Coverage Period: 01/01/2026-12/31/2026 Coverage for: Individual + Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://exchange.imperialhealthplan.com/arizona/ or contact us at 1-800-595-0619 or https://exchange.imperialhealthplan.com/arizona/contact-information/. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary https://exchange.imperialhealthplan.com/arizona/universal-glossary or call 1-800-595-0619 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$7500 per person \$15000 per group	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Primary care, specialist visits, preventive care, generic drugs, urgent care, outpatient mental, behavioral, or substance abuse services, office visits while pregnant, child eye care, child dental care, are covered before meeting your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-carebenefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$10000 per person \$20000 per group	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limit</u> s until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://www.imperialhealthplan.co m/arizona/hmo-exchange/provider- directory or call 1-800-838-5914 for	

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at https://exchange.imperialhealthplan.com/arizona/individual-eoc

Important Questions	Answers	Why This Matters:
	a list of <u>network provider</u> s.	
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

A

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You Will Pay		Limitations Evacutions 9 Other Important
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$50 <u>copay</u> /visit	Not covered	None
If you visit a health care	Specialist visit	\$100 copay/visit	Not covered	
provider's office or clinic	Preventive care/screening/ immunization	No Charge	Not covered	1 exam per year. You may have to pay for services that aren't preventive. Ask your_provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	50% coinsurance	Not covered	None
If you have a test	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not covered	
If you need drugs to	Preventive drugs (Tier 1)	No Charge	Not Covered	Covers up to a 30-day supply (retail
treat your illness or condition	Generic drugs (Tier 2)	\$25 copay/prescription	Not covered	subscription); 31-90 day supply (mail order prescription). Preauthorization is required for
More information about prescription drug	Preferred brand drugs (Tier 3)	\$50 copay/prescription	Not covered	certain drugs.
coverage is available at https://client.formularyna	Non-preferred brand drugs (Tier 4)	\$100 copay/prescription	Not covered	
vigator.com/Search.aspx ?siteCode=5261847175	Specialty drugs (Tier 5)	\$500 copay/prescription	Not covered	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered	None
surgery	Physician/surgeon fees	50% <u>coinsurance</u>	Not covered	
If you need immediate	Emergency room care	50% coinsurance	50% coinsurance	None
medical attention	Emergency medical	50% coinsurance	50% coinsurance	

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>https://exchange.imperialhealthplan.com/arizona/individual-eoc</u>

		What You Will Pay		Limitations Franctions 9 Other law autom
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>transportation</u>			
	<u>Urgent care</u>	\$75 <u>copay</u> /visit	\$75 copay/visit	
If you have a hospital	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	Not covered	All usual Hospital services and supplies, including semiprivate room, intensive care,
stay	Physician/surgeon fees	50% coinsurance	Not covered	and coronary care units; <u>Preauthorization</u> is required.
If you need mental health, behavioral	Outpatient services	\$50 <u>copay</u> /visit	Not covered	None
health, or substance abuse services	Inpatient services	50% coinsurance	Not covered	
	Office visits	\$50 copay/visit	Not covered	Cost sharing does not apply for preventive
If you are pregnant	Childbirth/delivery professional services	50% coinsurance	Not covered	services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	50% coinsurance	Not covered	
	Home health care	50% coinsurance	Not covered	42 visits per year.
	Rehabilitation services	50% coinsurance	Not covered	60 visits per year. Includes chiropractic,
If you need help	Habilitation services	\$50 copay/visit	Not covered	physical therapy, speech therapy, and occupational therapy
recovering or have other special health	Skilled nursing care	50% coinsurance	Not covered	90 days per year
needs	Durable medical equipment	50% <u>coinsurance</u>	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	50% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Coverage limited to 1 exam/year.
	Children's glasses	No Charge	Not covered	Coverage limited to 1 pair of glasses/year.
	Children's dental check-up	No Charge	Not covered	Coverage limited to 2 dental check-ups & cleanings/calendar year.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at https://exchange.imperialhealthplan.com/arizona/individual-eoc

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic Surgery

- Dental care (Adult)
- Infertility treatment (except diagnosis of the medical cause and surgery to treat medical cause)
- Long-term care

- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic care (limited to 20 visits per year)
- Hearing aids (limited to 1 item per benefit period)
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: Imperial Insurance Companies at 1-800-595-0619. You may also contact the Arizona Department of Insurance at 1-602-364-3100 at 100 North 15th Avenue, Ste 261, Phoenix, AZ or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace. visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Arizona Department of Insurance at 1-602-364-3100 or visit https://www.difi.az.gov. Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Arizona Department of Insurance at 1-602-364-3100.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this <u>plan</u> meet the Minimum Value Standards? Not Applicable.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at https://exchange.imperialhealthplan.com/arizona/individual-eoc

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-595-0619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-595-0619.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-595-0619.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-595-0619.

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

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$7,500
■ Specialist coinsurance	\$100
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$7,500	
Copayments	\$60	
Coinsurance	\$1,200	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$8,820	

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a wellcontrolled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$7,500
■ Specialist coinsurance	\$100
■ Hospital (facility) coinsurance	50%
■ Other <u>coinsurance</u>	50%

This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$12,700
In this example, Joe would pay:	
Cost Sharing	
<u>Deductibles</u>	\$4,000
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$4,720

Mia's Simple Fracture

(in-network emergency room visit and follow up

\$7,500
\$100
50%
50%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$12,700	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$2,100	
Copayments	\$500	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,600	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-595-0619

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