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 www.MyAmeriBen.com or call 1-855-350-8699. 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 at www.MyAmeriBen.com or call 1-855-350-8699 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Per participant:** $250 network **Per family:** $500 network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Some services such as office visits require a co-payment while preventive care is provided at no cost.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**For Medical:** **Per participant:** $2,500 network **Per family:** $5,000 network **For Prescription Drugs:** **Per participant:** $4,100 network **Per family:** $8,200 network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this Plan doesn't cover, pre-certification penalties, and medical food charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com or call 1-855-350-8699.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	**Yes, for medical:** BlueCross® BlueShield® of Arizona. For a list of network providers, call BCBSAZ at 1-800-232-2345 or visit www.azblue.com/CHSNetwork. **Yes, for prescription drugs:** Navitus. For a list of retail and mail pharmacies, log on to www.navitus.com.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		Note: EPO only offers coverage out-of-network in the case of a life threatening emergency.		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-payment/visit, deductible waived	Not Covered	——————————none——————————
	Specialist visit	$30 co-payment/visit, deductible waived	Not Covered	——————————none——————————
	Preventive care/screening/ immunization	No Charge	Not Covered	AzMT L.I.V.E. on-site wellness screenings and programs will be covered at no charge. Please refer to the Routine Preventive Care provision listed in the plan document for a further description and limitations to this benefit. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your Plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		Note: EPO only offers coverage out-of-network in the case of a life threatening emergency.		
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance after deductible	Not Covered	There is no charge when labs are received at a free-standing facility.
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible	Not Covered	**Pre-certification is required.** Benefits will be reduced by $300 per paid claim for non-compliance.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com.	Generic drugs	$10 co-payment/ 30-day supply $25 co-payment/ 90-day supply	You pay the network pharmacy co-payment plus the difference between the non-network and network pharmacy cost.	Prescription drug charges apply to the Prescription Drug out-of-pocket limit. Preventive prescription medications (including contraceptives) when purchased from a network pharmacy are paid at 100% and the co-payment/deductible (if applicable) is waived. Members who choose a brand name drug when a generic is available will be subject to a penalty equivalent to the cost difference between the brand and generic. Not all prescription drugs are covered. To determine if a specific drug is covered under your Plan, log into your account at www.navitus.com. Note: Specialty drugs are only available through the Navitus SpecialtyRx Program Pharmacy.
	Formulary brand drugs	$30 co-payment/ 30-day supply $75 co-payment/ 90-day supply		
	Non-formulary brand drugs	$50 co-payment/ 30-day supply $125 co-payment/ 90-day supply		
	Specialty drugs	20% co-payment to a maximum of $200/30-day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance after deductible	Not Covered	Providers who do not typically contract (e.g. anesthesiologist, pathologists, and assistant surgeons) are to be paid based on the network status of the facility in which the services were rendered.
	Physician/surgeon fees	10% co-insurance after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	$150 co-payment/visit, plus deductible and co-	EPO only offers non-network coverage in the	——————————none——————————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		Note: EPO only offers coverage out-of-network in the case of a life threatening emergency.		
		insurance Co-payment waived if admitted	case of a life threatening emergency	
	Emergency medical transportation	10% co-insurance after deductible		——————————none——————————
	Urgent care	$50 co-pay/visit, deductible waived	Not Covered	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance after deductible	Not Covered	Limited to the semi-private room rate. **Pre-certification is required.** Benefits will be reduced by $300 per paid claim for non-compliance.
	Physician/surgeon fees	10% co-insurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 co-payment/visit PCP or $30 co-pay/visit specialist, deductible waived	Not Covered	**Pre-certification is required** for psychiatric day treatment. Benefits will be reduced by $300 per paid claim for non-compliance.
	Inpatient services	10% co-insurance, after deductible	Not Covered	**Pre-certification is required.** Benefits will be reduced by $300 per paid claim for non-compliance.
If you are pregnant	Office visits	10% co-insurance, after deductible	Not Covered	First visit to confirm pregnancy is subject to a $15 co-pay for a PCP or a $30 co-pay for a specialist, deductible waived. Cost sharing does not apply for preventive services. Depending on the type of services, a co-payment, co-insurance, or deductible may apply.
	Childbirth/delivery professional services	10% co-insurance, after deductible	Not Covered	——————————none——————————
	Childbirth/delivery facility services	10% co-insurance, after deductible	Not Covered	——————————none——————————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		Note: EPO only offers coverage out-of-network in the case of a life threatening emergency.		
If you need help recovering or have other special health needs	Home health care	10% co-insurance, after deductible	Not Covered	Benefit year maximum: Sixty (60) visits per plan participant.
	Rehabilitation services	10% co-insurance, after deductible	Not Covered	Services include speech, occupational, or physical therapy provided on an inpatient or outpatient basis. Combined benefit year maximum: Twenty (20) visits per plan participant. **Pre-certification is required** for services in excess of the twenty (20) visit limit**.** Benefits will be reduced by $300 per paid claim for non-compliance.
	Habilitation services	Covered as any other illness depending on provider type, service performed, and place of service.	Not Covered	Coverage for Autism Spectrum Disorder – Behavior Therapy Services ONLY. Behavioral therapy services for the treatment of Autism spectrum disorder are available for plan participants who have been diagnosed with autism spectrum disorder. **Pre-certification is required.** Benefits will be reduced by $300 per paid claim for non-compliance.
	Skilled nursing care	10% co-insurance, after deductible	Not Covered	Benefit year maximum: Sixty (60) days per plan participant. **Pre-certification is required.** Benefits will be reduced by $300 per paid claim for non-compliance.
	Durable medical equipment	10% co-insurance, after deductible	Not Covered	——————————none——————————
	Hospice services	10% co-insurance, after deductible	Not Covered	Lifetime maximum: Six (6) months per plan participant. Services include bereavement counseling;

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		Note: EPO only offers coverage out-of-network in the case of a life threatening emergency.		
				limited to $300 per plan participant.
If your child needs dental or eye care	Children's eye exam	No charge, deductible waived	Not Covered	This describes benefits provided by your medical Plan. AzMT provides Dental and Vision coverage through stand-alone plans at a low monthly cost. If this is elected, please refer to your vision and/or dental administrator for additional benefits. This Plan provides coverage for certain wellness care services not defined by PPACA, including routine vision exams, up to $500 per benefit year per plan participant.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult and children covered under stand-alone dental plan)
- Glasses (adult and children)
- Infertility treatment
- Long-term care (except for a facility licensed to provide long term acute care)
- Non-emergency care provided by a non-network provider
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care (except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg)
- 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
- Hearing aids
- Routine eye care (adult and children)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. You may also contact the Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise ID 83707, 1-855-350-8699.
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 Plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the third party administrator (TPA) to assist the Plan Administrator with claims adjudication. The TPA's name, address, and telephone number are:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-855-350-8699

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-350-8699.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-350-8699.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-855-350-8699.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-350-8699.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. 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	$250
Specialist co-payment	$30
Hospital (facility) cost sharing	10%
Other cost sharing	10%

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	
Deductibles	$250
Copayments	$40
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,500**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The Plan's overall deductible	$250
Specialist co-payment	$30
Hospital (facility) cost sharing	10%
Other cost sharing	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$900
Coinsurance	$200
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,380**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The Plan's overall deductible	$250
Specialist co-payment	$30
Hospital (facility) cost sharing	10%
Other cost sharing	10%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

The **Plan** would be responsible for the other costs of these EXAMPLE covered services.