 50% of charges after deductible
7	Specialist	In Network $80 copay/visit after deductible Out of Network not covered	In Network $80 copay/ visit after deductible Out of Network 50% coinsurance	In Network 0% coinsurance after deductible Out of Network 50% of charges after deductible
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network not covered	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance after deductible
9	**OUTPATIENT CARE**	50% coinsurance per surgery for facility fee, physician/surgeon after deductible Out of Network not covered	50% coinsurance per surgery for facility fee, physician/surgeon after deductible Out of Network 50% coinsurance	0% coinsurance per surgery for facility fee, physician/surgeon after deductible Out of Network 50% coinsurance after deductible
10	Ambulance	50% coinsurance per transport for In and Out of Network	50% coinsurance per transport for In and Out of Network	0% coinsurance per transport for In and Out of Network
11	**HOSPITALIZATION**	50% coinsurance per admission - facility fee, physician/surgeon after deductible Out of Network not covered	50% coinsurance per admission - facility fee, physician/surgeon after deductible Out of Network 50% coinsurance	0% coinsurance per admission - facility fee, physician/surgeon after deductible Out of Network 50% coinsurance after deductible
12	Urgent Care Visit	In Network $80 per visit Out of Network not covered	In Network $80 per visit Out of Network 50% coinsurance	0% coinsurance per admission - facility fee, physician/surgeon after deductible Out of Network 50% coinsurance after deductible
13	**EMERGENCY SERVICES**	In Network and Out of Network $500 copay/visit after deductible	In Network and Out of Network $500 copay/visit after deductible	In Network and Out of Network 0% coinsurance after deductible
14	**REHABILITATION SERVICES**	50% coinsurance per visit Out of Network not covered	50% coinsurance per visit Out of Network50% coinsurance	0% coinsurance per visit after deductible Out of Network 50% coinsurance after deductible
15	**LABORATORY SERVICES**	$25 copay per blood test Out of Network not covered	$25 copay per blood test Out of Network 50% coinsurance	0% coinsurance per blood test after deductible Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	Inpatient services 50% coinsurance per admission Outpatient $80 copay per visit Out of Network not covered	Inpatient services 50% coinsurance per admission Outpatient $80 copay per visit Out of Network 50% coinsurance	Inpatient services 0% coinsurance per admission after deductible Outpatient $0 copay per visit after deductible Out of Network 50% coinsurance after deductible
17	**PRESCRIPTION DRUGS**	In Network Tier 1- maintenance generic: $10 copay retail; $30 mail order 90-day supply Non-maintenance $30 retail; mail order $90 90-day supply Tier 2- $90 retail; mail order $270 90-day supply Tier 3- $200 retail; $600 mail order 90-day supply Specialty- 50% coinsurance Out of Network not covered $300 deductible	In Network Tier 1- maintenance generic: $10 copay retail; $30 mail order 90-day supply Non-maintenance $30 retail; mail order $90 90-day supply Tier 2- $90 retail; mail order $270 90-day supply Tier 3- $200 retail; $600 mail order 90-day supply Specialty- 50% coinsurance Out of Network not covered $300 deductible	In Network all Tiers 0% coinsurance after deductible Out of Network 50% coinsurance
18	**MATERNITY**	In Network Prenatal and postnatal $40 copay Delivery and all inpatient services 50% coinsurance per admit after deductible Out of Network not covered	In Network Prenatal and postnatal $40 copay Delivery and all inpatient services 50% coinsurance per admit after deductible Out of Network 50% coinsurance	In Network Prenatal and postnatal 0% coinsurance after deductible Delivery and all inpatient services 0% coinsurance after deductible Out of Network 50% of charges after deductible
19	**PEDIATRIC DENTAL SERVICES**	Not Covered	Not Covered	Not Covered

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	**Phoenix Health Plans, Inc.**	**University of Arizona Health Plans (University Healthcare Marketplace)**
	Plan Name	Phoenix Choice	Canyon
	Plan Provisions		
1	Calendar Year Deductible	$5,000/Mbr and $10,000/family	$6,400/Mbr and $12,800/family
2	Out-of-Pocket Limit	$6,600/Mbr and $13,200/family	$6,600/Mbr and $13,200/family
3	Provider Network	HMO	HMO
4	Coverage Area	Statewide with exceptions	Pima
5	Coinsurance	30%	50%
6	Primary Care Physician	$35 copay/visit	$20 copayment per visit, covered 100% after deductible is met Out of Network not covered
7	Specialist	$80 copay/visit after deductible	In Network 50% coinsurance after deductible Out of Network not covered
8	**PREVENTIVE SERVICES**	No charge	In Network no charge Out of Network not covered
9	**OUTPATIENT CARE**	30% coinsurance after deductible	Facility fee, physician, surgeon 50% coinsurance after deductible Out of Network not covered
10	Ambulance	30% coinsurance after deductible	In Network 50% coinsurance after deductible Out of Network 100% coinsurance
11	**HOSPITALIZATION**	30% coinsurance after deductible	In Network no charge for facility fee, physician, surgeon $1,000 copay per day for hospital stay after deductible Out of Network not covered
12	Urgent Care Visit	30% coinsurance after deductible	In Network 50% coinsurance after deductible Out of Network 100% coinsurance
13	**EMERGENCY SERVICES**	30% coinsurance after deductible	In Network $300 copay per visit after deductible Out of Network 100% coinsurance
14	**REHABILITATION SERVICES**	30% coinsurance after deductible	In Network 50% coinsurance after deductible Out of Network not covered
15	**LABORATORY SERVICES**	30% coinsurance after deductible	In Network 50% coinsurance after deductible Out of Network not covered
16	**MENTAL HEALTH AND SUBSTANCE USE**	Inpatient 30% coinsurance/visit after deductible Outpatient $35 copay/visit after deductible	In Network inpatient $1,000 copay per day after deductible Outpatient 50% coinsurance after deductible Out of Network not covered
17	**PRESCRIPTION DRUGS**	Tier- $20 copay Tier 2- $60 copay after deductible Tier 3- $100 copay after deductible Specialty- 40% coinsurance after deductible	In Network Tier 1- $6 each prescription after deductible Tier 2- 50% coinsurance after deductible Tier 3- 60% coinsurance after deductible Specialty- 60% coinsurance after deductible Prescription Deductible $200 /$400 Out of Network not covered
18	**MATERNITY**	30% coinsurance after deductible	In Network Prenatal and postnatal care $20 copay after deductible Delivery and all inpatient services $1000 copay per day after deductible Out of Network not covered
19	**PEDIATRIC DENTAL SERVICES**	Not covered Available as a standalone plan in the Marketplace	Not covered Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Bronze Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	United Health One	
	Plan Name	Compass Plus Catastrophic $6,600	Compass Plus Bronze $5,500
	Plan Provisions		
1	Calendar Year Deductible	In Network $6,600/Mbr $13,200/family Out of Network $13,200/Mbr $26,400/family	In Network $5,500/Mbr $11,000/family Out of Network $11,000/Mbr $22,000/family
2	Out-of-Pocket Limit	In Network $6,600/Mbr $13,200/family Out of Network Mbr and family unlimited	In Network $6,600/ Mbr/ $13,200/ family Out of Network Mbr and family unlimited
3	Provider Network	Compass Plus	Compass Plus
4	Coverage Area	Statewide; National	Statewide; National
5	Coinsurance	In network 0% Out of Network 50%	In network 30% Out of Network 50%
6	Primary Care Physician	In Network 0% coinsurance after $50 copay Out of Network 50% coinsurance after deductible	In Network $35 copay Out of Network 50% coinsurance after deductible
7	Specialist	In Network 0% coinsurance after $100 copay with or without referral Out of Network 50% coinsurance after deductible	In Network $75 copay with referral; $100 copay without referral Out of Network 50% coinsurance after deductible
8	**PREVENTIVE SERVICES**	In Network 0% coinsurance, deductible waived Out of Network 50% coinsurance after deductible	In Network 0% coinsurance, deductible waived Out of Network 50% coinsurance after deductible
9	**OUTPATIENT CARE**	In Network 0% coinsurance after deductible at freestanding facilities; 30% coinsurance after deductible for services at hospital setting Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible with referral; 50% coinsurance after deductible without referral; Additional $500 per occurrence deductible for services at hospital setting Out of Network 50% coinsurance after deductible
10	Ambulance	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible
11	**HOSPITALIZATION**	In Network 0% coinsurance after deductible with referral; 30% coinsurance after deductible without referral Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible with referral; 50% coinsurance after deductible without referral Out of Network 50% coinsurance after deductible
12	Urgent Care Visit	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after $50 copay Out of Network 50% coinsurance after deductible
13	**EMERGENCY SERVICES**	0% coinsurance after deductible	$250 per occurrence deductible then 30% coinsurance after deductible
14	**REHABILITATION SERVICES**	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible
15	**LABORATORY SERVICES**	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible; 50% coinsurance after deductible if at hospital setting Out of Network 50% coinsurance after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Outpatient 0% coinsurance after $50 copay Inpatient 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network Outpatient 0% coinsurance after $35 copay Inpatient 30% coinsurance after deductible Out of Network 50% coinsurance after deductible
17	**PRESCRIPTION DRUGS**	Pharmacy benefits are subject to plan deductible In Network Tier 1 - 0% coinsurance Tier 2 - 0% coinsurance Tier 3 - 0% coinsurance Tier 4 - 0% coinsurance	Separate pharmacy deductible of $500 applies to Tiers 3 & 4 In Network Tier 1 - $10 copay Tier 2 - $50 copay Tier 3 - 20% coinsurance (minimum $90 copay) Tier 4 - 30% coinsurance (minimum $250 copay)
18	**MATERNITY**	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible
19	**PEDIATRIC DENTAL SERVICES**	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible

Arizona Health Insurance Marketplace
Silver Plans

Referred to as "metal plans," the different tiers are defined by the percentage each plan will pay toward health care expenses, known as the actuarial value, for an average person.

A Silver plan is designed to provide 70 percent coverage with the enrollee paying approximately 30 percent of eligible expenses.

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Aetna	
	Plan Name	Banner Health Network $5 copay 2750	Banner Health Network $10 copay
	Plan Provisions		
1	Calendar year Deductible	In Network $2,750/Mbr and $5,500/family Out of Network $7,500/ Mbr and $15,000/family	In Network $3,750/Mbr and $7,500/family Out of Network $7,500/ Mbr and $15,000/family
2	Out-of-Pocket Limit	In Network $6,000/Mbr and $12,000/family Out of Network $Unlimited/Mbr and $Unlimited/family	In Network $6,600/Mbr and $13,200/family Out of Network $Unlimited/Mbr and $Unlimited/family
3	Provider Network	PPO	PPO
4	Coverage Area	Maricopa	Maricopa
5	Coinsurance	30%	30%
6	Primary Care Physician	In Network $5 copay per visit, deductible waived Out of Network 50% coinsurance	In Network $10 copay per visit, deductible waived Out of Network 50% coinsurance
7	Specialist	In Network $75 copay per visit, deductible waived Out of Network 50% coinsurance	In Network $75 copay per visit, deductible waived Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee, physician/surgeon 30% coinsurance Out of Network 50% coinsurance	In Network facility fee, physician/surgeon 30% coinsurance after $250 copay per visit Out of Network 50% coinsurance
10	Ambulance	30% coinsurance after deductible	30% coinsurance after deductible
11	**HOSPITALIZATION**	In Network facility fee, physician/surgeon 30% coinsurance Out of Network 50% coinsurance	In Network facility fee, physician/surgeon 30% coinsurance after $500 copay per admission Out of Network 50% coinsurance
12	Urgent Care Visit	In Network $75 copay per visit, deductible waived Out of Network 50% coinsurance	In Network $75 copay per visit, deductible waived Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network/Out of Network $500 copay per visit, deductible waived Out of Network paid as In Network	In Network/Out of Network $500 copay per visit, deductible waived Out of Network paid as In Network
14	**REHABILITATION SERVICES**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Outpatient $75 copay per visit, deductible waived Inpatient 30% coinsurance Out of Network 50% coinsurance	In Network Outpatient $75 copay per visit, deductible waived Inpatient 30% coinsurance Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1A- $5 copay (retail), $10 copay (mail order) Tier 1 $15 (retail) $30 (mail order) deductible waived Tier 2- $45 copay (retail) $112.50 copay (mail order) Tier 3- $75 (retail) / $225 (mail order) Specialty- Preferred 40% coinsurance / non-Preferred 50% coinsurance Out of Network Tier 1A - $5 (retail) / $15 (mail order) Tier 1 50% coinsurance after copay Tier 2- 50% coinsurance (retail and mail order) Tier 3- 50% coinsurance (retail and mail order) Specialty- 50% coinsurance	In Network Tier 1A- $5 copay (retail), $10 copay (mail order) Tier 1 $15 (retail) $30 (mail order) deductible waived Tier 2- $45 copay (retail) $112.50 copay (mail order) Tier 3- $75 (retail) / $225 (mail order) Specialty- Preferred 40% coinsurance / non-Preferred 50% coinsurance Out of Network Tier 1A - $5 (retail) / $15 (mail order) Tier 1 50% coinsurance after copay Tier 2- 50% coinsurance (retail and mail order) Tier 3- 50% coinsurance (retail and mail order) Specialty- 50% coinsurance
18	**MATERNITY**	In Network prenatal no charge, postnatal $250 one time copay Delivery/impatient 30% coinsurance Out of Network 50% coinsurance	In Network prenatal no charge, postnatal $250 copay one time copay Delivery/impatient 30% coinsurance after $500 copay per admission Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Not covered Available as a standalone plan in the Marketplace	Not covered Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Assurant Health	
	Plan Name	Plan 001	Plan 002
	Plan Provisions		
1	Calendar year Deductible	In Network $3,500/Mbr $7,000/family Out of Network $10,500/Mbr $21,000/family	In Network $2,000/Mbr $4,000/family Out of Network $6,000/Mbr $12,000/family
2	Out-of-Pocket Limit	In Network $3,500/Mbr $7,000/family Out of Network $10,500/Mbr $21,000/family	In Network $6,350/Mbr $12,700/family Out of Network $19,050/Mbr $38,100/family
3	Provider Network	HDHP	PPO
4	Coverage Area	Statewide	Statewide
5	Coinsurance	0%	50%
6	Primary Care Physician	In Network and Out of Network no charge after deductible	In Network $30 copay Out of Network 70% coinsurance
7	Specialist	In Network and Out of Network no charge after deductible	In Network $30 copay Out of Network 70% coinsurance
8	**PREVENTIVE SERVICES**	In Network and Out of Network no charge after deductible	In Network 0% coinsurance Out of Network 70% coinsurance
9	**OUTPATIENT CARE**	In Network and Out of Network no charge after deductible	In Network 50% coinsurance Out of Network 70% coinsurance
10	Ambulance	In Network and Out of Network no charge after deductible	In Network and Out of Network 50% coinsurance
11	**HOSPITALIZATION**	In Network and Out of Network no charge after deductible	In Network 50% coinsurance Out of Network 70% coinsurance
12	Urgent Care Visit	In Network and Out of Network no charge after deductible	In Network 50% coinsurance Out of Network 70% coinsurance
13	**EMERGENCY SERVICES**	$100 access fee, then deductible	In Network and Out of Network $100 access fee, then deductible and 50% coinsurance
14	**REHABILITATION SERVICES**	In Network and Out of Network no charge after deductible	In Network 50% coinsurance Out of Network 70% coinsurance
15	**LABORATORY SERVICES**	In Network and Out of Network no charge after deductible	In Network 50% coinsurance Out of Network 70% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network and Out of Network no charge after deductible	In Network Inpatient 50% coinsurance Outpatient $30 copay/visit Out of Network 70% coinsurance
17	**PRESCRIPTION DRUGS**	In Network and Out of Network no charge after deductible Out of Network Specialty drugs not covered	In Network and Out of Network Tier 1 $15 copay retail; $45 mail order Tier 2 $35 copay retail; mail order $105 Tier 3 $60 copay retail ; mail order $180 Specialty 50% coinsurance Out of Network Specialty drugs not covered
18	**MATERNITY**	In Network and Out of Network no charge after deductible	In Network 50% coinsurance Out of Network 70% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	No charge	No charge

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Blue Cross Blue Shield of Arizona		
	Plan Name	EverydayHealth 3000 Statewide	EverydayHealth 4000 Statewide	CopayComplete 40 Statewide
	Plan Provisions			
1	Calendar year Deductible	In Network $3,000/Mbr and $6,000/family Out of Network $3,500/Mbr and $7,000/family	In Network $4,000/Mbr and $8,000/family Out of Network $4,500/Mbr and $9,000/family	In Network $0/Mbr and family Out of Network Mbr $5,000/Mbr and $10,000/family
2	Out-of-Pocket Limit	In Network $4,500/Mbr and $9,000/family Out of Network $9,000/Mbr and $18,000/family	In Network $6,350/Mbr and $12,700/family Out of Network $12,700/Mbr and $25,400/family	In Network $6,350/Mbr and $12,700/family Out of Network $12,700/Mbr and $25,400/family
3	Provider Network	PPO	PPO	PPO
4	Coverage Area	Statewide, National	Statewide, National	Statewide, National
5	Coinsurance	20%	20%	Copay
6	Primary Care Physician	In Network $30 copay/provider/day Out of Network 50% coinsurance	In Network $30 copay/provider/day Out of Network 50% coinsurance	In Network $40 copay/provider/day Out of Network 50% coinsurance
7	Specialist	In Network $60 copay/provider/day Out of Network 50% coinsurance	In Network $60 copay/provider/day Out of Network 50% coinsurance	In Network $80 copay/provider/day Out of Network 50% coinsurance & balance bill
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee, physician/surgeon fees 20% coinsurance Out of Network 50% coinsurance	In Network facility fee, physician/ surgeon fees 20% coinsurance Out of Network 50% coinsurance	In Network facility fee $750 copay/day, physician/surgeon fees no charge Out of Network 50% coinsurance
10	Ambulance	In Network and Out of Network 20% coinsurance deductible waived	In Network and Out of Network 20% coinsurance deductible waived	In Network and Out of Network $250 copay/provider/day deductible waived
11	**HOSPITALIZATION**	Facility fee, physician/surgeon fee 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	Facility fee, physician/surgeon fee 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network facility fee $1,500 copay/day for a maximum of four copays per admission, physician/surgeon no charge Out of Network 50% coinsurance after deductible
12	Urgent Care Visit	In Network $60 copay/provider/day Out of Network 50% coinsurance	In Network $60 copay/provider/day Out of Network 50% coinsurance	In Network $80 copay/provider/day Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network and Out of Network $500 copay/facility/day copay waived if admitted	In Network and Out of Network $350 copay/facility/day copay waived if admitted	In Network and Out of Network $500 copay/facility/day copay waived if admitted
14	**REHABILITATION SERVICES**	In Network office visit or 20% coinsurance after deductible 20% inpatient services Out of Network 50% coinsurance after deductible	In Network office visit or 20% coinsurance after deductible 20% inpatient services Out of Network 50% coinsurance after deductible	In Network Outpatient $80 copay/provider/visit Inpatient $1,500 copay/day, for a maximum of four copays per admission Out of Network 50% coinsurance after deductible
15	**LABORATORY SERVICES**	In Network office visit $30 copay or 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network office visit $30 copay or 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network copay outpatient facility $40 copay/provider/day Out of Network 50% coinsurance after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Outpatient office visit $30 copay or 20% coinsurance Inpatient 20% coinsurance Out of Network 50% coinsurance	In Network Outpatient office visit $30 copay or 20% coinsurance Inpatient 20% coinsurance Out of Network 50% coinsurance	In Network Outpatient office visit $40 copay or outpatient facility copay Inpatient $1,500 copay/day, for a maximum of four copays per admission Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $25 copay Tier 2- $50 copay Tier 3- $100 copay Specialty- 50% coinsurance Out of Network not covered for Specialty	In Network Tier 1- $15 copay Tier 2- $50 copay Tier 3- $100 copay Specialty- 50% coinsurance Out of Network not covered for Specialty	In Network Tier 1- $25 copay Tier 2- $70 copay Tier 3- $160 copay Specialty- 50% coinsurance Out of Network specialty not covered
18	**MATERNITY**	In Network prenatal and postnatal care, physician office visit copay $30 Delivery and all inpatient services 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network prenatal and postnatal care, physician office visit copay $30 Delivery and all inpatient services 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network prenatal and postnatal care physician office visit copay Delivery and all inpatient services Hospital $1,500 copay/day, for a maximum of four copays per admission Out of Network 50% coinsurance after deductible
19	**PEDIATRIC DENTAL SERVICES**	Dental check up & cleanings no charge, limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check up & cleanings no charge, limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check up & cleanings no charge, limit two per calendar year Basic/Major dental care 50% Orthodontia 50%

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Blue Cross Blue Shield of Arizona (continued)		
	Plan Name	Portfolio 3500 Statewide	Essential 4000 Statewide	Essential 4000 Alliance / Select 2 networks same plan provisions
	Plan Provisions			
1	Calendar year Deductible	In Network $3,500/Mbr and $7,000/family Out of Network $4,000/Mbr and $8,000/family	In Network $4,000/Mbr and $8,000/family Out of Network $4,500/Mbr and $9,000/family	In Network $4,000/Mbr and $8,000/family
2	Out-of-Pocket Limit	In Network $3,500/Mbr and $7,000/family Out of Network $7,000/Mbr and $14,000/family	In Network $6,350/Mbr and $12,700/family Out of Network $12,700/Mbr and $25,400/family	In Network $6,350/Mbr and $12,700/family
3	Provider Network	HSA - qualified PPO	PPO	HMO
4	Coverage Area	Statewide	Statewide, National	Statewide
5	Coinsurance	0%	20%	20%
6	Primary Care Physician	In Network no charge after deductible Out of Network 50% coinsurance	In Network $25 copay/visit/member for first three office visits (PCP and Specialist visits combined) then 20% after deduction Out of Network 50% coinsurance	In Network $25 copay/visit/member for first three office visits (PCP and Specialist visits combined) then 20% after deduction Out of Network not covered
7	Specialist	In Network no charge after deductible Out of Network 50% coinsurance & balance bill	In Network $50 copay/visit/member for first three office visits (PCP and Specialist visits combined) then 20% after deduction Out of Network 50% coinsurance	In Network $50 copay/visit/member for first three office visits (PCP and Specialist visits combined) then 20% after deduction Out of Network 50% coinsurance & balance bill
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network not covered
9	**OUTPATIENT CARE**	In Network facility fee, physician/ surgeon fees no charge after deductible Out of Network 50% coinsurance	In Network facility fee, physician/ surgeon fees 20% coinsurance Out of Network 50% coinsurance	In Network facility fee, physician/surgeon fees 20% coinsurance Out of Network 50% coinsurance
10	Ambulance	In Network no charge after deductible	In Network and Out of Network 20% coinsurance deductible waived	In Network and Out of Network 20% coinsurance deductible waived
11	**HOSPITALIZATION**	Facility fee, physician/surgeon fee no charge Out of Network 50% coinsurance	Facility fee, physician/surgeon fee 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	Facility fee, physician/surgeon fee 20% coinsurance after deductible Out of Network not covered
12	Urgent Care Visit	In Network no charge after deductible Out of Network 50% coinsurance	In Network $60 copay Out of Network 50% coinsurance	In Network $60 copay Out of Network not covered
13	**EMERGENCY SERVICES**	In Network no charge after deductible	In Network and Out of Network 20% after deductible copay waived if admitted	In Network and Out of Network 20% after deductible copay waived if admitted
14	**REHABILITATION SERVICES**	In Network no charge after deductible Out of Network 50% coinsurance after deductible	In Network 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 20% coinsurance after deductible Out of Network not covered
15	**LABORATORY SERVICES**	In Network no charge after deductible Out of Network 50% coinsurance after deductible	In Network office visit copay or 20% coinsurance after copay limit is reached Out of Network 50% coinsurance	In Network $25 copay or 20% coinsurance copay limit is reached Out of Network not covered
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network no charge after deductible Out of Network 50% coinsurance after deductible	In Network Outpatient office visit no charge if services in office, home, walk-in clinic, 20% coinsurance other locations Inpatient 20% coinsurance Out of Network 50% coinsurance	In Network Outpatient office visit no charge if services in office, home, walk-in clinic, 20% coinsurance other locations Inpatient 20% coinsurance Out of Network not covered
17	**PRESCRIPTION DRUGS**	No charge after deductible Out of Network 50% coinsurance Specialty drugs not covered	In Network Tier 1- $10 copay Tier 2- $45 copay Tier 3- $90 copay Specialty- 50% coinsurance Out of Network not covered for specialty drugs	In Network Tier 1- $10 copay Tier 2- $30 copay Tier 3- $90 copay Specialty- 50% coinsurance Out of Network not covered
18	**MATERNITY**	In Network no charge after deductible Out of Network 50% coinsurance after deductible	In Network prenatal and postnatal care, physician PCP copay of $25 or 20% coinsurance Delivery and all inpatient services hospital services 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network prenatal and postnatal care, physician office visit copay of $25 or 20% coinsurance Delivery and all inpatient services hospital services 20% coinsurance after deductible Out of Network not covered
19	**PEDIATRIC DENTAL SERVICES**	Dental check up & cleanings no charge, limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check-up & cleanings no charge, limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check-up & cleanings no charge, limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Blue Cross Blue Shield of Arizona (continued)	
	Plan Name	Portfolio 3500 Alliance / Select 2 networks same plan provisions	EverydayHealth 3000 Alliance / Select 2 networks same plan provisions
	Plan Provisions		
1	Calendar year Deductible	In Network $3,500/Mbr and $7,000/family	In Network $3,000/Mbr and $6,000/family
2	Out-of-Pocket Limit	In Network $3,500/Mbr and $7,000/family	In Network $4,500/Mbr and $9,000/family
3	Provider Network	HSA - qualified HMO	HMO
4	Coverage Area	Statewide	Statewide
5	Coinsurance	0%	20%
6	Primary Care Physician	In Network no charge after deductible Out of Network not covered	In Network $30 copay/provider/day Out of Network not covered
7	Specialist	In Network no charge after deductible Out of Network not covered	In Network $60 copay/provider/day Out of Network not covered
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network not covered	In Network no charge Out of Network not covered
9	**OUTPATIENT CARE**	In Network facility fee, physician/ surgeon fees no charge after deductible Out of Network not covered	In Network facility fee, physician/surgeon fees 20% coinsurance Out of Network not covered
10	Ambulance	In Network and Out of Network no charge after deductible	In Network and Out of Network 20% coinsurance deductible waived
11	**HOSPITALIZATION**	Facility fee, physician/surgeon fee no charge after deductible Out of Network 50% coinsurance after deductible	In Network facility fee, physician/surgeon fee 20% coinsurance after deductible Out of Network not covered
12	Urgent Care Visit	In Network no charge after deductible Out of Network 50% coinsurance	In Network $60 copay/provider/day Out of Network not covered
13	**EMERGENCY SERVICES**	In Network and Out of Network no charge after deductible copay waived if admitted	In Network and Out of Network $500 copay/facility/day copay waived if admitted
14	**REHABILITATION SERVICES**	In Network no charge after deductible Out of Network 50% coinsurance after deductible	In Network 20% coinsurance after deductible Out of Network not covered
15	**LABORATORY SERVICES**	In Network no charge after deductible Out of Network 50% coinsurance after deductible	In Network office visit copay or 20% coinsurance after deductible Out of Network not covered
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network outpatient and inpatient no charge after deductible Out of Network 50% coinsurance after deductible	In Network Outpatient office visit $30 copay or 20% coinsurance after deductible Inpatient 20% coinsurance after deductible Out of Network not covered
17	**PRESCRIPTION DRUGS**	In Network all Tiers no charge after deductible Out of Network not covered	In Network Tier 1- $25 copay Tier 2- $50 copay Tier 3- $100 copay Specialty- 50% coinsurance Out of Network not covered
18	**MATERNITY**	In Network prenatal and postnatal care, physician no charge after deductible Delivery and all inpatient services hospital services no charge after deductible Out of Network not covered	In Network prenatal and postnatal care, physician office visit copay of $30 Delivery and all inpatient services hospital services 20% coinsurance after deductible Out of Network not covered
19	**PEDIATRIC DENTAL SERVICES**	Dental check-up & cleanings no charge, limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check-up & cleanings no charge, limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Blue Cross Blue Shield of Arizona (continued)	
	Plan Name	EverydayHealth 4000 Alliance / Select 2 networks same plan provisions	CopayComplete Alliance 40 2 networks same plan provisions
	Plan Provisions		
1	Calendar year Deductible	In Network $4,000/Mbr and $8,000/family	In Network $0/Mbr and $0/family
2	Out-of-Pocket Limit	In Network $6,350/Mbr and $12,700/family	In Network $6,350/Mbr and $12,700/family
3	Provider Network	HMO	HMO
4	Coverage Area	Statewide	Statewide
5	Coinsurance	20%	Copay
6	Primary Care Physician	In Network $30 copay/provider/day Out of Network not covered	In Network $40 copay/provider/day Out of Network not covered
7	Specialist	In Network $60 copay/provider/day Out of Network not covered	In Network $80 copay/provider/day Out of Network not covered
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network not covered	In Network no charge Out of Network not covered
9	**OUTPATIENT CARE**	In Network facility fee, physician/surgeon fees 20% coinsurance Out of Network not covered	In Network facility fee, $750 copay/day, physician/surgeon fees no charge Out of Network not covered
10	Ambulance	In Network and Out of Network 20% coinsurance deductible waived	In Network and Out of Network $250 copay/provider/day
11	**HOSPITALIZATION**	In Network facility fee, physician/surgeon fee 20% coinsurance after deductible Out of Network not covered	In Network facility fee $1,500 copay/day, for a maximum of four copays per admission physician/surgeon fee no charge Out of Network not covered
12	Urgent Care Visit	In Network $60 copay/provider/day Out of Network not covered	In Network $80 copay/provider/day Out of Network not covered
13	**EMERGENCY SERVICES**	In Network and Out of Network $350 copay/facility/day copay waived if admitted	In Network and Out of Network $500 copay/facility/day copay waived if admitted
14	**REHABILITATION SERVICES**	In Network 20% coinsurance after deductible Out of Network not covered	In Network Outpatient $80 copay/provider/visit Inpatient $1,500 copay/day, for a maximum of four copays per admission after deductible Out of Network not covered
15	**LABORATORY SERVICES**	In Network office visit copay or 20% coinsurance after deductible Out of Network not covered	In Network Outpatient facility $40 copay/provider/day Out of Network not covered
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Outpatient office visit $30 copay or 20% coinsurance after deductible Inpatient 20% coinsurance after deductible Out of Network not covered	In Network Outpatient applicable physician office visit or outpatient facility copay after deductible Inpatient $1,500 copay/day, for a maximum of four copays per admission after deductible Out of Network not covered
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $15 copay Tier 2- $50 copay Tier 3- $100 copay Specialty- 50% coinsurance Out of Network not covered	In Network Tier 1- $25 copay Tier 2- $70 copay Tier 3- $160 copay Specialty- 50% coinsurance Out of Network not covered
18	**MATERNITY**	In Network prenatal and postnatal care, physician office visit copay of $30 Delivery and all inpatient services hospital services 20% coinsurance after deductible Out of Network not covered	In Network prenatal and postnatal care, physician office visit copay $40 Delivery and all inpatient services hospital services $1,500 copay/day for a maximum of four copays per admission Out of Network not covered
19	**PEDIATRIC DENTAL SERVICES**	Dental check-up & cleanings no charge, limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check-up & cleanings no charge, limit two per calendar year Basic/Major dental care 50% Orthodontia 50% after deductible

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Cigna Healthcare	
	Plan Name	Health Flex 1500	Health Flex 2750
	Plan Provisions		
1	Calendar year Deductible	In Network $1,500/Mbr and $3,000/family Out of Network $12,500/Mbr and $25,000/family	In Network $2,750/Mbr and $5,500/family Out of Network $12,500/Mbr and $25,000/family
2	Out-of-Pocket Limit	In Network; $6,350/Mbr and $12,700/family Out of Network $25,000/Mbr and $50,000/family	In Network; $6,350/Mbr and $12,700/family Out of Network $25,000/Mbr and $50,000/family
3	Provider Network	LocalPlus Plan	LocalPlus Plan
4	Coverage Area	Statewide	Statewide
5	Coinsurance	30%	20%
6	Primary Care Physician	In Network $30 copay for first two visits then 30% coinsurance Out of Network 50% coinsurance	In Network $30 copay/visit Out of Network 50% coinsurance
7	Specialist	In Network $60 copay for first two visits then 30% coinsurance Out of Network 50% coinsurance	In Network $60 copay/visit Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee and physician surgeon fees 30% coinsurance Out of Network 50% coinsurance	In Network facility fee and physician/surgeon fees 20% coinsurance Out of network 50% coinsurance
10	Ambulance	In Network and Out of Network 30% coinsurance	In Network and Out of Network 20% coinsurance
11	**HOSPITALIZATION**	In Network facility fees and physician/surgeon fees 30% coinsurance Out of Network 50% coinsurance	In Network facility fee and physician/surgeon fees 20% coinsurance Out of Network 50% coinsurance
12	Urgent Care Visit	In Network and Out of Network $75 copay/visit	In Network and Out of Network $75 copay/visit
13	**EMERGENCY SERVICES**	In Network and Out of Network 30% coinsurance	In Network and Out of Network 20% coinsurance
14	**REHABILITATION SERVICES**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 20% coinsurance Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 20% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network Inpatient 20% coinsurance Out Patient $60 copay/visit Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier1- $4 copay (retail), $10 copay (home delivery) Tier 2- $20 copay (retail), $50 copay (home delivery) Tier 3- $60 copay (retail), $150 copay (home delivery) Tier 4- 50% coinsurance for retail and home delivery Tier 5- 40% coinsurance (retail), 30% coinsurance (home delivery) copay Out of Network 50% coinsurance (retail) Not covered (home delivery)	In Network Tier 1- $4 copay (retail), $10 copay (home delivery) Tier 2- $15 copay (retail), $37 copay (home delivery) Tier 3- $45 copay (retail), $112 copay (home delivery) Tier 4- 50% coinsurance for retail and home delivery Tier 5- 40% coinsurance (retail), 30% coinsurance (home delivery) Out of Network 50% coinsurance (retail) Not covered (home delivery)
18	**MATERNITY**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 20% coinsurance Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Available as a standalone plan in the Marketplace	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Cigna Healthcare (continued)	
	Plan Name	Health Savings 3400	Health Flex 3500
	Plan Provisions		
1	Calendar year Deductible	In Network $3,400/Mbr and $6,800/family Out of Network $12,500/Mbr and $25,000/family	In Network $3,500/Mbr and $7,000/family Out of Network $12,500/Mbr and $25,000/family
2	Out-of-Pocket Limit	In Network $6,350/Mbr and $12,700/family Out of Network $25,000/Mbr and $50,000/family	In Network; $6,350/Mbr and $12,700/family Out of Network $25,000/Mbr and $50,000/family
3	Provider Network	LocalPlus Plan	LocalPlus Plan
4	Coverage Area	Statewide	Statewide
5	Coinsurance	0%	0%
6	Primary Care Physician	In Network no charge Out of Network 50% coinsurance	In Network $30 copay/visit Out of Network 50% coinsurance
7	Specialist	In Network no charge Out of Network 50% coinsurance	In Network $60 copay/visit Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee and physician surgeon fees no charge Out of Network 50% coinsurance	In Network facility fee and physician/surgeon fees no charge Out of Network 50% coinsurance
10	Ambulance	In Network and Out of Network no charge	In Network and Out of Network no charge
11	**HOSPITALIZATION**	In Network facility fee, physician/surgeon fees no charge Out of Network 50% coinsurance	In Network facility fee and physician/surgeon fees no charge Out of Network 50% coinsurance
12	Urgent Care Visit	In Network and Out of Network no charge	In Network and Out of Network $75 copay/visit
13	**EMERGENCY SERVICES**	In Network and Out of Network no charge	In Network and Out of Network no charge
14	**REHABILITATION SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network no charge Out of Network 50% coinsurance	In Network In patient no charge Outpatient $60 copay/visit Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1, 2 and 3 no charge for retail and home delivery after deductible Tier 4- 50% coinsurance after deductible for retail and home delivery Specialty no charge for retail/home delivery Out of Network 50% coinsurance (retail) Not covered (home delivery)	In Network Tier 1- $4 copay (retail), $10 copay (home delivery) Tier 2- $15 copay (retail), $37 copay (home delivery) Tier 3- $45 copay (retail), $112 copay (home delivery) Tier 4- 50% coinsurance for retail and home delivery Specialty- no charge for retail and home delivery Out of Network 50% coinsurance (retail) Not covered (home delivery)
18	**MATERNITY**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Available as a standalone plan in the Marketplace	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Health Choice Ins Co	
	Plan Name	Essential	Value
	Plan Provisions		
1	Calendar year Deductible	$1,600/Mbr and $3,200/family	$1,600/Mbr and $3,200/family
2	Out-of-Pocket Limit	$6,600/Mbr and $13,200/family	$6,600/Mbr and $13,200/family
3	Provider Network	HMO	HMO
4	Coverage Area	Statewide w/exceptions	Statewide w/exceptions
5	Coinsurance	20%	20%
6	Primary Care Physician	$15 copay per visit after deductible	$15 copay per visit after deductible
7	Specialist	$40 copay per visit after deductible	$40 copay per visit after deductible
8	**PREVENTIVE SERVICES**	No charge	No charge
9	**OUTPATIENT CARE**	20% coinsurance after deductible	20% coinsurance after deductible
10	Ambulance	20% coinsurance after deductible	20% coinsurance after deductible
11	**HOSPITALIZATION**	20% coinsurance after deductible	20% coinsurance after deductible
12	Urgent Care Visit	$50 copay/visit after deductible	$50 copay/visit after deductible
13	**EMERGENCY SERVICES**	$500 copay/visit after deductible	$500 copay/visit after deductible
14	**REHABILITATION SERVICES**	20% coinsurance after deductible	20% coinsurance after deductible
15	**LABORATORY SERVICES**	20% coinsurance after deductible	$20% coinsurance after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	Inpatient 20% coinsurance/visit after deductible Outpatient $15 copay/visit after deductible	Inpatient 20% coinsurance/visit after deductible Outpatient $15 copay/visit after deductible
17	**PRESCRIPTION DRUGS**	Tier 1- $10 copay after deductible Tier 2- $45 copay after deductible Tier 3- 50% coinsurance after deductible Specialty- 50% after deductible	Tier 1- $10 copay after deductible Tier 2- $45 copay after deductible Tier 3- 50% coinsurance after deductible Specialty- 50% after deductible
18	**MATERNITY**	Prenatal and postnatal no charge after deductible Delivery and inpatient services 20% coinsurance per visit after deductible	Prenatal and postnatal no charge after deductible Delivery and inpatient services 20% coinsurance per visit after deductible
19	**PEDIATRIC DENTAL SERVICES**	No charge after deductible is met	No charge after deductible is met

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	HEALTH NET		
	Plan Name	30% /30% /1500	30% /30% /1500	CommunityCare Open Access $30/$50/$4500
	Plan Provisions			
1	Calendar year Deductible	In Network $1,500/Mbr and $3,000/family Out of Network 3,000/Mbr and $6,000 family	In Network $1,500/Mbr and $3,000/family Out of Network 3,000/Mbr and $6,000 family	$4,500/Mbr and $9,000/family
2	Out-of-Pocket Limit	In Network $6,300/Mbr and $12,700/family Out of Network $12,700/Mbr and $23,400/family	In Network $6,300/Mbr and $12,700/family Out of Network $12,700/Mbr and $23,400/family	$6,350/Mbr and $12,700/family
3	Provider Network	PPO	PPO	HMO Community Care Network
4	Coverage Area	Statewide	Statewide	Maricopa, Pinal, Pima
5	Coinsurance	30%	30%	20%
6	Primary Care Physician	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network $30 copay/visit Out of Network not covered
7	Specialist	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network $50 copay/visit Out of Network not covered
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network not covered
9	**OUTPATIENT CARE**	Facility fee, physician/surgeon 30% coinsurance Out of Network 50% coinsurance	Facility fee, physician/surgeon 30% coinsurance Out of Network 50% coinsurance	In Network facility fee, physician/surgeon 20% coinsurance Out of Network not covered
10	Ambulance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network and Out of Network no charge
11	**HOSPITALIZATION**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network facility fee, physician/surgeon 20% coinsurance Out of Network not covered
12	Urgent Care Visit	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network $50 copay/visit Out of Network not covered
13	**EMERGENCY SERVICES**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network and Out of Network $400/visit
14	**REHABILITATION SERVICES**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network Outpatient $50/visit Inpatient 20% coinsurance Out of Network not covered
15	**LABORATORY SERVICES**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network Physician's office $20 copay/visit Hospital 20% coinsurance Out of Network not covered
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network Inpatient 20% coinsurance Outpatient $30/visit Out of Network not covered
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $15 retail, $45 mail order Tier 2- $35 retail, $105 mail order Tier 3- $60 retail, $180 mail order Specialty- 30% coinsurance Out of Network not covered	In Network Tier 1- $15, retail $45 mail order Tier 2- $35 retail, $105 mail order Tier 3- $60 retail, $180 mail order Specialty- 30% coinsurance Out of Network not covered	In Network Tier 1- $20 retail l, $60 mail order Tier 2- $40 retail, $150 mail order Tier 3- $70 retail, $210 mail order Specialty- 20% coinsurance Out of Network not covered
18	**MATERNITY**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network prenatal and postnatal care PCP $30 Specialist $50 Delivery and all inpatient services 20% coinsurance Out of Network not covered
19	**PEDIATRIC DENTAL SERVICES**	No charge after deductible is met	Available as a standalone plan in the Marketplace	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	HEALTH NET (continued)	Humana Inc.
	Plan Name	CommunityCare Open Access $30/$50/$4500	4600/Phoenix HMOx
	Plan Provisions		
1	Calendar year Deductible	$4,500/Mbr and $9,000/family	$4,600/Mbr and $9,200/family
2	Out-of-Pocket Limit	$6,350/Mbr and $12,700/family	$6,300/Mbr and $12,600/family
3	Provider Network	HMO Community Care Network	HMO
4	Coverage Area	Maricopa, Pinal, Pima	Maricopa, Pima
5	Coinsurance	20%	20%
6	Primary Care Physician	In Network $30 copay/visit Out of Network not covered	$25 copay
7	Specialist	In Network $50 copay/visit Out of Network not covered	$35 copay
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network not covered	No charge
9	**OUTPATIENT CARE**	In Network facility fee, physician/surgeon 20% coinsurance Out of Network not covered	20% coinsurance after deductible
10	Ambulance	In Network and Out of Network no charge	20% coinsurance after deductible
11	**HOSPITALIZATION**	In Network facility fee, physician/surgeon 20% coinsurance Out of Network not covered	20% coinsurance after deductible
12	Urgent Care Visit	In Network $50 copay/visit Out of Network not covered	$35 copay if use Concentra, $50 for non-Concentra
13	**EMERGENCY SERVICES**	In Network and Out of Network $400/visit	20% coinsurance after deductible
14	**REHABILITATION SERVICES**	In Network Outpatient $50/visit Inpatient 20% coinsurance Out of Network not covered	20% coinsurance after deductible
15	**LABORATORY SERVICES**	In Network Physician's office $20 copay/visit Hospital 20% coinsurance Out of Network not covered	No charge for the first $500 then 20% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Inpatient 20% coinsurance Outpatient $30/visit Out of Network not covered	20% coinsurance after deductible
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $20 retail l, $60 mail order Tier 2- $40 retail, $150 mail order Tier 3- $70 retail, $210 mail order Specialty- 20% coinsurance Out of Network not covered	In Network Tier 1- $10 copay Tier 2- $20 copay Tier 3- $50 copay Specialty- 50% coinsurance Deductible $1,500/Mbr, $3,000/family
18	**MATERNITY**	In Network prenatal and postnatal care PCP $30, specialist $50 Delivery and all inpatient services 20% coinsurance Out of Network not covered	20% coinsurance after deductible
19	**PEDIATRIC DENTAL SERVICES**	No charge after deductible is met	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Meritus Health Partners		
	Plan Name	Neighborhood Network MIHS	Community Network Silver HMO	Healthy Complete HMO 4000 Complete/Abrazo/Banner 3 Networks same plan provisions
	Plan Provisions			
1	Calendar year Deductible	$5,000/Mbr and $10,000/family	$5,000/Mbr and $10,000/family	$4,000/Mbr and $8,000/family
2	Out-of-Pocket Limit	$6,350/Mbr and $12,700/family	$6,350/Mbr and $12,700/family	$6,600/Mbr and $13,200/family
3	Provider Network	HMO - MIHS	HMO	HMO
4	Coverage Area	Maricopa, Pima, Santa Cruz	Statewide w/exceptions	Statewide w/exceptions
5	Coinsurance	N/A	N/A	30%
6	Primary Care Physician	$0 copay	In Network 0% coinsurance Out of Network not covered	In Network $30 copay Out of Network not covered
7	Specialist	$100 copay	In Network $100 copay per visit Out of Network not covered	In Network $60 copay Out of Network not covered
8	**PREVENTIVE SERVICES**	No charge	In Network $0 copay Out of Network not covered	In Network $0 copay Out of Network not covered
9	**OUTPATIENT CARE**	Outpatient Surgery–Ambulatory Surgical Center $400 copay per visit Outpatient Surgery–Hospital $500 copay per visit Outpatient Chemotherapy/Drugs $100 copay per treatment Outpatient Radiology–General $150 copay per test	Outpatient Surgery–Ambulatory Surgical Center $400 copay per visit Outpatient Surgery–Hospital $500 copay per visit Outpatient Chemotherapy/Drugs $100 copay per treatment Outpatient Radiology–General $150 copay per test	$500 copay per surgery facility fee Physician/surgeon 30% coinsurance Out of Network not covered
10	Ambulance	$0 copay	In Network no charge Out of Network not covered	$250 copay per transport Out of Network not covered
11	**HOSPITALIZATION**	$1,000 copay per admit after deductible	In Network facility fee $1,000 copay per admit after deductible physician/surgeon no charge Out of Network not covered	30% coinsurance per admit 30% coinsurance physician/surgeon fee after deductible Out of Network not covered
12	Urgent Care Visit	$100 copay per visit	In Network $100 copay per visit Out of Network not covered	$60 copay per visit Out of Network not covered
13	**EMERGENCY SERVICES**	$500 copay per visit	In Network $500 copay per visit Transportation no charge Out of Network not covered	$500 copay per visit Out of Network not covered
14	**REHABILITATION SERVICES**	Inpatient hospital services $1,000 copay per admission, after deductible Physical Therapy, Occupational Therapy, and Speech Therapy visits $100 copay per visit, no deductible	Inpatient hospital services $1,000 copay per admission, after deductible Physical Therapy, Occupational Therapy, and Speech Therapy visits $100 copay per visit, no deductible	$60 copay per visit Out of Network not covered
15	**LABORATORY SERVICES**	Office Pathology/Lab $100 copay per test, no deductible Outpatient Pathology/Lab $100 copay per test, no deductible	Office Pathology/Lab $100 copay per test, no deductible Outpatient Pathology/Lab $100 copay per test, no deductible	$25 copay per blood test after deductible Out of Network not covered
16	**MENTAL HEALTH AND SUBSTANCE USE**	Inpatient hospital services $1,000 copay per admission after deductible Outpatient office visit $100 copay per visit, no deductible, no cost for the first three visits during each calendar year	Inpatient hospital services $1,000 copay per admission after deductible Outpatient $100 copay per visit, no cost for the first three visits during each calendar year	Inpatient services 30% coinsurance per admission Outpatient $60 copay per visit Out of Network not covered
17	**PRESCRIPTION DRUGS**	Rx deductible $250 Tier 1- $0 copay maintenance and $20 copay non-maintenance, 30-day supply Tier 2- $72 copay 30-day supply Tier 3- $150 copay 30-day supply Specialty- 40% coinsurance Out of Network not covered	In Network Tier 1- maintenance generic, no copay Non-maintenance $20 retail 30-day supply, $60 mail order 90-day supply Tier $72 retail 30-day supply, $216 mail 90-day supply Tier 3- $150 retail 30-day supply, $450 mail 90-day supply Specialty- 40% coinsurance Out of Network not covered	In Network Tier 1- maintenance generic: $5 copay retail; $15 mail order 90-day supply Non-maintenance $20 retail; mail order $60 90-day supply Tier 2- $60 retail; mail order $180 90-day supply Tier 3- $150 retail; $450 mail order 90-day supply Specialty- 50% coinsurance Out of Network not covered $300 deductible
18	**MATERNITY**	In Network prenatal and postnatal no charge Delivery and all inpatient services $1,000 copay per admit after deductible Out of Network not covered	In Network prenatal and postnatal no charge Delivery and all inpatient services $1,000 copay per admit after deductible Out of Network not covered	In Network prenatal and postnatal $30 copay Delivery and all inpatient services 30% coinsurance per admit Out of Network not covered
19	**PEDIATRIC DENTAL SERVICES**	Class I- 0% coinsurance Class II- 45% coinsurance Class III- 65% coinsurance Orthodontia- 50% coinsurance	Class I- 0% coinsurance Class II- 45% coinsurance Class III- 65% coinsurance Orthodontia- 50% coinsurance	Not Covered

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Meritus Health Partners (continued)		
	Plan Name	Healthy Choice PPO Plus 4000	Healthy HSA Plus 2000	Community Network Silver HMO
	Plan Provisions			
1	Calendar year Deductible	$4,000/Mbr and $8,000/family Out of Network $12,000/Mbr and $24,000/family	$2,000/Mbr and $4,000/family Out of Network $6,000/Mbr and $12,000/family	$5,000/Mbr and $10,000/family
2	Out-of-Pocket Limit	$6,600/Mbr and $13,200/family Out of Network $19,000/Mbr and $38,000/family	$4,000/Mbr and $8,000/family Out of Network $13,500/Mbr $27,000/family	$6,350/Mbr and $12,700/family
3	Provider Network	PPO	HSA	HMO
4	Coverage Area	Statewide w/exceptions	Statewide w/exceptions	PIMA
5	Coinsurance	30%	30%	N/A
6	Primary Care Physician	In Network $30 copay Out of Network 50% coinsurance	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network no charge Out of Network not covered
7	Specialist	In Network $60 copay Out of Network 50% coinsurance	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network $100 copay Out of Network not covered
8	**PREVENTIVE SERVICES**	In Network 0% coinsurance Out of Network 50% coinsurance	In Network 0% coinsurance Out of Network 50% coinsurance	In Network $0 copay Out of Network not covered
9	**OUTPATIENT CARE**	$500 copay per surgery facility fee Physician/surgeon 30% coinsurance Out of Network 50% coinsurance	30% surgery facility fee after deductible Physician/surgeon 30% coinsurance after deductible Out of Network 50% coinsurance after deductible	Outpatient Surgery–Ambulatory Surgical Center $400 copay per visit Outpatient Surgery–Hospital $500 copay per visit Outpatient Chemotherapy/Drugs $100 copay per treatment Outpatient Radiology–General $150 copay per test Out of Network not covered
10	Ambulance	In Network and Out of Network $250 copay per transit	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network no charge Out of Network not covered
11	**HOSPITALIZATION**	30% coinsurance per admit 30% coinsurance physician/surgeon fee after deductible Out of Network 50% coinsurance	30% coinsurance per admit 30% coinsurance physician/surgeon fee after deductible Out of Network 50% coinsurance	In Network facility fee $1,000 copay per admit after deductible, physician/surgeon no charge Out of Network not covered
12	Urgent Care Visit	In Network and Out of Network $60 copay per visit	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network $100 copay per visit Out of Network not covered
13	**EMERGENCY SERVICES**	In Network and Out of Network $500 copay per visit	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network $500 copay per visit Transportation no charge Out of Network not covered
14	**REHABILITATION SERVICES**	$60 copay per visit Out of Network 50% coinsurance	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible	Inpatient hospital services $1,000 copay per admission after deductible Physical Therapy, Occupational Therapy, and Speech Therapy visits $100 copay per visit, no deductible Out of Network not covered
15	**LABORATORY SERVICES**	$25 copay per blood test after deductible Out of Network 50% after deductible	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible	Office Pathology/Lab $100 copay per test, no deductible Outpatient Pathology/Lab $100 copay per test, no deductible Out of Network not covered
16	**MENTAL HEALTH AND SUBSTANCE USE**	Inpatient services 30% coinsurance per admission Outpatient $60 copay per visit Out of Network 50% coinsurance	Inpatient services 30% coinsurance per admission after deductible Outpatient $60 copay per visit after deductible Out of Network 50% coinsurance	In Network Inpatient $1,000 copay per admit after deductible Inpatient hospital services $1,000 copay per admission after deductible Outpatient $100 copay per visit, no cost for the first three visits during each calendar year Out of Network not covered
17	**PRESCRIPTION DRUGS**	In Network Tier 1- maintenance generic: $5 copay retail; $15 mail order 90-day supply Non-maintenance $20 retail; mail order $60 90-day supply Tier 2- $60 retail; mail order $180 90-day supply Tier 3- $150 retail; $450 mail order 90-day supply Specialty- 50% coinsurance Out of Network 50% coinsurance $300 deductible	In Network all Tiers 30% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network Tier 1- generic maintenance no copay Non-maintenance $20 retail 30-day supply, $60 mail order 90-day supply Tier 2- $72 retail 30-day supply, $216 mail order 90-day supply Tier 3- $150 retail 30-day supply, $450 mail order 90-day supply Specialty- 40% coinsurance Out of Network not covered
18	**MATERNITY**	In Network prenatal and postnatal $30 copay Delivery and all inpatient services 30% coinsurance per admit Out of Network 50% coinsurance	In Network prenatal and postnatal $30 copay after deductible Delivery and all inpatient services 30% coinsurance per admit after deductible Out of Network 50% coinsurance after deductible	In Network prenatal and postnatal no charge Delivery and all inpatient services $1,000 copay per admit after deductible Out of Network not covered
19	**PEDIATRIC DENTAL SERVICES**	Not Covered	Not Covered	Class I- 0% coinsurance Class II- 45% coinsurance Class III- 65% coinsurance Orthodontia- 50% coinsurance

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	**Phoenix Health Plans, Inc.**	**University Healthcare Marketplace**
	Plan Name	Phoenix Choice	Silver Canyon
	Plan Provisions		
1	Calendar year Deductible	$3,500/Mbr and $7,000/family	$2,300/Mbr and $4,600/family
2	Out-of-Pocket Limit	$6,600/Mbr and $13,200/family	$6,600/Mbr and $13,720/family
3	Provider Network	HMO	HMO
4	Coverage Area	Statewide w/exceptions	Statewide
5	Coinsurance	30%	20%
6	Primary Care Physician	$30 copay/visit	$10 copay/visit Out of Network not covered
7	Specialist	$60 copay/visit	In Network $50 copay/visit after deductible Out of Network not covered
8	**PREVENTIVE SERVICES**	No charge	In Network no charge Out of Network not covered
9	**OUTPATIENT CARE**	30% coinsurance after deductible	Facility fee, physician/surgeon fee 20% coinsurance after deductible Out of Network not covered
10	Ambulance	30% coinsurance after deductible	In Network 20% coinsurance after deductible Out-of-Network 100% coinsurance
11	**HOSPITALIZATION**	30% coinsurance after deductible	No charge In Network facility fee, physician/surgeon $500 copay per day after deductible Out of Network not covered
12	Urgent Care Visit	30% coinsurance after deductible	In Network 20% coinsurance after deductible Out of Network 100% coinsurance
13	**EMERGENCY SERVICES**	30% coinsurance after deductible	In Network $250 copay per visit after deductible Out of Network 100% coinsurance
14	**REHABILITATION SERVICES**	30% coinsurance after deductible	In Network 20% coinsurance after deductible Out of Network not covered
15	**LABORATORY SERVICES**	30% coinsurance after deductible	In Network 20% coinsurance after deductible Out of Network not covered
16	**MENTAL HEALTH AND SUBSTANCE USE**	Inpatient 30% coinsurance/visit after deductible Outpatient $30 copay/visit after deductible	In Network Inpatient $500 copay per day after deductible Outpatient 20% coinsurance after deductible Out of Network not covered
17	**PRESCRIPTION DRUGS**	Tier- $10 copay Tier 2- $40 copay Tier 3- $80 copay Specialty- 35% coinsurance	In Network Tier 1- $6 each prescription after deductible Tier 2- 30% coinsurance after deductible Tier 3- 40% coinsurance after deductible Specialty- 40% coinsurance after deductible Out of Network not covered
18	**MATERNITY**	30% coinsurance after deductible	In Network prenatal and postnatal care $10 copay after deductible Delivery and all inpatient services $500 copay per day after deductible Out of Network not covered
19	**PEDIATRIC DENTAL SERVICES**	Not Covered Available as a standalone plan in the Marketplace	Not Covered Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	United Healthcare One	
	Plan Name	Compass Plus Silver $3500	Compass Plus Silver $2000
	Plan Provisions		
1	Calendar year Deductible	In Network $3,500/Mbr and $7,000/family Out of Network $7,000/Mbr and $14,000/family	In Network $2,000/Mbr and $4,000/family Out of Network $4,000/Mbr and $8,000/family
2	Out-of-Pocket Limit	In Network $6,600/Mbr and $13,200/family Out of Network Mbr and family Unlimited	In Network $6,600/Mbr and $13,200/family Out of Network Mbr and family Unlimited
3	Provider Network	Compass Plus	Compass Plus
4	Coverage Area	Statewide, National	Statewide, National
5	Coinsurance	In Network 20% Out of Network 50%	In Network 30% Out of Network 50%
6	Primary Care Physician	In Network $20 copay Out of Network 50% coinsurance after deductible	In Network $30 copay Out of Network 50% coinsurance after deductible
7	Specialist	In Network $60 copay with referral $100 copay without referral Out of Network 50% coinsurance after deductible	In Network $60 copay with referral $100 copay without referral Out of Network 50% coinsurance after deductible
8	**PREVENTIVE SERVICES**	In Network 0% coinsurance, deductible waived Out of Network 50% coinsurance after deductible	In Network 0% coinsurance, deductible waived Out of Network 50% coinsurance after deductible
9	**OUTPATIENT CARE**	In Network 20% coinsurance after deductible with referral 50% coinsurance after deductible without referral Additional $400 per occurrence deductible for services at hospital setting Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible with referral 50% coinsurance after deductible without referral Additional $400 per occurrence deductible for services at hospital setting Out of Network 50% coinsurance after deductible
10	Ambulance	In Network 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible
11	**HOSPITALIZATION**	In Network 20% coinsurance after deductible with referral 50% coinsurance after deductible without referral Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible with referral 50% coinsurance after deductible without referral Out of Network 50% coinsurance after deductible
12	Urgent Care Visit	In Network 0% coinsurance after $50 copay Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after $50 copay Out of Network 50% coinsurance after deductible
13	**EMERGENCY SERVICES**	$250 per occurrence deductible then 20% coinsurance after deductible	$250 per occurrence deductible then 30% coinsurance after deductible
14	**REHABILITATION SERVICES**	In Network 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible
15	**LABORATORY SERVICES**	In Network 20% coinsurance after deductible 40% coinsurance after deductible if at hospital setting Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible 50% coinsurance after deductible if at hospital setting Out of Network 50% coinsurance after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Outpatient 0% coinsurance after $20 copay Inpatient 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network Outpatient 0% coinsurance after $30 copay Inpatient 30% coinsurance after deductible Out of Network 50% coinsurance after deductible
17	**PRESCRIPTION DRUGS**	Separate pharmacy deductible of $1,000 applies to Tiers 3 & 4 In Network Tier 1- $5 copay Tier 2- $45 copay Tier 3- 20% coinsurance (minimum $85 copay) Tier 4- 30% coinsurance (minimum $250 copay)	Separate pharmacy deductible of $500 applies to Tiers 3 & 4 In Network Tier 1- $5 copay Tier 2- $40 copay Tier 3- 20% coinsurance (minimum $80 copay) Tier 4- 30% coinsurance (minimum $250 copay)
18	**MATERNITY**	In Network 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible
19	**PEDIATRIC DENTAL SERVICES**	In Network 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 30% coinsurance after deductible Out of Network 50% coinsurance after deductible

Arizona Health Insurance Marketplace
Silver Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	United Healthcare One	
	Plan Name	Compass Plus Silver Smart HSA $1600	Compass Plus Silver HSA $2600
	Plan Provisions		
1	Calendar year Deductible	In Network $1,600/Mbr and $3,200/family Out of Network $3,200/Mbr and $6,400/family	In Network $2,600/Mbr and $5,200/family Out of Network $5,200/Mbr and $10,400/family
2	Out-of-Pocket Limit	In Network $6,450 Mbr and $12,900/family Out of Network Mbr and family Unlimited	In Network $6,450 Mbr and $12,900/family Out of Network Mbr and family Unlimited
3	Provider Network	Compass Plus	Compass Plus
4	Coverage Area	Statewide; National	Statewide, National
5	Coinsurance	In Network 0% Out of Network 50%	In Network 0% Out of Network 50%
6	Primary Care Physician	In Network $15 copay after deductible Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible
7	Specialist	In Network $35 after deductible with referral $70 copay after deductible without referral Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after deductible with referral 70% coinsurance after deductible without referral Out of Network 50% coinsurance after deductible
8	**PREVENTIVE SERVICES**	In Network 0% coinsurance, deductible waived Out of Network 50% coinsurance after deductible	In Network 0% coinsurance, deductible waived Out of Network 50% coinsurance after deductible
9	**OUTPATIENT CARE**	In Network 0% coinsurance after deductible with referral 30% coinsurance after deductible without referral Additional $350 per occurrence deductible for services at a freestanding facility Additional $500 per occurrence deductible for services at hospital setting Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after deductible at freestanding facilities 70% coinsurance after deductible for services at hospital setting Out of Network 50% coinsurance after deductible
10	Ambulance	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible
11	**HOSPITALIZATION**	In Network $1,500 copay per admission after deductible with referral $2,000 copay per admission after deductible without referral Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after deductible with referral 30% coinsurance after deductible without referral Out of Network 50% coinsurance after deductible
12	Urgent Care Visit	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible
13	**EMERGENCY SERVICES**	$300 copay after deductible then 0% coinsurance	0% coinsurance after deductible
14	**REHABILITATION SERVICES**	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible
15	**LABORATORY SERVICES**	In Network 0% coinsurance after deductible 30% coinsurance after deductible if at hospital setting Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after deductible 30% coinsurance after deductible if at hospital setting Out of Network 50% coinsurance after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Outpatient $15 copay after deductible Inpatient $1,500 copay per admission after deductible Out of Network 50% coinsurance after deductible	In Network Outpatient 0% coinsurance after deductible In Network Inpatient 0% coinsurance after deductible Out of Network 50% coinsurance after deductible
17	**PRESCRIPTION DRUGS**	Pharmacy benefits are subject to plan deductible In Network Tier 1- $10 copay Tier 2- $50 copay Tier 3- 20% coinsurance (minimum $90 copay) Tier 4- 30% coinsurance (minimum $250 copay)	Pharmacy benefits are subject to plan deductible In Network Tier 1- $5 copay Tier 2- $40 copay Tier 3- 20% coinsurance (minimum $80 copay) Tier 4- 30% coinsurance (minimum $250 copay)
18	**MATERNITY**	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible
19	**PEDIATRIC DENTAL SERVICES**	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after deductible Out of Network 50% coinsurance after deductible

Arizona Health Insurance Marketplace
Gold Plans

Referred to as "metal plans," the different tiers are defined by the percentage each plan will pay toward health care expenses, known as the actuarial value, for an average person.

A Gold plan is designed to provide 80 percent coverage with the enrollee paying approximately 20 percent of eligible expenses.

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Aetna	Assurant Health
	Plan Name	Banner Health Network $5 copay	Plan 002
	Plan Provisions		
1	Calendar Year Deductible	In Network $1,400/Mbr and $2,800/family Out of Network $6,750/Mbr and $13,500/family	In Network $0 Mbr and $0/family Out of Network $5,000/Mbr and $10,000/family
2	Out-of-Pocket Limit	In Network $5,000/Mbr and $10,000/family Out of Network $Unlimited/Mbr and $Unlimited/family	In Network $6,350/Mbr and $12,700/family Out of Network $10,000/Mbr and $20,000/family
3	Provider Network	PPO	PPO
4	Coverage Area	Maricopa	Statewide
5	Coinsurance	In Network 20% Out of Network 50%	25%
6	Primary Care physician	In Network $5 copay/visit deductible waived Out of Network 50% coinsurance	In Network $25 copay Out of Network 50% coinsurance
7	Specialist	In Network $40 copay/visit deductible waived Out of Network 50% coinsurance	In Network $25 copay Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network 0% coinsurance Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	in Network surgery facility fee, physician/surgeon fees 20% coinsurance Out of Network 50% coinsurance	In Network 25% coinsurnace Out of Network 50% coinsurance
10	Ambulance	In Network and Out of Network 20% coinsurance	In Network and Out of Network 25% coinsurnace
11	**HOSPITALIZATION**	In Network facility fee, physician/surgeon fee 30% coinsurance Out of Network 50% coinsurance	In Network 25% coinsurnace Out of Network 50% coinsurance
12	Urgent Care Visit	In Network $75 copay/visit deductible waived Out of Network 50% coinsurance	In Network 25% coinsurnace Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network and Out of Network $250 copay/visit deductible waived	In Network and Out of Network $100 access fee, then deductible and 25% coinsurance
14	**REHABILITATION SERVICES**	In Network 20% coinsurance Out of Network 50% coinsurance	In Network 25% coinsurnace Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network 20% coinsurance Out of Network 50% coinsurance	In Network 25% coinsurnace Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network outpatient $40 copay/visit deductible waived Inpatient 20% coinsurance Out of Network 50% coinsurance	In Network inpatient 25% coinsurnace Outpatient $25 copay/visit Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1A- $3 copay (retail), $6 copay (mail order) Tier 1 $10 (retail) $20 (mail order) deductible waived Tier 2- $35 copay (retail) $87.50 copay (mail order) Tier 3- $70 (retial) / $210 (mail order) Specialty- Preferred 30% coinsurance / non-Preferred 50% coinsurance Out of Network Tier 1 50% coinsurance (retail and mail order) Tier 2- 50% coinsurance (retail and mail order) Tier 3- 50% coinsurance (retail and mail order) Specialty- 50% coinsurance	In Network and Out of Network Tier 1 $15 copay retail; $45 mail order Tier 2 $35 copay retail; mail order $105 Tier 3 $60 copay retail ; mail order $180 Specialty 25% coinsurance Out of Network specialty drugs not covered
18	**MATERNITY**	In Network Prenatal no charge, postnatal $250 one time copay, deductible waived Delivery/inpatient 20% coinsurance Out of Network 50% coinsurance	In Network 25% coinsurnace Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Not Covered Available as a standalone plan in the Marketplace	No charge

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Blue Cross Blue Shield of Arizona		
	Plan Name	EverydayHealth 1000 A lliance / Select 2 networks same plan provisions	CopayComplete 25 Alliance / Select 2 networks same plan provisions	Essential 1500 Statewide
	Plan Provisions			
1	Calendar Year Deductible	In Network $1,000/Mbr and $2,000/family	In Network $0/Mbr and $0/family	In Network $1,500/Mbr and $3,000/family Out of Network $2,000/Mbr and $4,000/family
2	Out-of-Pocket Limit	In Network $4,500/Mbr and $9,000/family	In Network $6,375/Mbr and $12,700/family	In Network $3,000/Mbr and $6,000/family Out of Network $6,000/Mbr and $12,000/family
3	Provider Network	HMO	HMO	PPO
4	Coverage Area	Statewide	Statewide	Statewide, National
5	Coinsurance	20%	Copay	20%
6	Primary Care physician	In Network $20 copay/provider/day Out of Network not covered	In Network $25 copay/provider/day Out of Network not covered	In Network $25 copay/provider/day (PCP and Specialist visits combined) then 20% coinsurance Out of Network 50% coinsurance
7	Specialist	In Network $40 copay/provider/day Out of Network not covered	In Network $50 copay/provider/day Out of Network not covered	In Network $50 copay/provider/day (PCP and Specialist visits combined) then 20% coinsurance Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network not covered	In Network no charge Out of Network not covered	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee, physician/surgeon 20% coinsurance after deductible Out of Network not covered	In Network facility fee $500 copay/day physician/surgeon no charge after deductible Out of Network not covered	In Network facility fee, physician/surgeon 20% coinsurance after deductible Out of Network 50% coinsurance after deductible
10	Ambulance	In Network and Out of Network 20% coinsurance deductible waived	In Network and Out of Network $150 copay/provider/day deductible waived	In Network and Out of Network 20% coinsurance deductible waived
11	**HOSPITALIZATION**	In Network facility fee, physician/surgeon 20% coinsurance Out of Network not covered	In Network facility fee $900 copay/day for a maximum of four copays per admission; physician/surgeon no charge Out of Network not covered	In Network facility fee, physician/surgeon 20% coinsurance Out of Network 50% coinsurances
12	Urgent Care Visit	In Network $60 copay/provider/day Out of Network not covered	In Network $60 copay/provider/day Out of Network not covered	In Network $60 copay/provider/day Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network and Out of Network $250 copay/facility /day	In Network and Out of Network $300 copay/facility/day after deductible	In Network and Out of Network 20% coinsurance
14	**REHABILITATION SERVICES**	In Network 20% coinsurance Out of Network not covered	In Network outpatient $50 copay/provider/visit Inpatient $900 copay/day for a maximum of four copays per admission Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network office visit $20 copay or 20% coinsurance Out of Network not covered	In Network outpatient facility $25 copay/provider/day Out of Network not covered	In Network office visit copay of $25 or 20% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network inpatient services 20% coinsurance Outpatient services physician office visit copay or 20% coinsurance Out of Network not covered	In Network inpatient services $900 copay/day for a maximum of four days per admission Outpatient services physician office visit copay of $25 or outpatient facility copay Out of Networknot covered	In Network inpatient services 20% coinsurance Outpatient services no charge if services in office home walk-in clinic 20% coinsurance other locations Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $15 copay Tier 2- $40 copay Tier 3- $80 copay Specialty- 45% coinsurance Out of Network not covered	In Network Tier 1- $10 copay Tier 2- $45 copay Tier 3- $90 copay Specialty- 45% coinsurance Out of Network not covered	In Network and Out of Network Tier 1- $10 copay Tier 2- $55 copay Tier 3- $90 copay Specialty- 45% coinsurance Out of Network Specialty not covered
18	**MATERNITY**	In Network Prenatal and postnatal physician office visit copay of $20 Delivery and all inpatient services 20% coinsurance Out of Network not covered	In Network Prenatal and postnatal physician office visit copay of $25 Delivery and all inpatient services hospital $900 copay/day for a maximum of four copays per admission Out of Network not covered	In Network Prenatal and postnatal PCP copay of $25 or 20% coinsurance Delivery and all inpatient services 20% coinsurance Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Dental check up & cleanings no charge limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check up & cleanings no charge limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check up & cleanings no charge limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Blue Cross Blue Shield (continued)		
	Plan Name	Essential 1500 A lliance / Select 2 networks same plan provisions	Portfolio 1500 A lliance / Select 2 networks same plan provision	Portfolio 1500 Statewide
	Plan Provisions			
1	Calendar Year Deductible	In Network $1,500/Mbr and $3,000/family	In Network $1,500/Mbr and $3,000/family	In Network $1,500/Mbr and $3,000/family Out of Network $2,000/Mbr and $4,000/family
2	Out-of-Pocket Limit	In Network $3,000/Mbr and $6,000/family	In Network $3,000/Mbr and $6,000/family	In Network $3,000/Mbr and $6,000/family Out of Network $6,000/Mbr and $12,000/family
3	Provider Network	HMO	HMO - qualified HMO	PPO
4	Coverage Area	Statewide	Statewide	Statewide, National
5	Coinsurance	20%	10%	10%
6	Primary Care physician	In Network $25 copay/visit for three visits/Mbr (PCP and specialist combined) then 20% coinsurance Out of Network 50% coinsurance & balance bill	In Network 10% coinsurance Out of Network not covred	In Network 10% coinsurance Out of Network 50% coinsurance
7	Specialist	In Network $50 copay/visit for three visits/Mbr (PCP and specialist combined) then 20% coinsurance Out of Network 50% coinsurance & balance bill	In Network 10% coinsurance Out of Network not covered	In Network 10% coinsurance Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network not covered	In Network no charge Out of Network not covered	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee, physician/surgeon 20% coinsurance after deductible Out of Network not covered	In Network facility fee, physician/surgeon 10% coinsurance after deductible Out of Network not covered	In Network facility fee, physician/surgeon 10% coinsurance after deductible Out of Network 50% coinsurance
10	Ambulance	In Network and Out of Network 20% coinsurance deductible waived	In Network and Out of Network 10% coinsurance after deductible	In Network and Out of Network 10% coinsurance deductible waived
11	**HOSPITALIZATI ON**	In Network facility fee, physician/surgeon 20% coinsurance Out of Network not covered	In Network facility fee, physician/surgeon 10% coinsurance Out of Network not covered	In Network facility fee, physician/surgeon 10% coinsurance after deductible Out of Network 50% coinsurance after deductible
12	Urgent Care Visit	In Network $60 copay/provider/day Out of Network not covered	In Network 10% coinsurance Out of Network not covered	In Network 10% coinsurance Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network and Out of Network 20% coinsurance	In Network and Out of Network 10% coinsurance	In Network and Out of Network 10% coinsurance
14	**REHABILITATIO N SERVICES**	In Network 20% coinsurance Out of Network 50% coinsurance	In Network 10% coinsurance Out of Network not covered	In Network 10% coinsurance Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network copay of $25 or 20% coinsurance after copay limit is reached Out of Network not covered	In Network 10% coinsurance Out of Network not covered	In Network 10% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network inpatient services 20% coinsurance Outpatient services no charge for physician office, walk-in or clinic or 20% coinsurance other locations Out of Network not covered	In Network inpatient services 10% coinsurance Out of Network not covered	In Network inpatient services 10% coinsurance after deductible Outpatient services 20% coinsurance after deductible Out of Network 50% coinsurance after deductible
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $10 copay Tier 2- $25 copay Tier 3- $90 copay Specialty- 45% coinsurance Out of Network not covered	In Network all Tiers 10% coinsurance Out of Network not covered	In Network all Tier 10% coinsurance Specialty- 45% coinsurance Out of Network 50% coinsurance Specialty not covered
18	**MATERNITY**	In Network Prenatal and postnatal physician office visit copay of $25 or 20% coinsurance Delivery and all inpatient services 20% coinsurance Out of Network not covred	In Network Prenatal and postnatal 10% coinsurance Delivery and all inpatient services 10% coinsurance Out of Network not covered	In Network Prenatal and postnatal physician 10% coinsurance Delivery and all inpatient services 10% coinsurance Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Dental check up & cleanings no charge limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check up & cleanings no charge limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check up & cleanings no charge limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Blue Cross Blue Shield (continued)		Cigna Healthcare
	Plan Name	EverydayHealth 1000 Statewide	CopayComplete 25 Statewide	Health Flex 1250
	Plan Provisions			
1	Calendar Year Deductible	In Network $1,000/Mbr and $2,000/family Out of Network $1,500/Mbr and $3,000/family	In Network $0/Mbr and $0/family Out of Network $3,000/Mbr and $6,000/family	In Network $1,250/Mbr and $2,500 /family Out of Network $12,500/Mbr and $25,000 /family
2	Out-of-Pocket Limit	In Network $4,500/Mbr and $9,000/family Out of Network $9,000/Mbr and $18,000/family	In Network $6,350/Mbr and $12,700/family Out of Network $12,700/Mbr and $25,400/family	In Network; $4,000/Mbr and $8,000/family Out of Network $25,000/Mbr and $50,000 /family
3	Provider Network	PPO	PPO	LocalPlus Plan
4	Coverage Area	Statewide, National	Statewide, National	Statewide
5	Coinsurance	20%	0%	In Network 20% Out of Network 50%
6	Primary Care physician	In Network $20 copay/provider/day Out of Network 50% coinsurance	In Network $25 copay/provider/day Out of Network 50% coinsurance	In Network $20 copay/visit Out of Network 50% coinsurance
7	Specialist	In Network $40 copay/provider/day Out of Network 50% coinsurance	In Network $50 copay/provider/day Out of Network 50% coinsurance	In Network $40 copay/visit Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee, physician/surgeon 20% coinsurance after deductible Out of Network 50% coinsurance	In Network facility fee $500 copay/day Physician/surgeon no charge after deductible Out of Network 50% coinsurance	In Network facility fee, physician/surgeon fees 20% coinsurance Out of Network 50% coinsurance
10	Ambulance	In Network and Out of Network 20% coinsurance deductible waived	In Network and Out of Network $150 copay/provider/day deductible waived	In Network and Out of Network 20% coinsurance
11	**HOSPITALIZATION**	In Network facility fee, physician/surgeon 20% coinsurance after deductible Out of Network 50% coinsurance	In Network facility fee $900 copay/day for a maximum of four copays per admission; physician/surgeon no charge after deductible Out of Network 50% coinsurance after deductible	In Network facility fee, physician/surgeon fees 20% coinsurance Out of Network 50% coinsurance
12	Urgent Care Visit	In Network $60 copay/provider/day Out of Network 50% coinsurance	In Network $60 copay/provider/day Out of Network 50% coinsurance	In Network and out Network $75 copay/visit
13	**EMERGENCY SERVICES**	In Network and Out of Network $250 copay/facility /day	In Network and Out of Network $300 copay/facility /day	In Network and Out of Network 20% coinsurance
14	**REHABILITATION SERVICES**	In Network 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network outpatient $50 copay/provider/visit Inpatient $900 copay/day for a maximum of four copays per admission after deductible Out of Network 50% coinsurance	In Network 20% coinsurance Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network office visit copay of $20 or 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network outpatient facility $25 copay/provider/day after deductible Out of Network 50% coinsurance	In Network 20% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network inpatient services 20% coinsurance after deductible Outpatient services office visit copay of $20 or 20% coinsurance after deductible Out of Network 50% coinsurance	In Network inpatient services $900 copay/day for a maximum of four days per admission after deductible Outpatient services physician office visit copay of $25 or outpatient facility copay after deductible Out of Network 50% coinsurance after deductible	In Network Inpatient 20% coinsurance Outpatient $40 copay/visit Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network and Out of Network Tier 1- $15 copay Tier 2- $40 copay Tier 3- $80 copay Specialty- 45% coinsurance Out of Network specialty not covered	In Network and Out of Network Tier 1- $10 copay Tier 2- $45 copay Tier 3- $90 copay Specialty- 45% coinsurance Out of Network specialty not covered	In Network Tier 1- $4 copay (retail) /$10 copay (home delivery) Tier 2- $10 copay (retail)/ $25 copay (home delivery) Tier 3- $30 copay (retail)/$75 copay (home delivery) Tier 4- 50% coinsurance for retail and home delivery Specialty- 40% coinsurance (retail)/ 30% coinsurance (home delivery) Out of Network 50% coinsurance (retail)/not covered (home delivery)
18	**MATERNITY**	In Network Prenatal and postnatal physician office visit copay of $20 Delivery and all inpatient services 20% coinsurance after deductible Out of Network 50% coinsuranc after deductible	In Network Prenatal and postnatal physician office visit copay of $25 Delivery and all inpatient services hospital $900 copay/day for a maximum of four copays per admission after deductible Out of Network 50% coinsurance after deductible	In Network 20% coinsurance after deductible Out of Network 50% coinsurance & balance bill after deductible
19	**PEDIATRIC DENTAL SERVICES**	Dental check up & cleanings no charge limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Dental check up & cleanings no charge limit two per calendar year Basic/Major dental care 50% after deductible Orthodontia 50% after deductible	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Health Net		
	Plan Name	CommunityCare Open Access $30/$60/$6,000/$375	CommunityCare Open Access $30/$60/$6,000/$375	PPO $25/$50/$500
	Plan Provisions			
1	Calendar Year Deductible	$450/Mbr and $900/family	$450/Mbr and $900/family	In Network $500/Mbr and $1,000/family Out of Network $1,000/Mbr and $2,000/family
2	Out-of-Pocket Limit	$6,000/Mbr and $12,000/family	$6,000/Mbr and $12,000/family	In Network $3,500/Mbr and $7,000/family Out of Network $7,000/Mbr and $14,000/family
3	Provider Network	HMO Community Care Network	HMO Community Care Network	PPO
4	Coverage Area	Maricopa, Pinal, Pima	Maricopa, Pinal, Pima	Statewide
5	Coinsurance	10%	10%	30%
6	Primary Care physician	In Network $30 copay/visit Out of Network not covered	In Network $30 copay/visit Out of Network not covered	In Network $25 Out of Network 50% coinsurance
7	Specialist	In Network $60 copay/visit Out of Network not covered	In Network $60 copay/visit Out of Network not covered	In Network $50 Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network not covered	In Network no charge Out of Network not covered	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee, physician/surgeon 10% coinsurance Out of Network not covered	In Network facility fee, physician/surgeon 10% coinsurance Out of Network not covered	In Network facility fee, physician/surgeon fee 30% coinsurance Out of Network 50% coinsurance
10	Ambulance	In Network and Out of Network no charge	In Network and Out of Network no charge	In Network and Out of Network 30% coinsurance
11	**HOSPITALIZATION**	In Network facility fee $375/day, physician/surgeon no charge Out of Network not covered	In Network facility fee $375/day, physician/surgeon no charge Out of Network not covered	In Network 30% coinsurance Out of Network 50% coinsurance
12	Urgent Care Visit	In Network $50 copay/visit Out of Network not covered	In Network $50 copay/visit Out of Network not covered	In Network $50/visit Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network and Out of Network $150/visit	In Network and Out of Network $150/visit Transportation no charge	In Network Out Network $300/visit
14	**REHABILITATION SERVICES**	In Network Outpatient $60/visit Inpatient 375/day Out of Network not covered	In Network Outpatient $60/visit Inpatient 375/day Out of Network not covered	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network physician's office no charge Hospital 10% coinsurance Out of Network not covered	In Network physician's office no charge Hospital 10% coinsurance Out of Network not covered	In Network office no charge Hospital 30% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network inpatient $375/day Outpatient $30/visit Out of Network not covered	In Network inpatient $375/day Outpatient $30/visit Out of Network not covered	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $20/retail&$60 mail Tier 2- $50 retail&$150 mail Tier 3- $70 retail&$210 mail Specialty- 20% coinsurance Out of Network not covered	In Network Tier 1- $20/retail&$60 mail Tier 2- $50 retail&$150 mail Tier 3- $70 retail&$210 mail Specialty- 20% coinsurance Out of Network not covered	In Network Tier 1- $15/retail $45 mail Tier 2- $30 retail $90 mail Tier 3- $60 retail $180 mail Specialty- 30% coinsurance Out of Network not covered
18	**MATERNITY**	In Network Prenatal and postnatal care PCP $30/visit; specialist $60/visit Delivery and all inpatient services $375/day Out of Network not covered	In Network Prenatal and postnatal care PCP $30/visit; specialist $60/visit Delivery and all inpatient services $375/day Out of Network not covered	In Network Prenatal and postnatal PCP $25 specialist $50 Delivery and all inpatient services 30% Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	No charge after deductible is met	Available as a standalone plan in the Marketplace	No charge after deductible is met

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Health Net (continued)		
	Plan Name	PPO $25/$50/$500	PPO $25/$50/$1,500	PPO $25/$50/$1,500
	Plan Provisions			
1	Calendar Year Deductible	In Network $500/Mbr and $1,000/family Out of Network $1,000/Mbr and $2,000/family	In Network $1,500/Mbr and $3,000/family Out of Network $3,000/Mbr and $6,000/family	In Network $1,500/Mbr and $3,000/family Out of Network $3,000/Mbr and $6,000/family
2	Out-of-Pocket Limit	In Network $3,500/Mbr and $7,000/family Out of Network $7,000/Mbr and $14,000/family	In Network $4,000/Mbr and $8,000/family Out of Network $8,000/Mbr and $16,000/family	In Network $4,000/Mbr and $8,000/family Out of Network $8,000/Mbr and $16,000/family
3	Provider Network	PPO	PPO	PPO
4	Coverage Area	Statewide	Statewide	Statewide
5	Coinsurance	30%	30%	30%
6	Primary Care physician	In Network $25 Out of Network 50% coinsurance	In Network $25 Out of Network 50% coinsurance	In Network $25 Out of Network 50% coinsurance
7	Specialist	In Network $50 Out of Network 50% coinsurance	In Network $50 Out of Network 50% coinsurance	In Network $50 Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	In Network facility fee, physician/surgeon fee 30% coinsurance Out of Network 50% coinsurance	In Network facility fee, physician/surgeon fee 30% coinsurance Out of Network 50% coinsurance	In Network facility fee, physician/surgeon fee 30% coinsurance Out of Network 50% coinsurance
10	Ambulance	In Network and Out of Network 30% coinsurance	In Network and Out of Network 30% coinsurance	In Network and Out of Network 30% coinsurance
11	**HOSPITALIZATION**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance
12	Urgent Care Visit	In Network $50/visit Out of Network 50% coinsurance	In Network $50/visit Out of Network 50% coinsurance	In Network $50/visit Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network Out Network $300/visit	In Network Out Network $300/visit	In Network Out Network $300/visit
14	**REHABILITATION SERVICES**	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network office no charge Hospital 30% coinsurance Out of Network 50% coinsurance	In Network office no charge Hospital 30% coinsurance Out of Network 50% coinsurance	In Network office no charge Hospital 30% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $15/retail $45 mail Tier 2- $30 retail $90 mail Tier 3- $60 retail $180 mail Specialty- 30% coinsurance Out of Network not covered	In Network Tier 1- $15/retail $45 mail Tier 2- $30 retail $90 mail Tier 3- $60 retail $180 mail Specialty- 30% coinsurance Out of Network not covered	In Network Tier 1- $15/retail $45 mail Tier 2- $30 retail $90 mail Tier 3- $60 retail $180 mail Specialty- 30% coinsurance Out of Network not covered
18	**MATERNITY**	In Network Prenatal and postnatal PCP $25 specialist $50 Delivery and all inpatient services 30% Out of Network 50% coinsurance	In Network Prenatal and postnatal PCP $25 specialist $50 Delivery and all inpatient services 30% Out of Network 50% coinsurance	In Network Prenatal and postnatal PCP $25 specialist $50 Delivery and all inpatient services 30% Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Available as a standalone plan in the Marketplace	No charge after deductible is met	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Health Net (continued)		Humana Inc.
	Plan Name	PPO $25/$50/$2,500	PPO $25/$50/$2,500	2500/Phoenix HMOx
	Plan Provisions			
1	Calendar Year Deductible	In Network $2,500/Mbr and $5,000/family Out of Network $5,000/Mbr and $10,000/family	In Network $2,500/Mbr and $5,000/family Out of Network $5,000/Mbr and $10,000/family	$2,500/Mbr and $5,000/family
2	Out-of-Pocket Limit	In Network $4,000/Mbr and $8,000/family Out of Network $8,000/Mbr and $16,000/family	In Network $4,000/Mbr and $8,000/family Out of Network $8,000/Mbr and $16,000/family	$3,500/Mbr and $7,000/family
3	Provider Network	PPO	PPO	HMO
4	Coverage Area	Statewide	Statewide	Maricopa, Pima
5	Coinsurance	30%	30%	20%
6	Primary Care physician	In Network $25 Out of Network 50% coinsurance	In Network $25 Out of Network 50% coinsurance	$25 copay
7	Specialist	In Network $50 Out of Network 50% coinsurance	In Network $50 Out of Network 50% coinsurance	$35 copay
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance	No charge
9	**OUTPATIENT CARE**	In Network facility fee, physician/surgeon fee 30% coinsurance Out of Network 50% coinsurance	In Network facility fee, physician/surgeon fee 30% coinsurance Out of Network 50% coinsurance	20% coinsurance after deductible
10	Ambulance	In Network and Out of Network 30% coinsurance	In Network Out of Network 30% coinsurance	20% coinsurance after deductible
11	**HOSPITALIZATION**	In Network 30% coinsurance Out of Network 50% coinsurance	In Network 30% coinsurance Out of Network 50% coinsurance	20% coinsurance after deductible
12	Urgent Care Visit	In Network $50/visit Out of Network 50% coinsurance	In Network $50/visit Out of Network 50% coinsurance	$35 copay if use Concentra, $50 for non-Concentra
13	**EMERGENCY SERVICES**	In Network Out Network $300/visit	In Network Out Network $300/visit	20% coinsurance after deductible
14	**REHABILITATION SERVICES**	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance	20% coinsurance after deductible
15	**LABORATORY SERVICES**	In Network office no charge Hospital 30% coinsurance Out of Network 50% coinsurance	In Network office no charge Hospital 30% coinsurance Out of Network 50% coinsurance	No charge for the first $500 then 20% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance	In Network inpatient 30% coinsurance Outpatient $25/visit Out of Network 50% coinsurance	20% coinsurance after deductible
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $15/retail $45 mail Tier 2- $30 retail $90 mail Tier 3- $60 retail $180 mail Specialty- 30% coinsurance Out of Network not covered	In Network Tier 1- $15/retail $45 mail Tier 2- $30 retail $90 mail Tier 3- $60 retail $180 mail Specialty- 30% coinsurance Out of Network not covered	In Network Tier 1- $5 copay Tier 2- $10 copay Tier 3- $20 copay Specialty- 35% coinsurance Deductible $500 Mbr, $1,000 family
18	**MATERNITY**	In Network Prenatal and postnatal PCP $25 specialist $50 Delivery and all inpatient services 30% Out of Network 50% coinsurance	In Network Prenatal and postnatal PCP $25 specialist $50 Delivery and all inpatient services 30% Out of Network 50% coinsurance	20% coinsurance after deductible
19	**PEDIATRIC DENTAL SERVICES**	No charge after deductible is met	Available as a standalone plan in the Marketplace	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Health Choice Ins Co	Meritus Health Partners	
	Plan Name	Value Gold	Healthy Complete HMO 2000	Choice PPO Plus 2000
	Plan Provisions			
1	Calendar Year Deductible	$500/Mbr and $1,000/family	$2,000/Mbr and $4,000/family	$2,000/Mbr and $4,000/family Out of Network $6,000/Mbr and $12,000/family
2	Out-of-Pocket Limit	$3,800/Mbr and $7,600/family	$4,500/Mbr and $9,000/family	$4,500/Mbr and $9,000/family Out of Network $13,500/Mbr and $27,000/family
3	Provider Network	HMO	HMO	PPO
4	Coverage Area	Statewide w/exceptions	Maricopa, Pima, Santa Cruz	Maricopa, Pima, Santa Cruz
5	Coinsurance	20%	20%	20%
6	Primary Care physician	$10 copay/visit after deductible	In Network $15 copay/ visit Out of Network not covered	In Network $15 copay/ visit Out of Network 50% coinsurance
7	Specialist	$30 copay/visit after deductible	In Network $40 copay/ visit Out of Network not covered	In Network $40 copay/ visit Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	No charge	In Network no charge Out of Network not covered	In Network 0% coinsurance Out of Network 50% coinsurance
9	**OUTPATIENT CARE**	20% coinsurance after deductible.	$300 copay per surgery facility fee Physician/surgeon 20% coinsurance Out of Network not covered	$300 copay per surgery facility fee Physician/surgeon 20% coinsurance Out of Network 50% coinsurance
10	Ambulance	20% coinsurance after deductible	$200 coapy per transport Out of Network not covered	In Network and Out of Network $200 copay per transit
11	**HOSPITALIZATION**	20% coinsurance after deductible.	20% coinsurance peradmission - facility fee, physician/surgeon after deductible Out of Network not covered	20% coinsurance peradmission - facility fee, physician/surgeon after deductible Out of Network 50% coinsurance
12	Urgent Care Visit	$60 copay/visit after deductible	$40 copay per visit Out of Network not covered	In Network and Out of Network $40 copay per visit
13	**EMERGENCY SERVICES**	$225 copayment/visit after deductible	$300 copay per visit Out of Network not covered	In Network and Out of Network $300 copay per visit
14	**REHABILITATION SERVICES**	20% coinsurance after deductible	$40 copay per visit Out of Network not covered	$40 copay per visit Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	20% coinsurance after deductible	$25 copay per blood test after deductible Out of Network not covered	$25 copay per blood test after deductible Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	Inpatient 20% coinsurance/visit after deductible Outpatient $10 copay/visit after deductible	Inpatient services 20% coinsurance per admission Outpatitent $40 copay per visit Out of Network not covered	Inpatient services 20% coinsurance per admission Outpatitent $40 copay per visit Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	Tier 1- $4 copay after deductible Tier 2- $25 copay after deductible Tier 3- 30% coinsurance after deductible Specialty- 40% coisnurance after dedcutible	In Network Tier 1- maintenance generic: $0 copay retail; $0 mail order 90-day supply; Non-maintenance $10 retail; mail order $30 90-day supply Tier 2- $30 retail; mail order $90 90-day supply Tier 3- $75 retail; $225 mail order 90-day supply Specialty- 50% coinsurance Out of Network not covered	In Network Tier 1- maintenance generic: $0 copay retail; $0 mail order 90-day supply; Non-maintenance $10 retail; mail order $30 90-day supply Tier 2- $30 retail; mail order $90 90-day supply Tier 3- $75 retail; $225 mail order 90-day supply Specialty- 50% coinsurance Out of Network not covered
18	**MATERNITY**	Prenatal and postnatal no charge after deductible Delivery and inpatient services 20% coinsurance after deductible	In Network Prenatal and postnatal $30 copay Delivery and all inpatient services 20% coinsuance per admit Out of Network not covered	In Network Prenatal and postnatal $30 copay Delivery and all inpatient services 20% coinsuance per admit Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	No charge	Not Covered	Not Covered

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Meritus Health Partners (continued)		
	Plan Name	Saver HSA Plus 1500	Healthy Gold	Clear Choice
	Plan Provisions			
1	Calendar Year Deductible	$1,500/Mbr and $3,000/family Out of Network $4,500/Mbr and $9,00/family	$700/Mbr and $1,400/family	$1,500/Mbr and $3,000/family
2	Out-of-Pocket Limit	$3,000/Mbr and $6,000/family Out of Network $9,000/Mbr and $18,000/family	$5,500/Mbr and $11,000/family	$5,500/Mbr and $11,000/family
3	Provider Network	HSA	HSA	HSA
4	Coverage Area	Maricopa, Pima, Santa Cruz	Maricopa, Pima, Santa Cruz	Maricopa, Pima, Santa Cruz
5	Coinsurance	10%	20%	20%
6	Primary Care physician	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network and Out of Network 0% coinsurance	In Network and Out of Network 0% coinsurance
7	Specialist	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network and Out of Network $50 copay	In Network and Out of Network $50 copay
8	**PREVENTIVE SERVICES**	In Network 0% coinsurance Out of Network 50% coinsurance	In Network and Out of Network no charge	In Network and Out of Network no charge
9	**OUTPATIENT CARE**	$200 copay surgery facility fee per surgery after deductible Physician/surgeon 10% coinsurance after deductible Out of Network not covered	In Network and Out of Network Outpatient Surgery-Ambulatory surgical center 20% after deductible Outpatient Surgery-hospital 20% after deductible Outpatient Chemotherapy/Drugs 20% after deductible Outpatient Radiology-General 20% no deductible	In Network and Out of Network Outpatient Surgery-Ambulatory Surgical Center 20% after deductible Outpatiend Surgery-hospital 20% after deductible Outpatient Chemotherapy/Drugs 20% after deductible Outpatient Radiology-General 20% no deductible
10	Ambulance	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network and Out of Network 20% coinsurance after deductible	In Network and Out of Network 0% coinsurance after deductible
11	**HOSPITALIZATION**	10% coinsurance per admit after deductible 10% coinsurance physician/surgeon fee after deductible Out of Network 50% coinsurance	In Network 20% after deductible Out of Network not covered	In Network 20% after deductible Out of Network not covered
12	Urgent Care Visit	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network and Out of Network $75 copay	In Network and Out of Network $75 copay no deductible
13	**EMERGENCY SERVICES**	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network and Out of Network Emergency Room $500 copay/visit Transportation 20% coinsurance after deductible	In Network and Out of Network Emergency Room $500 copay/visit Transportation 0% coinsurance after deductible
14	**REHABILITATION SERVICES**	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network and Out of Network inpatient hospital services 20% after deductible In Network and Out of Network Physical Therapy, Occupational Therapy and Speech Therapy visits 20% after deductible	In Network and Out of Network inpatient hospital services 20% after deductible In Network and Out of Network Physical Therapy, Occupational Therapy and Speech Therapy visits 20% after deductible
15	**LABORATORY SERVICES**	$25 copay per blood test after deductible Out of Network 50% coinsurance	In Network 20% coinsurance Out of Network not covered In Network and Out of Network office pathology/lab 20% no deductible In Network and Out of Network outpatient pathology/lab 0% no deductible	In Network $25 copay/visit Out of Network not covered In Network and Out of Network office pathology/lab 20% no deductible In Network and Out of Network outpatient pathology/lab 20% no deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	Inpatient services 10% coinsurance per admission after deductible Outpatitent $60 copay per visit after deductible Out of Network 50% coinsurancee	In Network and Out of Network inpatient hospital services 20% after deductible In Network and Out of Network outpatient office visit no charge for the first three visits then 20% no deductible	In Network and Out of Network inpatient hospital services 20% after deductible In Network and Out of Network outpatient office visit no charge first three visits then 20% no deductible
17	**PRESCRIPTION DRUGS**	In Network all Tiers 10% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network Tier 1- maintenance no charge non-maintenance $5 retail 30-day supply $15 mail 90-day supply Tier 2- $35 retail 30-day supply $105 mail 90-day supply Tier 3- $75 retail 30-day supply $225 mail 90-day supply Specialty- 20% coinsurance Out of Network not covered	In Network Tier 1- maintenance no charge non-maintenance $5 retail 30-day supply $15 mail 90-day supply Tier 2- $35 retail 30-day supply $105 mail 90-day supply Tier 3- $75 retail 30-day supply $225 mail 90-day supply Specialty- 20% coinsurance Out of Network not covered
18	**MATERNITY**	In Network Prenatal and postnatal $30 copay after deductible Delivery and all inpatient services 10% coinsuance per admit after deductible Out of Network 50% coinsurance after deductible	In Network and Out of Network Prenatal and postnatal 0% coinsurance Delivery and all inpatient services 20% coinsurance after deductible	In Network and Out of Network Prenatal and postnatal 0% coinsurance Delivery and all inpatient services 20% coinsurance after deductible
19	**PEDIATRIC DENTAL SERVICES**	Not Covered	Class I- 0% coinsurance Class II- 45% coinsurance Class III-65% coinsurance Orthodontia- 50% coinsurance	Class I- 0% coinsurance Class II- 45% coinsurance Class III-65% coinsurance Orthodontia- 50% coinsurance

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	**Phoenix Health Plans, Inc**	**University Healthcare Marketplace**
	Plan Name	Phoenix Choice	Canyon
	Plan Provisions		
1	Calendar Year Deductible	$1,500/Mbr and $3,000/family	$600/Mbr and $1,200/family
2	Out-of-Pocket Limit	$4,500/Mbr and $9,000/family	$6,600/Mbr and $13,200/family
3	Provider Network	HMO	HMO
4	Coverage Area	Statewide w/exceptions	Statewide
5	Coinsurance	20%	15%
6	Primary Care physician	$15 copay/visit	$10 copay/visit before deductible Out of Network not covered
7	Specialist	$30 copay/visit	$50 copay/visit after deductible Out of Network not covered
8	**PREVENTIVE SERVICES**	No Charge	In Network no charge Out of Network not covered
9	**OUTPATIENT CARE**	20% coinsurance after deductible	Facility fee, physician/surgeon fee 15% coinsurance after deductible Out of Network not covered
10	Ambulance	20% coinsurance after deductible	In Network 15% coinsurance after deductible Out-of-Network 100% coinsurance
11	**HOSPITALIZATION**	20% coinsurance after deductible	No charge In Network facility fee, physician/surgeon $250 copay per day after deductible Out of Network not covered
12	Urgent Care Visit	20% coinsurance after deductible	In Network 15% coinsurance after deductible Out of Network 15% coinsurance
13	**EMERGENCY SERVICES**	20% coinsurance after deductible	In Network $200 coapy per visit after deductible Out of Network 100% coinsurance
14	**REHABILITATION SERVICES**	20% coinsurance after deductible	In Network 15% coinsurance after deductible Out of Network not covered
15	**LABORATORY SERVICES**	20% coinsurance after deductible	In Network 15% coinsurance after deductible Out of Network not covered
16	**MENTAL HEALTH AND SUBSTANCE USE**	Inpatient 20% coinsurance/visit after deductible Outpatient $15 copay/visit after deductible	In Network inpatient $250 copay per day after deductible Outpatient 15% coinsurance after deductible Out of Network not covered
17	**PRESCRIPTION DRUGS**	Tier 1- $5 copay Tier 2- $30 copay Tier 3- $65 copay Specialty- 35% coinsurance	In Network Tier 1- $4 each prescription after deductible Tier 2- 20% coinsurance after deductible Tier 3- 30% coinsurance after deductible Specialty- 30% coinsurance after deductible Out of Network not covered
18	**MATERNITY**	20% coinsurance after deductible	In Network Prenatal and postnatal care $5 copay after deductible Delivery and all inpatient services $250 copay per day after deductible Out of Network not covered
19	**PEDIATRIC DENTAL SERVICES**	Not Covered Available as a standalone plan in the Marketplace	Not Covered Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Gold Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	United Health One	
	Plan Name	Compass Plus Gold $500	Compass Plus Gold $1250
	Plan Provisions		
1	Calendar Year Deductible	In Network $500/Mbr and $1,000/Family Out of Network $1,000/Mbr and $2,000/Family	In Network $1,250/Mbr and $2,500/Family Out of Network $2,500/Mbr and $5,000/Family
2	Out-of-Pocket Limit	In Network $6,600 Member/$13,200 Family Out of Network Member and Family Unlimited	In Network $6,600 Member/$13,200 Family Out of Network Member and Family Unlimited
3	Provider Network	Compass Plus	Compass Plus
4	Coverage Area	Statewide, National	Statewide, National
5	Coinsurance	In network 20% Out of Network 50%	In network 10% Out of Network 50%
6	Primary Care physician	In Network $20 copay Out of Network 50% coinsurance after deductible	In Network $10 copay Out of Network 50% coinsurance after deductible
7	Specialist	In Network $40 copay with referral; $80 copay without referral Out of Network 50% coinsurance after deductible	In Network $30 copay with referral; $60 copay without referral Out of Network 50% coinsurance after deductible
8	**PREVENTIVE SERVICES**	In Network 0% coinsurance, deductible waived Out of Network 50% coinsurance after deductible	In Network 0% coinsurance, deductible waived Out of Network 50% coinsurance after deductible
9	**OUTPATIENT CARE**	In Network 20% coinsurance after deductible with referral 50% coinsurance after deductible without referral Additional $250 per occurrence deductible for services at hospital setting Out of Network 50% coinsurance after deductible	In Network 10% coinsurance after deductible with referral 40% coinsurance after deductible without referral Additional $250 per occurrence deductible for services at hospital setting Out of Network 50% coinsurance after deductible
10	Ambulance	In Network 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible
11	**HOSPITALIZATION**	In Network 20% coinsurance after deductible with referral 50% coinsurance after deductible without referral Out of Network 50% coinsurance after deductible	In Network 10% coinsurance after deductible with referral 40% coinsurance after deductible without referral Out of Network 50% coinsurance after deductible
12	Urgent Care Visit	In Network 0% coinsurance after $50 copay Out of Network 50% coinsurance after deductible	In Network 0% coinsurance after $50 copay Out of Network 50% coinsurance after deductible
13	**EMERGENCY SERVICES**	$250 per occurrence deductible then 20% coinsurance after deductible	$250 per occurrence deductible then 10% coinsurance after deductible
14	**REHABILITATION SERVICES**	In Network 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible
15	**LABORATORY SERVICES**	In Network 20% coinsurance after deductible 40% coinsuranc after deductible if at hospital setting Out of Network 50% coinsurance after deductible	In Network 10% coinsurance after deductible 30% coinsuranc after deductible if at hospital setting Out of Network 50% coinsurance after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Outpatient 0% coinsurance after $20 copay In Network Inpatient 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network Outpatient 0% coinsurance after $10 copay In Network Inpatient 10% coinsurance after deductible Out of Network 50% coinsurance after deductible
17	**PRESCRIPTION DRUGS**	Separate pharmacy deductible of $250 applies to Tiers 3 & 4 In Network Tier 1- $5 copay Tier 2- $40 copay Tier 3- 20% coinsurance (minimum $80 copay) Tier 4- 30% coinsurance (minimum $250 copay)	Separate pharmacy deductible of $500 applies to Tiers 3 & 4 In Network Tier 1- $5 copay Tier 2- $40 copay Tier 3- 20% coinsurance (minimum $80 copay) Tier 4- 30% coinsurance (minimum $250 copay)
18	**MATERNITY**	In Network 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible
19	**PEDIATRIC DENTAL SERVICES**	In Network 20% coinsurance after deductible Out of Network 50% coinsurance after deductible	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible

Arizona Health Insurance Marketplace
Platinum Plans

Referred to as "metal plans," the different tiers are defined by the percentage each plan will pay toward health care expenses, known as the actuarial value, for an average person.

A Platinum plan is designed to provide 90 percent coverage with the enrollee paying approximately 10 percent of eligible expenses.

Arizona Health Insurance Marketplace
Platinum Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	**Assurant Health**	**Health Net**	
	Plan Name	Plan 002	$15/$30/$500	$15/$30/$500
	Plan Provisions			
1	Calendar Year Deductible	In Network $0 Mbr and $0/family Out of Network $5,000/Mbr and $10,000/family	In Network $500/Mbr and $1,000/family Out of Network 1,000/Mbr and $2,000/family	In Network $500/Mbr and $1,000/family Out of Network 1,000/Mbr and $2,000/family
2	Out-of-Pocket Limit	In Network $2,000/Mbr $4,000/family Out of Network $10,000/Mbr $20,000/family	In Network $1,750/Mbr and $3,500/family Out of Network $3,500/Mbr and $7,000/family	In Network $1,750/Mbr and $3,500/family Out of Network $3,500/Mbr and $7,000/family
3	Provider Network	PPO	PPO	PPO
4	Coverage Area	Statewide	Statewide	Statewide
5	Coinsurance	25%	20%	20%
6	Primary Care Physician	In Network $25 copay Out of Network 50% coinsurance	In Network $15 Out of Network 50% coinsurance	In Network $15 Out of Network 50% coinsurance
7	Specialist	In Network $25 copay Out of Network 50% coinsurance	In Network $30 Out of Network 50% coinsurance	In Network $30 Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network 0% coinsurance Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**Outpatient Care**	In Network 25% coinsurance Out of Network 50% coinsurance	Facility fee, physician/surgeon fee 20% coinsurance Out of Network 50% coinsurance	Facility fee, physician/surgeon fee 20% coinsurance Out of Network 50% coinsurance
10	Ambulance	In Network and Out of Network 25% coinsurance	In Network Out of Network 20% coinsurance	In Network Out of Network 20% coinsurance
11	**HOSPITALIZATION**	In Network 25% coinsurance Out of Network 50% coinsurance	In Network 20% coinsurance Out of Network 50% coinsurance	In Network 20% coinsurance Out of Network 50% coinsurance
12	Urgent Care Visit	In Network 25% coinsurance Out of Network 50% coinsurance	In Network $50/visit Out of Network 50% coinsurance	In Network $50/visit Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network and Out of Network $100 access fee, then deductible and 25% coinsurance	In Network and Out of Network $250/visit	In Network and Out of Network $250/visit
14	**REHABILITATION SERVICES**	In Network 25% coinsurance Out of Network 50% coinsurance	In Network Inpatient 20% coinsurance Outpatient $30/visit Out of Network 50% coinsurance	In Network Inpatient 20% coinsurance Outpatient $30/visit Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network 25% coinsurance Out of Network 50% coinsurance	In Network Office no charge Hospital 20% coinsurance Out of Network 50% coinsurance	In Network Office no charge Hospital 20% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Inpatient 25% coinsurance Outpatient $25 copay/visit Out of Network 50% coinsurance	In Network Inpatient 20% coinsurance Outpatient $15/visit Out of Network 50% coinsurance	In Network Inpatient 20% coinsurance Outpatient $15/visit Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network and Out of Network Tier 1 $10 copay retail; $30 mail order Tier 2 $30 copay retail; mail order $90 Tier 3 $50 copay retail ; mail order $150 Specialty 25% coinsurance Out of Network specialty drugs not covered	In Network Tier 1- $10 retail $30 mail Tier 2- $20 retail $60 mail Tier 3- $50 retail $150 mail Specialty- 20% coinsurance Out of Network not covered	In Network Tier 1- $10 retail $30 mail Tier- 2 $20 retail, $60 mail Tier 3- $50 retail, $150 mail Specialty- 20% coinsurance Out of Network not covered
18	**MATERNITY**	In Network 25% coinsurance Out of Network 50% coinsurance	In Network Prenatal and postnatal PCP $15 Specialist $30 Delivery and all inpatient services 20% Out of Network 50% coinsurance	In Network Prenatal and postnatal PCP $15 Specialist $30 Delivery and all inpatient services 20% Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	No charge	No charge after deductible is met	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Platinum Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Health Net (continued)		
	Plan Name	$15/$30/$750	$15/$30/$750	$15/$30/$1000
	Plan Provisions			
1	Calendar Year Deductible	In Network $750/Mbr and $1,500/family Out of Network 1,500/Mbr and $3,000/family	In Network $750/Mbr and $1,500/family Out of Network 1,500/Mbr and $3,000/family	In Network $1,000/Mbr and $2,000/family Out of Network 2,000/Mbr and $4,000/family
2	Out-of-Pocket Limit	In Network $1,250/Mbr and $2,500/family Out of Network $2,500/Mbr and $5,000/family	In Network $1,250/Mbr and $2,500/family Out of Network $2,500/Mbr and $5,000/family	In Network $1,500/Mbr and $3,000/family Out of Network $3,000/Mbr and $6,000/family
3	Provider Network	PPO	PPO	PPO
4	Coverage Area	Statewide	Statewide	Statewide
5	Coinsurance	20%	20%	20%
6	Primary Care Physician	In Network $15 Out of Network 50% coinsurance	In Network $15 Out of Network 50% coinsurance	In Network $15 Out of Network 50% coinsurance
7	Specialist	In Network $30 Out of Network 50% coinsurance	In Network $30 Out of Network 50% coinsurance	In Network $30 Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**Outpatient Care**	Facility fee, physician/surgeon fee 20% coinsurance Out of Network 50% coinsurance	Facility fee, physician/surgeon fee 20% coinsurance Out of Network 50% coinsurance	Facility fee, physician/surgeon fee 20% coinsurance Out of Network 50% coinsurance
10	Ambulance	In Network Out of Network 20% coinsurance	In Network Out of Network 20% coinsurance	In Network Out of Network 20% coinsurance
11	**HOSPITALIZATION**	In Network 20% coinsurance Out of Network 50% coinsurance	In Network 20% coinsurance Out of Network 50% coinsurance	In Network 20% coinsurance Out of Network 50% coinsurance
12	Urgent Care Visit	In Network $50/visit Out of Network 50% coinsurance	In Network $50/visit Out of Network 50% coinsurance	In Network $50/visit Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Networkand Out of Network $250/visit	In Network Out Network $250/visit	In Network Out Network $250/visit
14	**REHABILITATION SERVICES**	In Network Inpatient 20% coinsurance Outpatient $30/visit Out of Network 50% coinsurance	In Network Inpatient 20% coinsurance Outpatient $30/visit Out of Network 50% coinsurance	In Network Inpatient 20% coinsurance Outpatient $30/visit Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network Office no charge Hospital 20% coinsurance Out of Network 50% coinsurance	In Network Office no charge Hospital 20% coinsurance Out of Network 50% coinsurance	In Network Office no charge Hospital 20% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Inpatient 20% coinsurance Outpatient $15/visit Out of Network 50% coinsurance	In Network Inpatient 20% coinsurance Outpatient $15/visit Out of Network 50% coinsurance	In Network Inpatient 20% coinsurance Outpatient $15/visit Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $10 retail $30 mail Tier 2- $20 retail $60 mail Tier 3- $50 retail $150 mail Specialty- 20% coinsurance Out of Network not covered	In Network Tier 1- $10 retail $30 mail Tier 2- $20 retail $60 mail Tier 3- $50 retail $150 mail Specialty- 20% coinsurance Out of Network not covered	In Network Tier 1- $10 retail $30 mail Tier 2- $20 retail $60 mail Tier 3- $50 retail $150 mail Specialty- 20% coinsurance Out of Network not covered
18	**MATERNITY**	In Network Prenatal and postnatal PCP $15 Specialist $30 Delivery and all inpatient services 20% Out of Network 50% coinsurance	In Network Prenatal and postnatal PCP $15 Specialist $30 Delivery and all inpatient services 20% Out of Network 50% coinsurance	In Network Prenatal and postnatal PCP $15 Specialist $30 Delivery and all inpatient services 20% Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	No charge after deductible is met	Available as a standalone plan in the Marketplace	No charge after deductible is met

Arizona Health Insurance Marketplace
Platinum Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Health Net (continued)		
	Plan Name	$15/$30/$1000	$15/$30/$3000	$15/$30/$3000
	Plan Provisions			
1	Calendar Year Deductible	In Network $1,000/Mbr and $2,000/family Out of Network 2,000/Mbr and $4,000/family	In Network $200/Mbr and $400/family	In Network $1,000/Mbr and $2,000/family Out of Network 2,000/Mbr and $4,000/family
2	Out-of-Pocket Limit	In Network $1,500/Mbr and $3,000/family Out of Network $3,000/Mbr and $6,000/family	In Network $300/Mbr and $600/family	In Network $1,500/Mbr and $3,000/family Out of Network $3,000/Mbr and $6,000/family
3	Provider Network	PPO	HMO Community Care Network	HMO Community Care Network
4	Coverage Area	Statewide	Maricopa, Pinal, Pima	Maricopa, Pinal, Pima
5	Coinsurance	20%	10%	10%
6	Primary Care Physician	In Network $15 Out of Network 50% coinsurance	In Network $15 Out of Network 50% coinsurance	In Network $15 Out of Network 50% coinsurance
7	Specialist	In Network $30 Out of Network 50% coinsurance	In Network $30 Out of Network 50% coinsurance	In Network $30 Out of Network 50% coinsurance
8	**PREVENTIVE SERVICES**	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance	In Network no charge Out of Network 50% coinsurance
9	**Outpatient Care**	Facility fee, physician/surgeon fee 20% coinsurance Out of Network 50% coinsurance	Facility fee, physician/surgeon fee 10% coinsurance Out of Network 50% coinsurance	Facility fee, physician/surgeon fee 10% coinsurance Out of Network 50% coinsurance
10	Ambulance	In Network Out of Network 20% coinsurance	In Network Out of Network 20% coinsurance	In Network Out of Network 20% coinsurance
11	**HOSPITALIZATION**	In Network 20% coinsurance Out of Network 50% coinsurance	Facility fee $375/day Physician/surgeon fee no charge	Facility fee $375/day Physician/surgeon fee no charge
12	Urgent Care Visit	In Network $50/visit Out of Network 50% coinsurance	In Network $50/visit Out of Network 50% coinsurance	In Network $50/visit Out of Network 50% coinsurance
13	**EMERGENCY SERVICES**	In Network and Out of Network $250/visit	In Network and Out of Network $250/visit	In Network and Out of Network $250/visit
14	**REHABILITATION SERVICES**	In Network Inpatient 20% coinsurance Outpatient $30/visit Out of Network 50% coinsurance	In Network Inpatient $375/day Outpatient $30/visit Out of Network 50% coinsurance	In Network Inpatient $375/day Outpatient $30/visit Out of Network 50% coinsurance
15	**LABORATORY SERVICES**	In Network Office no charge Hospital 20% coinsurance Out of Network 50% coinsurance	In Network Office no charge Hospital 10% coinsurance Out of Network 50% coinsurance	In Network Office no charge Hospital 10% coinsurance Out of Network 50% coinsurance
16	**MENTAL HEALTH AND SUBSTANCE USE**	In Network Inpatient 20% coinsurance Outpatient $15/visit Out of Network 50% coinsurance	In Network Inpatient $375/day Outpatient $15/visit Out of Network 50% coinsurance	In Network Inpatient $375/day Outpatient $15/visit Out of Network 50% coinsurance
17	**PRESCRIPTION DRUGS**	In Network Tier 1- $10 retail $30 mail Tier 2- $20 retail $60 mail Tier 3- $50 retail $150 mail Specialty- 20% coinsurance Out of Network not covered	In Network Tier 1- $5 retail $15 mail Tier 2- $15 retail $45 mail Tier 3- $35 retail $105 mail Specialty- 20% coinsurance Out of Network not covered	In Network Tier 1- $5 retail $15 mail Tier 2- $15 retail $45 mail Tier 3- $35 retail $105 mail Specialty- 20% coinsurance Out of Network not covered
18	**MATERNITY**	In Network Prenatal and postnatal PCP $15 Specialist $30 Delivery and all inpatient services 20% Out of Network 50% coinsurance	In Network Prenatal and postnatal PCP $15 Specialist $30 Delivery and all inpatient services $375/day Out of Network 50% coinsurance	In Network Prenatal and postnatal PCP $15 Specialist $30 Delivery and all inpatient services $375/day Out of Network 50% coinsurance
19	**PEDIATRIC DENTAL SERVICES**	Available as a standalone plan in the Marketplace	No charge after deductible is met	Available as a standalone plan in the Marketplace

Arizona Health Insurance Marketplace
Platinum Plans
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	Humana Inc.	Meritus Health Partners	United Health One
	Plan Name	1000/Phoenix HMOx	Healthy HMO 500+ Complete/Abrazo/Banner/ 3 Networks same plan provisions	Compass Plus Platinum $250
	Plan Provisions			
1	Calendar Year Deductible	$1,000/Mbr and $2,000/family	$500/Mbr and $1,000/family	In Network $250 Mbr and $500/family Out of Network $500 Mbr and $1,000/family
2	Out-of-Pocket Limit	In Network $1,500/Mbr and $3,000/family	$2,000/Mbr and $4,000/family	In Network $1,500 Member/$3,000 Family Out of Network Member and Family Unlimited
3	Provider Network	HMO	HMO	Compass Plus
4	Coverage Area	Maricopa, Pima	Maricopa, Pima, Santa Cruz	Statewide, National
5	Coinsurance	20%	10%	In network 10% Out of Network 50%
6	Primary Care Physician	$25 copay	In Network $5 copay Out of Network not covered	In Network $10 copay Out of Network 50% coinsurance after deductible
7	Specialist	$35 copay	In Network $30 copay Out of Network not covered	In Network $30 copay with referral; $60 copay without referral Out of Network 50% coinsurance after deductible
8	**PREVENTIVE SERVICES**	No charge	In Network $0 copay Out of network not covered	In Network 0% coinsurance, deductible waived Out of Network 50% coinsurance after deductible
9	**Outpatient Care**	20% coinsurance after deductible	$200 copay surgery facility fee per surgery Physician/surgeon 10% coinsurance Out of Network not covered	In Network 10% coinsurance after deductible with referral 40% coinsurance after deductible without referral Additional $150 per occurrence deductible for services at hospital setting Out of Network 50% coinsurance after deductible
10	Ambulance	20% coinsurance after deductible	In Network 10% coinsurance after deductible Out of Network not covered	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible
11	**HOSPITALIZATION**	20% coinsurance after deductible	10% coinsurance per admit after deductible 10% coinsurance physician/surgeon fee after deductible Out of Network not covered	In Network 10% coinsurance after deductible with referral 40% coinsurance after deductible without referral Out of Network 50% coinsurance after deductible
12	Urgent Care Visit	$35 copay if use Concentra $50 for non-Concentra	In Network $30 copay per visit Out of Network not covered	In Network 0% coinsurance after $50 copay Out of Network 50% coinsurance after deductible
13	**EMERGENCY SERVICES**	20% coinsurance after deductible	In Network $200 copay per visit Out of Network not covered	$250 per occurrence deductible then 10% coinsurance after deductible
14	**REHABILITATION SERVICES**	20% coinsurance after deductible	In Network $30 copay per visit Out of Network not covered	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible
15	**LABORATORY SERVICES**	No charge for the first $500 then 20% coinsurance	$25 copay per blood test after deductible Out of Network not covered	In Network 10% coinsurance after deductible 30% coinsurance after deductible if at hospital setting Out of Network 50% coinsurance after deductible
16	**MENTAL HEALTH AND SUBSTANCE USE**	20% coinsurance after deductible	In Network Inpatient services 10% coinsurance per admission after deductible Outpatient $30 copay per visit after deductible Out of Network not covered	In Network Outpatient 0% coinsurance after $10 copay Inpatient 10% coinsurance after deductible Out of Network 50% coinsurance after deductible
17	**PRESCRIPTION DRUGS**	Tier 1- $5 copay Tier 2- $10 copay Tier 3- $20 copay Specialty- 35% coinsurance Deductible $500/Mbr and $1,000/family	In Network Tier 1- maintenance generic: $0 copay retail; $0 mail order 90-day supply Non-maintenance $5 retail; mail order $15 90-day supply Tier 2- $15 retail; mail order $45 90-day supply Tier 3- $60 retail; $180 mail order 90-day supply Specialty- 50% coinsurance Out of Network not covered	In Network Separate pharmacy deductible of $250 applies to Tiers 3 & 4 Tier 1 - $5 copay Tier 2 - $35 copay Tier 3 - 20% coinsurance (minimum $75 copay) Tier 4 - 30% coinsurance (minimum $250 copay)
18	**MATERNITY**	20% coinsurance after deductible	In Network Prenatal and postnatal $5 copay after deductible Delivery and all inpatient services 10% coinsurance per admit after deductible Out of Network not covered	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible
19	**PEDIATRIC DENTAL SERVICES**	Available as a standalone plan in the Marketplace	Not Covered	In Network 10% coinsurance after deductible Out of Network 50% coinsurance after deductible

ASRS and ADOA non-Medicare Retiree Plans Comparison

The following pages compare the in-state non-Medicare eligible retiree health insurance plans offered by the Arizona State Retirement System (ASRS) and the Arizona Department of Administration (ADOA).

Between the ASRS and ADOA, more than 54,000 retirees, dependents and surviving beneficiaries receive health care coverage with more than 15,000 being non-Medicare eligible. These non-Medicare eligible retirees and surviving beneficiaries are eligible to participate in the plans offered through the Arizona Health Insurance Marketplace.

For non-Medicare retirees and surviving beneficiaries, the ASRS has an in-state, in-network health insurance plan, and a PPO (preferred provider organization) plan for out-of-state members. ADOA offers an EPO (exclusive provider organization) plan as well as a PPO plan for its in-state and out-of-state retirees.

Information provided in this section pertains to in-state plans only. ASRS retirees residing outside Arizona should refer to the ASRS group insurance guide on the ASRS website for information, and may wish to explore available Marketplace insurance plans offered in the state in which they reside.

ASRS plans are offered through UnitedHealthcare of Arizona, which also participates in the Arizona Health Insurance Marketplace. ADOA plans are offered through provider networks that are contracted with Aetna, Blue Cross/Blue Shield, Cigna and UnitedHealthcare.

The ASRS and ADOA comparisons are in greater detail than the Health Insurance Marketplace plans and this reflects only ASRS's familiarity with ADOA's plans. For these plans, 2015 monthly premiums are noted at the bottom of each comparison.

Individuals enrolled in an ASRS retiree health insurance plan or have retiree health care coverage from ADOA may not only compare their enrolled plan to the other, but also compare their enrolled plan to any plan offered through the Arizona Health Insurance Marketplace on a provision-by-provision basis.

Please note that while the Marketplace may offer reductions in premiums and costs because of select factors (see Page 7, Subsidies and Tax Credits), only ASRS and employer plans, like those offered by ADOA, allow the ASRS premium benefit to be applied to reduce the ASRS or employer premium.

You should weigh the advantages and disadvantages of the net cost as a result of participating in a Marketplace plan as compared to an ASRS or ADOA retiree health insurance plan.

ASRS and ADOA Retiree Medical Plans
Non-Medicare In-State
(Bold/All Cap Type in the Lefthand Column Represents Essential Health Benefits)

	Carrier	**ASRS Choice Plan**	**ADOA PPO Plan**		**ADOA**
	Plan Name	IN-Network Only	In-Network	Out-of-Network	EPO*
	Plan Provisions				
1	Calendar Year Deductible	None	$500 individual $1,000 family	$500 individual $1000 family	None
2	Out-of-Pocket Limit	$3,500 individual $7,000 family	$1,000 individual $2,000 family (deductible must be met before copay applies)	$4,000 individual $8,000 family (deductible must be met before copay applies)	None
3	Provider Network	HMO	PPO	PPO	EPO
4	Coverage Area	Statewide	Statewide	Statewide	Statewide
5	Coinsurance	copay	copay	50%	copay
6	Primary Care Physician	$20 copay	$15 copay after deductible	50% coinsurance	$15 copay
7	Specialist	$50 copay	$30 copay after deductible	50% coinsurance	$30 copay
8	**PREVENTIVE SERVICES**	No charge	No charge	No charge	No charge
9	**OUTPATIENT CARE**	Facility fee, physician/surgeon fee 30% coinsurance	$50 copay after deductible	Facility fee, physician/surgeon fee 50% coinsurance	$50 copay
10	Ambulance	No charge	0% after deductible	$125 per visit 50% coinsurance after deductible	No charge
11	**HOSPITALIZATION**	$100 copay per admission 30% of expenses	$150 copay per admission after deductible	50% coinsurance	$150 copay
12	Urgent Care Visit	$50 copay	$40 copay after deductible	$125 per visit 50% coinsurance after deductible	$40 copay
13	**EMERGENCY SERVICES**	$150 copay	$125 copay after deductible	$125 per visit 50% coinsurance after deductible	$125 copay
14	**REHABILITATION SERVICES**	$40 copay	$15 copay after deductible	50% coinsurance	$15 copay
15	**LABORATORY SERVICES**	$10 copay	0% coinsurance after deductible	50% coinsurance	No charge
16	**MENTAL HEALTH SUBSTANCE USE**	Inpatient and Outpatient 30% coinsurance	Inpatient $150 copay after deductible Outpatient $15 after deductible	50% coinsurance	Inpatient $150 copay Outpatient $15 copay
17	**PRESCRIPTION DRUGS**	Tier 1- $10 Tier 2- $50 Tier 3- $100 (retail) Tier 1- $25 Tier 2- $125 Tier 3- $250 (mail)	Tier 1- $10 Tier 2-$20 Tier 3- $40 (retail) Tier 1- $20 Tier 2- $40 Tier 3- $80 (mail)	In Network Pharmacy only	Tier 1- $10 Tier 2- $20 Tier 3- $40 (retail) Tier 1- $20 Tier 2- $40 Tier 3- $80 (mail)
18	**MATERNITY**	$20 copay	$10 copay after deductible	50% coinsurance	$10 copay
19	**PEDIATRIC DENTAL SERVICES**	Available through a separately purchased ASRS dental plan	Available through a separately purchased ADOA dental plan	Available through a separately purchased ADOA dental plan	Available through a separately purchased ADOA dental plan

*The ADOA EPO plan networks offer nationwide coverage

PREMIUMS	Retiree / Family	Single / Retiree + 1 / Family	Single / Retiree +1 / Family
Maricopa, Pima, Pinal	$793 ($713) / $1,586 ($1,426)**	$943 / $2,219 / $3,074	$593 / $1,387 / $1,869
All other AZ counties	$793 ($713) / $1,586 ($1,426)**	$943 / $2,219 / $3,074	$593 / $1,387 / $1,869

**For ASRS, the monthly premium in the parentheses is the premium the retiree pays. The difference between the actual premium and what the retiree pays is funded by monies received from the U.S. Department of Health and Human Services' Early Retiree Reinsurance Program. This program expires December 31, 2014.

More than the basics . . .

Benefits included in ASRS health insurance plans

The Arizona State Retirement System retiree health insurance plans offer additional benefits that go beyond those required by the Affordable Care Act.

There is no added costs for these benefits:

- SilverSneakers, a senior fitness program with free membership at participating clubs
- Hearing services, including hearing aids
- Vision exams
- Solutions for Caregivers
- Disease management programs, including help for chronic conditions
- 24-hour NurseLine
- Wellness programs
- Optical benefits, including refraction exams
- Bonus drug list adds additional 530 Medicare prescription drugs not covered by Medicare
- HouseCalls to support and complement regular doctor care through visits to your home
- Passport program for travel or if you live away from home up to 9 consecutive months.

See the latest ASRS Retiree Group Health Insurance guide on the ASRS website for additional information.

Premium Benefit Programs

As part of your benefits, the ASRS provides a health insurance premium benefit to supplement the cost of retiree health insurance. ASRS retirees with five or more years of credited service who have health insurance through the ASRS or their former employer are eligible for a monthly premium benefit, which is paid to the health insurer or your former employer.

Retirees of the Public Safety Personnel Retirement System, Elected Officials' Retirement Plan or Corrections Officer Retirement Plan who have health insurance through the ASRS or their former employer are eligible for a monthly premium benefit as noted on Page 60.

The Premium Benefit ranges from $75 to $260 per month, depending upon years of service and coverage selected.

See the next page for details.

Premium Benefit Programs

	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
Years of Service	Retiree Only	Retiree & Dependents	Retiree Only	Retiree & Dependents	Retiree & Dependents One with Medicare, the other(s) without	Retiree & Dependent with Medicare other depend-ents without
Arizona State Retirement System (ASRS) Members						
5.0-5.9	$75.00	$130.00	$50.00	$85.00	$107.50	$107.50
6.0-6.9	$90.00	$156.00	$60.00	$102.00	$129.00	$129.00
7.0-7.9	$105.00	$182.00	$70.00	$119.00	$150.50	$150.50
8.0-8.9	$120.00	$208.00	$80.00	$136.00	$172.00	$172.00
9.0-9.9	$135.00	$234.00	$90.00	$153.00	$193.50	$193.50
10.0+	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Elected Officials' Retirement Plan (EORP) Members						
5.0-5.9	$90.00	$156.00	$60.00	$102.00	$129.00	$129.00
6.0-6.9	$112.00	$195.00	$75.00	$127.50	$161.25	$161.25
7.0-7.9	$135.00	$234.00	$90.00	$153.00	$193.00	$193.50
8.0-8.9	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Corrections Officer Retirement Plan (CORP) Members						
Not applicable	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Public Safety Personnel Retirement System (PSPRS) Members						
Not applicable	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00

NOTES