	<b>EMPLOYMENT STATUS</b>	<b>EFFECTIVE DATE OF COVERAGE/CHANGE</b>	
	<input type="checkbox"/> Active Employee <input type="checkbox"/> COBRA		
<b>SOC. SEC. #</b>	<b>EMPLOYEE'S LAST NAME</b>	<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>

<b>MAILING ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	<b>HOME PHONE NUMBER</b>	<b>EMAIL ADDRESS</b>

<b>MARITAL STATUS</b>	<b>GENDER</b>	<b>DATE OF BIRTH</b>	<b>DATE OF FULL TIME HIRE</b>	<b>HOURS WORKED PER WEEK (ACTIVE EMPLOYEES ONLY)</b>
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DOMESTIC PARTNER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<small>MONTH DAY YEAR</small>		

**MEDICAL COVERAGE OPTIONS**

<p style="text-align: center;"><b>Select one health plan and one coverage level to enroll:</b></p> <p> <input type="checkbox"/> PPO    <input type="checkbox"/> PPO BUY-UP    <input type="checkbox"/> HDHP    <input type="checkbox"/> Waive Coverage*         </p> <p style="text-align: center;"><b>ENROLL IN HSA?</b>    <input type="checkbox"/> Yes**    <input type="checkbox"/> No</p> <p> <input type="checkbox"/> Employee    <input type="checkbox"/> Employee + Spouse/DP    <input type="checkbox"/> Employee + Child(ren)    <input type="checkbox"/> Employee + Family         </p>	<p>*Employees waiving coverage must complete the Waiver of Coverage located on Page 2 of this Benefit Enrollment/Change Form</p> <p>**You can only enroll in the HSA if the HDHP is selected. If enrolling in the HSA separate forms are required to be filled out.</p> <p><i>NOTE: Eligible children include natural, step, adopted, or children for which you have legal guardianship. Please refer to your current Summary Plan Document for full eligibility requirements.</i></p>
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<b>DENTAL COVERAGE OPTIONS</b>	<b>VISION COVERAGE OPTIONS</b>
--------------------------------	--------------------------------

<p style="text-align: center;"><b>Select one dental plan and one coverage level to enroll:</b></p> <p> <input type="checkbox"/> Basic Dental (\$2,000 Annual Benefit)*    <input type="checkbox"/> Buy-Up Dental (\$4,000 Annual Benefit)**         </p> <p> <input type="checkbox"/> Employee    <input type="checkbox"/> Employee + Spouse/DP    <input type="checkbox"/> Employee + Child(ren)    <input type="checkbox"/> Employee + Family         </p> <p style="text-align: center;"><input type="checkbox"/> Waive Coverage</p> <p><small>*Basic Dental Plan – Dependent children are eligible up to age 19 only.  **Buy-Up Dental Plan – Dependent children are eligible up to age 26.</small></p>	<p style="text-align: center;"><b>Select one vision plan and one coverage level to enroll:</b></p> <p> <input type="checkbox"/> Basic Vision*    <input type="checkbox"/> Buy-Up Vision**         </p> <p> <input type="checkbox"/> Employee    <input type="checkbox"/> Employee + Spouse/DP    <input type="checkbox"/> Employee + Child(ren)    <input type="checkbox"/> Employee + Family         </p> <p style="text-align: center;"><input type="checkbox"/> Waive Coverage</p> <p><small>*Basic Vision Plan – Dependent children are eligible up to age 19 only.  **Buy-Up Vision Plan – Dependent children are eligible up to age 26.</small></p>
---	---

**IMPORTANT: YOU MUST FULLY COMPLETE THE FOLLOWING IF SPOUSE AND/OR DEPENDENT COVERAGE IS BEING REQUESTED**

ADD	DEL	NAME	DATE OF BIRTH	SOCIAL SECURITY # (REQUIRED)	RELATION	PLAN
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision

**OTHER INSURANCE INFORMATION**

Do you or your dependents currently have other: Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, give name of policyholder and insurance company.		
If anyone you are requesting coverage for is currently on Medicare please provide the following:	ID Number _____	Part A Effective Date _____/_____/_____	Part D Effective Date _____/_____/_____
	Part B Effective Date _____/_____/_____		

**AUTHORIZATION AND SIGNATURE**

The group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits. I hereby apply for benefits to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the policyholder. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this benefit.

The information provided above is correct to the best of my knowledge. I certify under penalty of perjury that the dependents listed on this form fully meet the listed definition of eligibility. I will provide, if requested, documentation regarding my relationship (marriage or birth certificate, adoption certificate, divorce decree, etc.) to any dependent and his/her age. I will notify my employer within 31 days of a change in my listed dependents eligibility for employer-provided health benefits. I understand that if I do not enroll myself or my dependents, I must read and sign the waiver portion of this form.

\_\_\_\_\_  
**Signature of Employee**

\_\_\_\_\_  
**Date**

**WAIVER OF COVERAGE (COMPLETE AND SIGN THIS SECTION IF YOU ARE WAIVING COVERAGE)**

Medical/Rx benefits are being waived for (Name) \_\_\_\_\_ for the following reason(s): \_\_\_\_\_

- Group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits.
- I waive coverage for myself and/or my dependents and elect not to participate.
- I understand that I am waiving this coverage even though my employer may be providing the coverage at little or no cost to me.
- I understand that by waiving enrollment because of other health insurance coverage, I may in the future be able to enroll in this plan, provided that I request enrollment within 31 days after other coverage ends. In addition, I understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself or my dependents provided that I request enrollment within 31 days of the status change.
- I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.

\_\_\_\_\_  
**Signature of Employee**

\_\_\_\_\_  
**Date**

**TO BE COMPLETED BY HUMAN RESOURCES ONLY**

<input type="checkbox"/> New Employee/Rehire	Hire/Rehire Date _____/_____/_____	Effective Date _____/_____/_____
<input type="checkbox"/> Add/Delete Dependents	Effective Date of Change _____/_____/_____	Qualifying Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Loss of Dependent Status <input type="checkbox"/> Death <input type="checkbox"/> Other
<input type="checkbox"/> Termination of Insurance	Termination Date _____/_____/_____	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Name/Address Change	HR Dept. Initials _____ Date _____/_____/_____    Data Input: _____ (HR Initials)



# Health Savings Account (HSA) Employer Payroll Deduction

### What you should know when completing this form:

- This form supports your request to have HSA contributions deducted from your pay by your employer
- You may use this form to authorize either a one-time transaction or periodic transfer
- You'll need to keep a copy of the completed form for your files
- You'll need to submit the completed form directly to your employer

### Account Holder Information

Name : Last		First		MI
Birthdate (MM/DD/YYYY) / /	Social Security Number - -	Telephone Number ( ) -	Email Address	
Street Address (Don't use a PO Box Address) _____ _____				
City		State	ZIP Code	Country
Employer Name				

### Payroll Deduction

Check the box that applies to you and specify a dollar amount:

**Lump sum:** I wish to authorize a **one time** contribution to my HSA in the amount of \$ \_\_\_\_\_.

**Periodic deduction:** I wish to authorize a periodic contribution to my HSA.  
I choose this period:  weekly  bi-weekly  semi-monthly or  monthly for this amount: \$ \_\_\_\_\_.

### Authorization

I authorize my employer to deduct the amount(s) above from my pay. My employer will remit such amount(s) to my HSA administrator or its designee for deposit into my HSA. I know my employer will establish the timing of contributions.

If I have authorized periodic deductions, I know I can terminate it by giving written notice to my employer. And that I must do it at least one month before the effective date of the change.

**X** \_\_\_\_\_

**Signature** **Print Name** **Date Signed**

# Group Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company  
Group Customer Service • 400 Robert Street North • St. Paul, Minnesota 55101-2098



A Securian Company

## MINNESOTA LIFE

**EMPLOYER NAME:**

**POLICY NUMBER:**

1. Return completed and signed form to
2. Please complete the Group Life Evidence of Insurability form for coverage that is not guaranteed.

### A. EMPLOYEE INFORMATION

First name	Middle initial	Last name		
Email address				
Street address		City	State	Zip code
Date of birth		Date of employment	Salary	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

### B. SPOUSE INFORMATION Is your spouse also an employee covered under this policy? Yes No

First name	Middle initial	Last name		
Email address			Marriage date	
Date of birth	Social Security number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

### C. CHILDREN INFORMATION

List of names and dates of birth for your eligible children:

### D. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage.

Employee signature <b>X</b>	Daytime phone number	Evening phone number	Date signed
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# Group Accidental Death and Dismemberment Insurance Employee and Family Enrollment

**MINNESOTA LIFE**

Minnesota Life Insurance Company - A Securian Company  
400 Robert Street North • 18-3789 • St. Paul, Minnesota 55101-2098

Employer name		Policy number	Unit
Employee name		Social Security number	Date of birth
Street address		City	State Zip code
Occupation	Employee location		Insurance class
Date employed	Monthly salary \$	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you actively working at your employer's normal place of business at least _____ hours per week?
Beneficiary		Relationship	
<input type="checkbox"/> I would like to enroll in the Employee Plan OR <input type="checkbox"/> I would like to enroll in the Family Plan		Total amount of voluntary AD&D insurance requested \$_____ Effective Date: _____	

I understand that Minnesota Life Insurance Company shall incur no liability until the first premium is paid, and that premiums for the contributory insurance will be deducted from my pay.

Applicant signature <b>X</b>	Daytime telephone number	Date signed
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# Group Life Insurance Evidence of Insurability



**Minnesota Life Insurance Company** - a Securian Financial company  
 Administered by Ochs, Inc. • 18-3789 • 400 Robert Street North, St. Paul, MN 55101-2025  
 1-800-392-7295 • Fax 651-665-3791

**EMPLOYER NAME:**

**POLICY NUMBER:**

## EMPLOYEE INFORMATION

Name (first, middle initial, last)	Date of birth	Phone number
------------------------------------	---------------	--------------

Address (street, city, state, zip)

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Annual salary	Date of employment
---	---------------	--------------------

Total amount of insurance requested \$	Email address
---	---------------

## SPOUSE INFORMATION (only complete if coverage requires evidence of insurability)

Name (first, middle initial, last)	Date of birth	Phone number
------------------------------------	---------------	--------------

Address (street, city, state, zip; check here if same as above )

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Email address
---	---------------

Total amount of insurance requested \$
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## CHILDREN INFORMATION (only complete if coverage requires evidence of insurability)

Name	Date of birth	Name	Date of birth	Total amount of insurance requested \$

## HEALTH QUESTIONS (always complete for coverage that requires evidence of insurability)

Employee height	Employee weight	Spouse height	Spouse weight	Spouse occupation
-----------------	-----------------	---------------	---------------	-------------------

Employee Yes No	Spouse Yes No	Children Yes No	
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	1. In the last 7 years have you been diagnosed or treated for any of the following: <ul style="list-style-type: none"> <li>• Heart disease or disorder, chest pain</li> <li>• High blood pressure</li> <li>• Cancer or tumor</li> <li>• COPD, sleep apnea or other lung or respiratory disease</li> <li>• Stroke, TIA, seizure, epilepsy, or multiple sclerosis</li> <li>• Kidney or pancreas disorder</li> <li>• Ulcerative Colitis, Crohn's disease, bariatric surgery, or any stomach or intestinal disorder</li> <li>• Anemia, leukemia, or other blood disorder</li> <li>• Hepatitis B, Hepatitis C, or other liver disorder</li> <li>• Diabetes</li> <li>• Depression, bipolar disorder, or any mental disorder</li> <li>• Drug or alcohol misuse including addiction</li> <li>• Chronic pain, rheumatoid arthritis, psoriatic arthritis, lupus</li> <li>• AIDS, AIDS Related Complex, or HIV, including positive test results</li> <li>• ALS or muscular dystrophy</li> </ul>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	2. During the past 5 years, have you, for any reason other than the conditions in question 1, been hospitalized, had surgery, received medication, treatment or diagnostic testing (other than: acid reflux; allergies; birth control; high cholesterol; cold; appendix or gallbladder removal; underactive thyroid; kidney stones; pregnancy without complications; or minor infection)?
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	3. Are any future inpatient or outpatient medical, surgical, or diagnostic procedures recommended or being considered by a medical professional (other than: routine lab testing or physical)?

Securian Financial is the marketing name for Minnesota Life Insurance Company. Insurance products are issued by Minnesota Life Insurance Company.

⇨⇨⇨⇨⇨ **Please provide details to all "Yes" answers on page 2 and sign page 3** ⇨⇨⇨⇨⇨



**EMPLOYER NAME:**

**POLICY NUMBER:**

**AUTHORIZATION**

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, data aggregator, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Minnesota Life Insurance Company, (the Company), and its employees, reinsurers and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

I also authorize any person(s), medical practitioner, institution, insurance company or MIB, Inc. to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, Inc., to give such information to any agency employed by the Company to collect and transmit such information. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

This protected health information is to be disclosed under this Authorization so the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below. HIV-related information may not be released after 180 days from the date this Authorization is signed. Disclosure of HIV test results pertaining to my application for insurance is governed by A.R.S. 20-448.01. A copy of this Authorization is as valid as the original. I understand I or my authorized representative is entitled to receive a copy of this Authorization. I understand the information may be used for the purpose of performing actuarial or internal business studies, research, analytics and other analysis. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company. I understand that a revocation does not apply to any action that was taken in reliance on this Authorization or to the Company's legal right to contest the policy. In the case of an Authorization signed for the purpose of collecting information in connection with a claim for benefits under the policy, this Authorization shall be no longer than the term of coverage of the policy if the claim is for a health insurance benefit or the duration of the claim if the claim is not for a health insurance benefit. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I have read this Authorization and Consumer Privacy Notice and I understand I can have copies. The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I authorize my employer to withdraw premiums from my salary to pay for this coverage. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

Employee signature <b>X</b>	Date signed	Employee name (please print)	Date of birth
Spouse signature <b>X</b>	Date signed	Spouse name (please print)	Date of birth
Children (age 18 and older) signature <b>X</b>	Date signed	Children name (please print)	Date of birth

**FOR OFFICE USE ONLY:**

Employee		Spouse		Children		Dependent Life Package - Coverage Code 94	
Current in force	U/W applied for	Current in force	U/W applied for	Current in force	U/W applied for	U/W applied for spouse	U/W applied for child
\$	\$	\$	\$	\$	\$	\$	\$

# Understanding your health plan

Working together to streamline healthcare and manage costs so you receive the most effective and appropriate care and medications.



## Important things to remember:

- Ensure your provider has your ID card.
- Match bills received from providers with the Explanation of Benefits (EOB) from AmeriBen. If missing an EOB, contact your provider.
- Review EOBs carefully and pay providers directly. For claim questions, call Member Services at 855-350-8699

## The four key elements to your health plan:

- 1. Third party administrator — AmeriBen**

AmeriBen handles and processes your health insurance claims. After receiving services, claims are sent to AmeriBen for processing and payment, based on the plan language. 855-350-8699
- 2. Utilization management (precertification review) — AmeriBen**

Some health services require precertification. Utilization management reviews if services will be covered but doesn't guarantee benefits or eligibility. Failure to pre-certify may lead to covering the full cost of care. 855-778-9053
- 3. Preferred network — Blue Cross Blue Shield of Arizona**

Choose in-network providers to minimize costs. Out-of-network care costs more. Using network providers reduces expenses for both you and your employer.
- 4. Pharmacy benefit manager provider — SmithRx**

For prescription coverage, SmithRx provides lower fees for medications. Contact SmithRx at 844-454-5201. This information is on your ID card.



## Beneficiary Designation



### Securian Life Insurance Company Minnesota Life Insurance Company

Administered by Ochs, Inc.

Group Customer Service • 400 Robert Street North, Suite 1880, St. Paul, MN 55101-2025

#### INSTRUCTIONS

1. Clearly print or type the information.
2. Sign and date the completed form.
3. Return to:
  - Attach and submit on: [www.LifeBenefits.com/filetransfer](http://www.LifeBenefits.com/filetransfer)
  - Fax to: 651-665-4827
  - Mail to: Securian Financial  
PO Box 64546  
St Paul, MN 55164-0546

INSURANCE CARRIER STORES THE BENEFICIARY DESIGNATIONS

#### GENERAL BENEFICIARY INFORMATION

- Completing this Beneficiary Designation form will revoke all current beneficiary designations.
- The same person(s) cannot be named as both a primary and contingent beneficiary.
- If you need more space, attach an additional sheet of paper with all of the information required. Be sure to sign and date this additional information page.
- To receive a death benefit, a beneficiary must survive the insured. If the named beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category.
- When the signed and completed beneficiary form has been accepted, you will be mailed a confirmation.
- **Primary Beneficiary:** This is the individual(s), trust, charity, or estate that you want to receive the insurance benefit. You can divide the insurance proceeds between primary beneficiaries. The total shares must equal 100%.
- **Contingent Beneficiary:** If all the primary beneficiary(ies) are no longer living, eligible, or able to receive the benefits, it will be paid to the contingent beneficiary(ies) designated. You can divide the insurance proceeds between your named contingent beneficiaries. The total shares must equal 100%.
- **Naming Minor Children:** You may name your children (by name) directly, or to a trust. Minors cannot directly receive life insurance proceeds; however, they may be paid to a court-appointed guardian or held until the minor child is legal age.
- **Trust:** Provide the trust name, effective date and tax ID or Social Security number (if applicable) - i.e., "John Smith Trust dated 01/01/20xx."
- **Charity:** Provide the full name, address, tax ID number.

CONTINUE ON TO NEXT PAGE

Securian Financial is the marketing name for Securian Life Insurance Company and Minnesota Life Insurance Company. Insurance products are issued by Minnesota Life Insurance Company or Securian Life Insurance Company, a New York authorized insurer. Minnesota Life is not an authorized New York insurer and does not do insurance business in New York. Both companies are headquartered in Saint Paul, MN. Product availability and features may vary by state. Each insurer is solely responsible for the financial obligations under the policies or contracts it issues.

# Beneficiary Designation

Securian Life Insurance Company • Minnesota Life Insurance Company

Employer name		Policy number
Insured's name (first, middle initial, last)		ID (or last four of SSN)
Address (street, city, state, zip)		Email address
Insured's date of birth	Policyowner (if different than insured)	Policyowner's phone number

**This designation applies to selected coverage(s).** If this section is left blank, your designation will apply to all coverages. If your beneficiary(ies) are different by coverage, use a separate beneficiary form for each coverage.

All coverages

### PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit.

Beneficiary full name/trust name	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	

**Total Primary Shares Must Equal 100%**

### CONTINGENT BENEFICIARY(IES) - Receives a benefit ONLY if all primary beneficiaries are no longer living.

Beneficiary full name/trust name	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	

**Total Contingent Shares Must Equal 100%**

### SIGNATURE REQUIRED - This beneficiary form revokes all prior designations.

Insured or policyowner's penned signature	Date
---	------

**X**

**Community Property State Consent for current and former residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin.** If you are married and live in, or previously lived in, a community property state and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit. You should consult with a qualified tax advisor and/or seek legal advice if you have any questions in connection with the Beneficiary Designation.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any right that I may have to the proceeds of such insurance under applicable community property laws. My spouse may withdraw this designation at any time but may not designate a different primary beneficiary without my consent.

Signature of spouse	Please print spouse name clearly	Date signed
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**X**

# Introducing MyAmeriBen.com and MyAmeriBen Mobile



## Check Claims

See the status of claims 24/7.  
View general summaries and  
details of reports.



## Share ID Card Digitally

Never lose your card again. Its'  
easy to download and send  
straight to providers.



## Chat with Support

Contact online support specialists  
in real time or submit a question  
to be answered via email or chat.



## Access Benefit Information

View information including your  
plan documents, benefit  
information, and provider networks.



## Upload Documents

Use your smartphone's  
camera to instantly upload  
claims documents.

## Start managing all your resources all in one place — register today.

### Desktop

1. Visit: [myameriben.com](http://myameriben.com)
2. Click "Register" (if you've already registered enter your username and password enjoy managing all your resources in one place).
3. Fill out the form using your full legal name
4. Create a secure password with at least eight characters including one special character (!@#\$\$&\*).
5. Submit and accept the Terms and Conditions.

### Mobile Device

1. Visit the App Store or Google Play and search for "MyAmerBen Mobile." Download and open the app on your device.
2. If you've already registered on MyAmeriBen.com use the same username and password. If you haven't registered yet, tap "Create an Account" and follow the steps.
4. Accept the licensing agreement.
5. Confirm your identity.

## Need help registering?

Call AmeriBen Customer Care 855-350-8699 from 6:00 a.m. - 6:00 p.m., Monday - Friday



# Emergency Room or Urgent Care?

Making the right choice ensures quicker, cost-effective care.

## Make Informed Choices

### Urgent Care

Ideal for non-life-threatening issues such as:

- Severe headaches
- Cold or sore throat
- Rashes or minor swelling
- Earaches
- Minor cuts and burns

Time: Around 30 minutes per visit,

Cost: \$100-\$150

### Emergency Room

Best for severe conditions like:

- Chest pain
- Loss of consciousness
- Major trauma or bleeding
- Uncontrollable pain
- Coughing or vomiting blood
- Confusion or mental changes

Time: About 2.25 hours per visit,

Cost: \$1,389



### Unsure?

- Call your doctor or urgent care for advice.
- Know your nearest urgent care and ER locations for peace of mind.



# Case Management

## AmeriBen's Case Management supports you and your family

### Personalized care at no extra cost

Navigating a health diagnosis or hospitalization can be challenging. AmeriBen Case Management is here to support you by coordinating care and simplifying the insurance process. Our services, part of your company benefits, include:

- **Communication coordination:** Connecting you with doctors, hospitals, and insurers.
- **Cost management:** Assisting with precertification and finding in-network providers.
- **Care transition:** Facilitating smooth transitions and follow-ups after hospitalization.
- **Expert support:** Registered nurses and behavioral health managers provide confidential, personalized care.

### Care when you need it

Registered nurses and behavioral health case managers offer confidential services to ensure you and your family receive personalized, high-quality, and cost-effective care.



### Questions?

- Call: 855-778-9053
- Visit: [MyAmeriBen.com](https://www.MyAmeriBen.com)
- Email: [casemanagement@ameriben.com](mailto:casemanagement@ameriben.com)



# FINDING A DOCTOR



Want to discover which providers are participating in the Blue Cross® Blue Shield® of Arizona (AZ Blue) networks? This tool helps you find doctors, other healthcare professionals, hospitals, and facilities that are part of our networks.

## How to Find a Healthcare Provider

- 1** Go to [azblue.com](https://azblue.com) and select **Find care**. Click on **Find a Doctor, Provider, or Facility**.
- 2** Choose **Browse the network as a guest**, and then click on the box that reads **Continue as a guest**.
- 3** Click on the arrow next to **Type of Coverage** and select the type of plan.
- 4** Select from **Type of Provider** and **Network** from the drop-down menu, and then click **Search**.
- 5** Click on **Choose a location** and type your information in the box or select **Use my current location**. You can then search **Doctors by Name**, **Doctors by Specialty**, and more.



## Search options

- There are several search options available. You can select one, or **Search all** using a keyword.
- The **Advanced search** helps you filter your search for providers who match your preferences in categories such as languages spoken, specialty, and quality certifications.
- Results are displayed in a list and on a map.
- You can change how your results are displayed through the **Sort** menu on the top right, or refine your results by selecting one of the options in the left column.

**Tip:** Results default to a 25-mile radius. If you don't see enough options, you may want to increase the radius.



An Independent Licensee of the Blue Cross Blue Shield Association

# Welcome to SmithRx

Welcome to SmithRx! We're excited to partner with Arizona Metropolitan Trust to provide your pharmacy benefits.

We understand that navigating healthcare can be confusing, and that's why we've built SmithRx differently. We're on a mission to reduce the cost and complexity of pharmacy benefits.

Our commitment is to you, ensuring you have clear access to the medications you need at the best possible price. Your plan includes access to a variety of **savings programs** to help you lower your medication costs. And the **Find My Meds tool** in your Member Portal makes it easy to compare pharmacy prices and find your medications at the lowest price. We're dedicated to helping you keep more money in your pocket.

We're also committed to providing the tools and resources you need to make using your benefits easy. Your SmithRx Member Portal is a central hub where you can securely manage your benefits and get the assistance you need. We offer support via chat, phone, and email, ensuring you can access help when and where you need it. Our Member Services team is here to listen, help, and ensure you feel confident and cared for every step of the way

We're excited for you to discover the SmithRx difference. Welcome aboard!



Jake Frenz | Founder and CEO



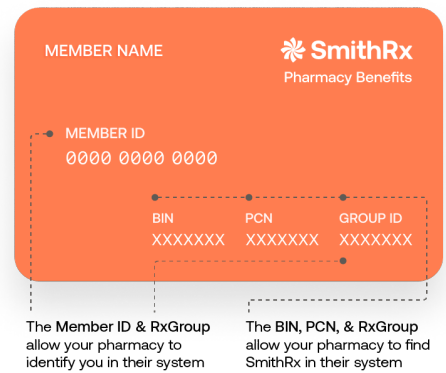
# Getting Started with SmithRx

## Get Ready to Use Your New Pharmacy Benefits

Once your plan is active, get started with SmithRx in 3 easy steps!

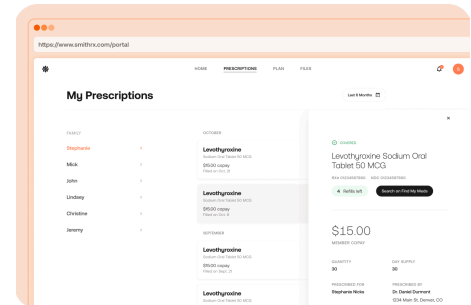
### 1. Update your Rx insurance with your pharmacy

If you haven't already, in the next few days you will receive an updated benefits ID card in the mail. This will include your plan information that you will need to present to your pharmacy before filling medications. The BIN, PCN, & group ID allows your pharmacy to find SmithRx in their system.



### 2. Sign up for the Member Portal

Once you have your new ID card, [create a Member Portal account](https://www.smithrx.com/portal) (SmithRx.com/Members) to view your plan details, find the lowest-cost medication at a pharmacy near you, track Rx spend, and more.



### 3. Connect with us for more savings

At SmithRx, our mission is to help you save money on your medications. If you have a prescription eligible for savings, our Connect Team will reach out to you via phone, text, email and a notification in your Member Portal.

**Simply connect with a Patient Access Specialist to start saving!**

# Getting Started with SmithRx

## Refilling your Prescriptions with Ease

### Retail Pharmacy Network

SmithRx partners over 65,000 retail pharmacies across the nation, including major national chains, regional chains, grocers and independent pharmacies. So chances are, you can keep using your current pharmacy. Here are just a few of the retail pharmacies in our network.



### Mail Order Pharmacies

Take advantage of the cost savings and convenience of mail order services through our preferred partners:



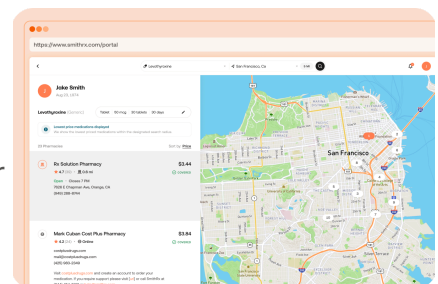
### Specialty Pharmacy Network

Costco Specialty Pharmacy and Senderra are available to fill your specialty medications.



Download the [pharmacy overview document](#) for more information on getting started with our mail order and speciality pharmacy partners.

**Tip:** Use the “Find My Meds” tool in the SmithRx [Member Portal](#) to locate pharmacies offering the lowest medication prices under your plan.



# Frequently Asked Questions

## What is a Pharmacy Benefits Manager (PBM)?

Pharmacy benefits managers (or PBMs) like SmithRx administer prescription drug benefits on behalf of your employer's benefits plan. Your PBM powers your pharmacy experience by:

- Making sure you're charged the correct copay at the pharmacy
- Setting up and approving your medications to be covered according to your plan design
- Reviewing clinical requirements related to your prescriptions

## What Can I Do in the SmithRx Member Portal?

- Find the lowest-cost pharmacy near you with "Find My Meds"
- View your plan and summary of benefits
- Look up prescription details
- See your prior authorization status in the notifications center
- Access or reorder your Member ID Card
- Get prescription savings alerts

## What is a formulary?

A formulary is a list of brand-name and generic medications that are covered by your benefit plan. Formularies vary by plan. SmithRx regularly reviews this list based on clinical guidelines, safety, effectiveness, and cost. Being on the formulary doesn't guarantee coverage, and the list may change over time.

## Where can I find the drug formulary?

You can access your plan's drug formulary by visiting the SmithRx member portal at [smithrx.com/members](https://smithrx.com/members). Please note that your plan benefits may also have coverage restrictions that may not be represented on the drug formulary.

# Frequently Asked Questions

## What if my medication is not in the formulary?

The formulary lists medications in many therapeutic areas. If your medication is not covered, there may be a lower cost alternative available. If you have explored all other alternatives, your doctor may be able to seek an exception based on medical necessity. Please contact SmithRx Member Support to assist with finding alternatives if your medication is not listed in the formulary.

## My medication needs prior authorization. What does this mean?

A prior authorization (PA) is a review your plan requires for certain medications. If a PA is required, your doctor will submit the request to SmithRx—no action is usually required from you. While our team aims to act promptly, it can take up to 15 days to receive a response on non-urgent PA's and up to 72 hours for urgent cases. You'll get a decision by mail. For text updates, add your mobile number in the member portal or contact Member Support at [smithrx.com](http://smithrx.com), [help@smithrx.com](mailto:help@smithrx.com), or (844) 454-5201. You can also get timely [notifications](#) and track your PA process through the Member Portal.

To check if your medication needs a PA, log into the SmithRx Member Portal and use "Find My Meds".

## What is Step Therapy?

In some cases, your plan requires you to first try one medication for your condition before it will cover another medication. This is most common if there is a generic medication available. You can identify which drugs require step therapy by using the formulary lookup tool on the member portal.

## How can I get another copy of my ID Card?

Your pharmacy benefit information is located on your SmithRx benefits ID card. You can access your SmithRx benefits ID card through the SmithRx member portal.

YOUR NEW PHARMACY BENEFIT PARTNER

# We Are Here to Help

The **SmithRx Member Support Team** is dedicated to connecting you with the tools and resources needed to lower your out of pocket costs for medications. We can answer your questions and support you throughout the process. Our goal is to simplify your pharmacy benefits and connect you to savings on your prescriptions.

Live assistance is available **Monday through Friday, 8 am - 9 pm ET** and **Saturdays 11 am - 4 pm ET**.

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## Chat

Chat live with a member service representative on our [website](#) or in the [member portal](#)



## Portal

Find plan info, ID cards and documents at [smithrx.com/portal](https://smithrx.com/portal)



## Email

Email our team at [help@smithrx.com](mailto:help@smithrx.com)



## Phone

Call us at [844-454-5201](tel:844-454-5201)

# Connect 360 Support

For assistance with **Connect 360 Programs**, contact our dedicated support team at [844- 385-7612](tel:844-385-7612) or [connect@smithrx.com](mailto:connect@smithrx.com).

# SmithRx Connect 360 Overview

SmithRx's Connect 360 programs help you access cost-saving options, often reducing medication costs to little or nothing. Continuously evolving, Connect 360 ensures members get the best prices on their medications.

## Here is the current list of Connect 360 Programs:

<b>Connect Access (CA-T &amp; CA-S)</b>	Capture manufacturer coupon savings on traditional and specialty medications. Members have a low or \$0 copay on prescriptions while also helping employers save on pharmacy benefit costs.
<b>Access Plus</b>	Leverages advocacy foundations and grant programs to reduce cost when a high-cost specialty medication is not covered under the pharmacy benefit. We assist members in navigating and applying to these different programs.
<b>Cost Plus Drugs</b>	Cost Plus Drugs is building an innovative pharmacy model that delivers medications at cost, plus a straightforward 15% markup, along with a \$5 dispensing fee and shipping. Cost Plus Drugs carries over 1,000 medications and is continuing to expand their drug list weekly.
<b>Autoimmune</b>	Through this program, SmithRx members can now access low cost, FDA-approved biosimilars such as Yusimry, a biosimilar for Humira, and Otulfi, a biosimilar for Stelara, through Cost Plus Drugs and Costco Specialty Pharmacy. FDA-approved biosimilars have no clinically meaningful differences in terms of safety and effectiveness from their brand-name counterparts, while offering a more affordable option for members with autoimmune conditions.
<b>Multiple Sclerosis (MS)</b>	Through the MS Program, members will transition to the lowest- cost Multiple Sclerosis treatment options on the market through Cost Plus Drugs.
<b>Low-Cost Insulin (LCI)</b>	This program helps reduce insulin costs at the pharmacy by transitioning to generic and biosimilar insulin products.
<b>Diabetes Non-Insulin (DNI)</b>	Through our partnership with Cost Plus Drugs, we are offering Brenzavvy, an SGLT2 inhibitor, as the lowest cost option for members with type 2 diabetes.
<b>Referral Partner Program (340 B)</b>	Provides members with lower net costs for eligible program medications. By providing access to discounted medications, the 340B program helps eligible healthcare organizations stretch their resources further, enhance patient care, and improve health outcomes.



## Member Eligibility & Enrollment

A dedicated team of Connect 360 specialists proactively identifies medications eligible for the Connect 360 program(s). They reach out to the member to offer enrollment support in the program that provides the lowest net cost for that medication.

## Maximizing Savings

Certain medications may be eligible for multiple Connect 360 programs. During our claims analysis process, we will identify the program that results in the **lowest net cost** for each drug and initiate the enrollment process with the member.

## SmithRx Connect 360 Workflow

1. **Identify Eligible Member Claims:** Through claims data analysis, identify claims for each program and create cases in SmithRx systems.
2. **Outreach Member:** The connect team will reach out via phone, SMS text, email and through the member portal (for registered users).
3. **Complete intake via phone or online form:** HIPAA secure intake form for member convenience. Patient Specialists walk through process and documentation.
4. **Coordinate with Provider:** Coordination with physician's office.
5. **Program submission and decision:** Enrollment with partners and programs. Follow through on medication dispense.

## Support for Members

The SmithRx Connect 360 team is committed to providing a personalized, seamless experience for members eligible for a Connect 360 program by offering:

- Dedicated agent assigned to each case to support the member through the enrollment process
- Direct email and phone line to the Connect Team

Phone: **(844) 385-7612**

Email: **[connect@smithrx.com](mailto:connect@smithrx.com)**



**Delta Dental PPO plus Premier™  
Summary of Benefits  
For Group# 4720 Low Plan  
Arizona Metropolitan Trust (AZMT)**

This Summary of Benefits should be read along with your Dental Benefits Booklet. Your Dental Benefits Booklet provides additional information about your Group Plan Sponsor's dental plan administered by Delta Dental, including information about plan exclusions and limitations. If a statement in this Summary of Benefits conflicts with a statement in the Dental Benefits Booklet, the statement in this Summary of Benefits applies to you and you should ignore the conflicting statement in the Dental Benefits Booklet. The percentages below are applied to your Group Plan Sponsor's dental plan allowance for each service and it may vary due to the dentist's network participation.\*

**Group Plan Sponsor** – Arizona Metropolitan Trust (AZMT)

**Dental Claims Administrator** – Delta Dental of Arizona

**Benefit Year** – July 1 through June 30

**Deductible** – \$50 Deductible per person total per Benefit Year limited to a maximum Deductible of \$150 per family per Benefit Year. The Deductible does not apply to oral exams, preventive services, X-rays, sealants, periodontal maintenance, and orthodontic services.

**Benefit Maximum Payment** – \$2,000 per person total per Benefit Year on all services except orthodontic services. \$2,000 per person total per lifetime on orthodontic services.

**Child Age Limit** – To age 19

**Student Age Limit** – To age 19

**Covered Services** –

	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays	Non-Participating Dentist Plan Pays*
<b>Diagnostic &amp; Preventive</b>			
<b>Diagnostic and Preventive Services</b> – exams, cleanings, fluoride, and space maintainers	100%	100%	80%
<b>Sealants</b> – to prevent decay of permanent teeth	100%	100%	80%
<b>Radiographs</b> – X-rays	100%	100%	80%
<b>Periodontal Maintenance</b> – cleanings following periodontal therapy	100%	100%	80%
<b>Basic Services</b>			
<b>Emergency Palliative Treatment</b> – to temporarily relieve pain	80%	80%	60%
<b>Minor Restorative Services</b> – fillings	80%	80%	60%
<b>Endodontic Services</b> – root canals	80%	80%	60%
<b>Periodontic Services</b> – to treat gum disease	80%	80%	60%
<b>Oral Surgery Services</b> – extractions and dental surgery	80%	80%	60%
<b>Other Basic Services</b> – misc. services	80%	80%	60%
<b>Major Services</b>			
<b>Crown Repair</b> – to individual crowns	50%	50%	40%
<b>Major Restorative Services</b> – crowns	50%	50%	40%
<b>Relines and Repairs</b> – to bridges, implants, and dentures	50%	50%	40%
<b>Prosthodontic Services</b> – bridges, implants, and dentures	50%	50%	40%
<b>Orthodontic Services</b>			
<b>Orthodontic Services</b> – braces	50%	50%	50%
<b>Orthodontic Age Limit</b> –	from the age of 8 - No Age Limit	from the age of 8 - No Age Limit	from the age of 8 - No Age Limit

\* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

## Frequencies and Limitations

- Oral exams are payable twice per benefit year.
- Prophylaxes (cleanings) are payable three times per benefit year. Scaling (equivalent to one cleaning) is payable once in any two-year period. Full mouth debridement (equivalent to one cleaning) is payable once in any five-year period.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable twice per benefit year for people age 17 and under.
- Sealants are payable once per tooth in any three-year period for bicuspids and first and second molars for people age 18 and under. The surface must be free from decay and restorations. Preventive resin restoration on molars is payable once per lifetime for people age 15 and under with moderate to high caries risk. Treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament is payable twice per tooth per calendar year for people age 18 and under.
- Bitewing X-rays are payable once per benefit year. Full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any three-year period.
- Space maintainers and recement or rebond of space maintainers are payable once per area per lifetime for people age 13 and under. Distal shoe space maintainers are payable once per area per lifetime for people age eight and under.
- Endodontic treatment is payable once per tooth per lifetime. Endodontic retreatment is payable once per tooth in any three-year period.
- Root planing and scaling is payable once per quadrant in any two-year period. Only two quadrants of root planing and scaling can be performed on the same day.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are payable.
- Implants and prefabricated and custom fabricated abutments are payable once per tooth in any five-year period and subject to a \$1,000 maximum per tooth. Implant-related services are payable.
- Silver amalgam and composite resin (white) restorations are payable once per surface in any two-year period.
- Porcelain and resin facings on crowns are optional treatment.
- Crowns and onlays and associated procedures (cores, substructures) are payable once per tooth in any five-year period.
- Oral surgery, including simple and surgical extractions, is payable.
- Fabrication of athletic mouthguard is payable once in any two-year period for people age 18 and under. Occlusal guards are not payable.

## Special Health Care Needs

Members diagnosed with "special health care needs" (as defined below) that significantly impair the Member's ability to obtain routine covered dental services, may be eligible for additional services, including:

- Additional visits, consultations and/or exams
- Up to four total dental cleanings per benefit year
- Treatment delivery modifications, which may include limited anesthesia, when necessary for dental staff to provide oral health care

"Special health care needs" are any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition requiring medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Special health care needs may include:

- Intellectual and neurodevelopmental disabilities
- Environmental or congenital injuries leading to disability
- Chromosomal abnormalities
- Syndromes or sequences with craniofacial or airway abnormalities
- Other sequences that require special dental care needs
- Any other syndrome, sequence, or abnormality which is not otherwise specified but has a significant deleterious effect in activities of daily living and/or requires significant modification at home and/or in care settings

Special health care needs does not include anxiety, depression, or a fear of dentists or dental treatment (odontophobia).

In evaluating whether you qualify for this special health care needs benefit, your dentist will determine whether they need to change or add new equipment, increase procedure time, and/or change or require additional therapeutic regimes and/or techniques in order to treat you. In making the assessment, your dentist may ask you for documentation evidencing your special health care need. Your dentist will submit the required paperwork to us, and we will determine if you qualify for this benefit. There is no age limit on the special health care need benefit.

**Payment for Orthodontic Service** – When orthodontic treatment begins, your Dentist will submit a treatment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon treatment plan, Delta Dental will make an initial payment to you or your Participating Dentist upon insertion of the appliances or initial banding, equal to 50% of Delta Dental's stated Copayment on the Maximum Payment for Orthodontic Services as set forth in this Summary of Benefits. Provided Member has current eligibility on the date of service 12 months from the date the appliances or initial banding were placed, Delta Dental will make an additional payment equal to the balance of Delta Dental's stated Copayment on the Maximum Payment for Orthodontic Services. Maximum Payment for Orthodontic Services equals the lesser of Delta Dental's total Copayment for Orthodontic Services, the Maximum Payment per person total per lifetime on orthodontic services or the fee charged by your provider for orthodontic services.

**Eligible People** – As defined by the Employer Group. The Subscriber pays the full cost of this plan.

Enrollees and dependents choosing this Dental Plan are required to remain enrolled for a minimum of 12 months. Should a Subscriber or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Subscriber is enrolled (except under COBRA) and must be enrolled in the same plan as the Subscriber. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

**Dual Spouse** – If you and your Spouse are both eligible to enroll in this Dental Plan as Subscribers, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Subscribers under this Dental Plan.

Coverage ends at the end of the month that the Subscriber and/or Dependent is no longer eligible.



**Delta Dental PPO plus Premier™  
Summary of Benefits  
For Group# 4720 High Plan  
Arizona Metropolitan Trust (AZMT)**

This Summary of Benefits should be read along with your Dental Benefits Booklet. Your Dental Benefits Booklet provides additional information about your Group Plan Sponsor's dental plan administered by Delta Dental, including information about plan exclusions and limitations. If a statement in this Summary of Benefits conflicts with a statement in the Dental Benefits Booklet, the statement in this Summary of Benefits applies to you and you should ignore the conflicting statement in the Dental Benefits Booklet. The percentages below are applied to your Group Plan Sponsor's dental plan allowance for each service and it may vary due to the dentist's network participation.\*

**Group Plan Sponsor** – Arizona Metropolitan Trust (AZMT)

**Dental Claims Administrator** – Delta Dental of Arizona

**Benefit Year** – July 1 through June 30

**Deductible** – \$50 Deductible per person total per Benefit Year limited to a maximum Deductible of \$150 per family per Benefit Year. The Deductible does not apply to oral exams, preventive services, X-rays, sealants, periodontal maintenance, and orthodontic services.

**Benefit Maximum Payment** – \$4,000 per person total per Benefit Year on all services except orthodontic services. \$2,000 per person total per lifetime on orthodontic services.

**Child Age Limit** – To age 26

**Student Age Limit** – To age 26

**Covered Services** –

	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays	Non-Participating Dentist Plan Pays*
<b>Diagnostic &amp; Preventive</b>			
<b>Diagnostic and Preventive Services</b> – exams, cleanings, fluoride, and space maintainers	100%	100%	80%
<b>Sealants</b> – to prevent decay of permanent teeth	100%	100%	80%
<b>Radiographs</b> – X-rays	100%	100%	80%
<b>Periodontal Maintenance</b> – cleanings following periodontal therapy	100%	100%	80%
<b>Basic Services</b>			
<b>Emergency Palliative Treatment</b> – to temporarily relieve pain	80%	80%	60%
<b>Minor Restorative Services</b> – fillings	80%	80%	60%
<b>Endodontic Services</b> – root canals	80%	80%	60%
<b>Periodontic Services</b> – to treat gum disease	80%	80%	60%
<b>Oral Surgery Services</b> – extractions and dental surgery	80%	80%	60%
<b>Other Basic Services</b> – misc. services	80%	80%	60%
<b>Major Services</b>			
<b>Crown Repair</b> – to individual crowns	50%	50%	40%
<b>Major Restorative Services</b> – crowns	50%	50%	40%
<b>Relines and Repairs</b> – to bridges, implants, and dentures	50%	50%	40%
<b>Prosthodontic Services</b> – bridges, implants, and dentures	50%	50%	40%
<b>Orthodontic Services</b>			
<b>Orthodontic Services</b> – braces	50%	50%	50%
<b>Orthodontic Age Limit</b> –	from the age of 8 - No Age Limit	from the age of 8 - No Age Limit	from the age of 8 - No Age Limit

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Members diagnosed with "special health care needs" (as defined below) that significantly impair the Member's ability to obtain routine covered dental services, may be eligible for additional services, including:

- Additional visits, consultations and/or exams
- Up to four total dental cleanings per benefit year
- Treatment delivery modifications, which may include limited anesthesia, when necessary for dental staff to provide oral health care

"Special health care needs" are any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition requiring medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Special health care needs may include:

- Intellectual and neurodevelopmental disabilities
- Environmental or congenital injuries leading to disability
- Chromosomal abnormalities
- Syndromes or sequences with craniofacial or airway abnormalities
- Other sequences that require special dental care needs
- Any other syndrome, sequence, or abnormality which is not otherwise specified but has a significant deleterious effect in activities of daily living and/or requires significant modification at home and/or in care settings

Special health care needs does not include anxiety, depression, or a fear of dentists or dental treatment (odontophobia).

In evaluating whether you qualify for this special health care needs benefit, your dentist will determine whether they need to change or add new equipment, increase procedure time, and/or change or require additional therapeutic regimes and/or techniques in order to treat you. In making the assessment, your dentist may ask you for documentation evidencing your special health care need. Your dentist will submit the required paperwork to us, and we will determine if you qualify for this benefit. There is no age limit on the special health care need benefit.

**Payment for Orthodontic Service** – When orthodontic treatment begins, your Dentist will submit a treatment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon treatment plan, Delta Dental will make an initial payment to you or your Participating Dentist upon insertion of the appliances or initial banding, equal to 50% of Delta Dental's stated Copayment on the Maximum Payment for Orthodontic Services as set forth in this Summary of Benefits. Provided Member has current eligibility on the date of service 12 months from the date the appliances or initial banding were placed, Delta Dental will make an additional payment equal to the balance of Delta Dental's stated Copayment on the Maximum Payment for Orthodontic Services. Maximum Payment for Orthodontic Services equals the lesser of Delta Dental's total Copayment for Orthodontic Services, the Maximum Payment per person total per lifetime on orthodontic services or the fee charged by your provider for orthodontic services.

**Eligible People** – As defined by the Employer Group. The Subscriber pays the full cost of this plan.

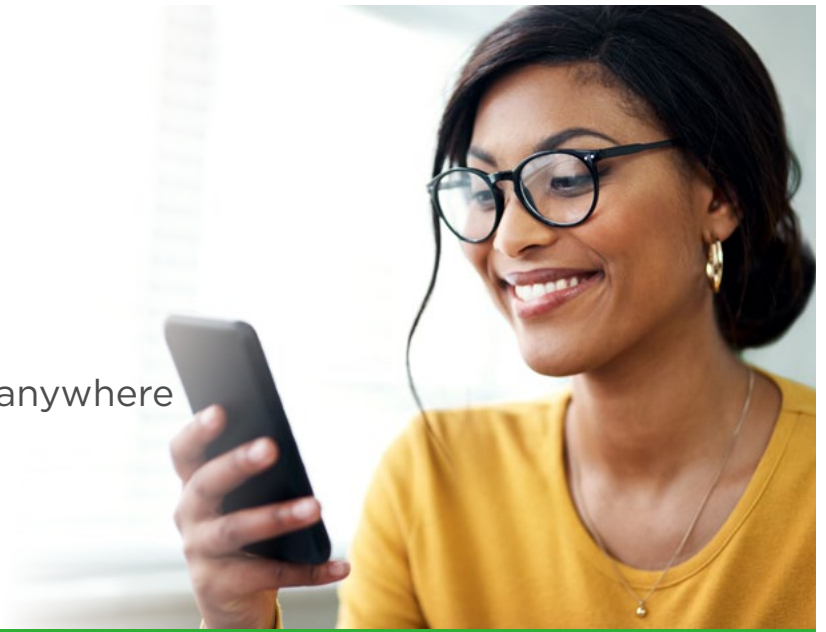
Enrollees and dependents choosing this Dental Plan are required to remain enrolled for a minimum of 12 months. Should a Subscriber or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Subscriber is enrolled (except under COBRA) and must be enrolled in the same plan as the Subscriber. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

**Dual Spouse** – If you and your Spouse are both eligible to enroll in this Dental Plan as Subscribers, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Subscribers under this Dental Plan.

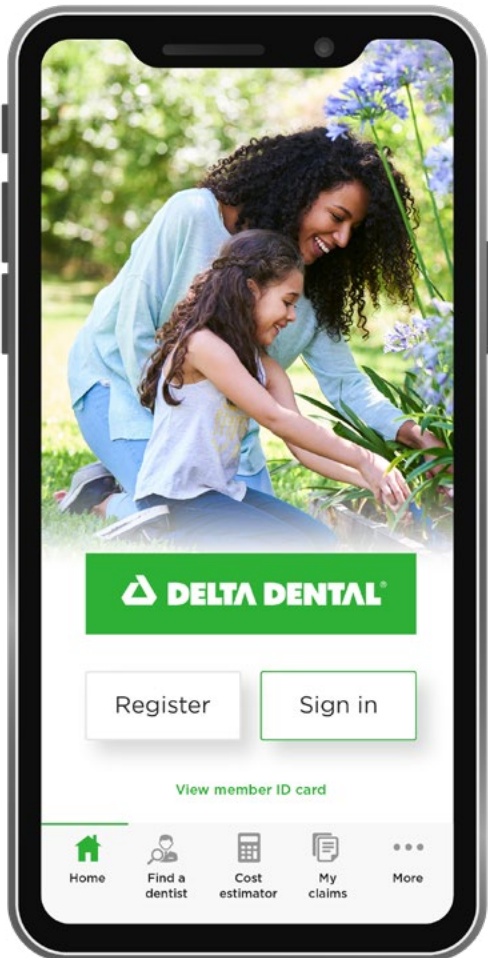
Coverage ends at the end of the month that the Subscriber and/or Dependent is no longer eligible.

# Delta Dental Mobile App

Manage your oral health anytime, anywhere



Your oral health is important to Delta Dental — and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Search for a dentist near you, view ID cards and more, right on your mobile device.



## Getting started

The Delta Dental Mobile App is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental Mobile App. Or, scan the QR code below. You will need an internet connection in order to download and use most features of our free app.

## Logging in to view benefits

Delta Dental members can sign in using the username and password they use to sign in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via the Delta Dental Mobile App.



SCAN TO DOWNLOAD  
DELTA DENTAL MOBILE APP

# Delta Dental Mobile App features

Sign in to access the full range of tools and resources



## Mobile ID card

No need for a paper card. View and share your ID card from your phone, and easily save it to your device for quick access, including Apple Passbook and Google Wallet.



## Find a dentist

It's easy to find a dentist near you. Search and compare dental offices to find one that suits your needs. Save your family's preferred dentists to your account for easy access.



## Dental Care Cost Estimator

Find out what to expect with our Dental Care Cost Estimator. Our easy to use tool provides estimated cost ranges on common dental care needs for dentists in your area, now with the option to select your dentist for tailored cost estimates.



## Save your preferred dentist for quick access

Save your favorite dentists using the Delta Dental Mobile App for quick access to contact information making it easy to schedule your routine cleaning.



## My claims

Look up detailed claims information for your dentist visits over the last 18 months.

## Secure access to your benefits

You must sign in each time you access the secure portion of the mobile app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed by clicking the lock icon on the main menu.

Please note information displayed may vary based on your particular coverage. For more information on your coverage, contact your Delta Dental company. "Delta Dental" refers to the national network of 39 independent Delta Dental companies that provide dental benefits and is a registered trademark of Delta Dental Plans Association.

[deltadentalaz.com](https://deltadentalaz.com)

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Arizona Dental Insurance Service, Inc. dba Delta Dental of Arizona. DDPA-0009-rev0622



# A Look at Your VSP Vision Coverage

With VSP and Arizona Metropolitan Trust,  
your health comes first.




**Enroll in VSP® Vision Care to get access to savings and personalized vision care from a VSP network doctor for you and your family.**


### Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over \$3,000 in savings.

### Provider choices you want.

 With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

### Shop online and connect your benefits.

 Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

### Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

### Using your benefit is easy!

Create an account on [vsp.com](http://vsp.com) to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

  
vision care

More Ways  
to Save

Extra

\$20

to spend on

Featured Frame Brands†

bebe

Calvin Klein

COLE HAAN

DRAGON

FLEXON

LONGCHAMP  
PARIS



and more

See all brands and offers  
at [vsp.com/offers](http://vsp.com/offers).

+

Up to

40%

Savings on

lens enhancements‡

Enroll through your employer today.  
Contact us: **800.877.7195** or [vsp.com](http://vsp.com)

# Your VSP Vision Benefits Summary

Arizona Metropolitan Trust and VSP provide you with a choice of affordable vision plans. Choose the eye care essentials, or upgrade to give your eyes extra love.

## PROVIDER NETWORK:

VSP Choice

## EFFECTIVE DATE:

07/01/2025



BENEFIT	DESCRIPTION	COPAY
<b>Standard Coverage with a VSP Provider</b>		
<b>WELLVISION EXAM</b>	<ul style="list-style-type: none"> <li>Focuses on your eyes and overall wellness</li> <li>Routine retinal screening</li> <li>Every plan year*</li> </ul>	\$10 Up to \$39
<b>ESSENTIAL MEDICAL EYE CARE</b>	<ul style="list-style-type: none"> <li>Retinal imaging for members with diabetes covered-in-full</li> <li>Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.</li> <li>Coordination with your medical coverage may apply. Ask your VSP network doctor for details.</li> <li>Available as needed</li> </ul>	\$20 per exam
<b>PRESCRIPTION GLASSES \$20</b>		
<b>FRAME*</b>	<ul style="list-style-type: none"> <li>\$170 Featured Frame Brands allowance</li> <li>\$150 frame allowance</li> <li>20% savings on the amount over your allowance</li> <li>\$150 Walmart/Sam's Club frame allowance</li> <li>\$80 Costco frame allowance</li> <li>Every plan year</li> </ul>	Included in Prescription Glasses
<b>LENSES</b>	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Impact-resistant lenses for dependent children</li> <li>Every plan year</li> </ul>	Included in Prescription Glasses
<b>LENS ENHANCEMENTS</b>	<ul style="list-style-type: none"> <li>Standard progressive lenses</li> <li>Premium progressive lenses</li> <li>Custom progressive lenses</li> <li>Average savings of 30% on other lens enhancements</li> <li>Every plan year</li> </ul>	\$0 \$95 - \$105 \$150 - \$175
<b>CONTACTS (INSTEAD OF GLASSES)</b>	<ul style="list-style-type: none"> <li>\$150 allowance for contacts; copay does not apply</li> <li>Contact lens exam (fitting and evaluation)</li> <li>Every plan year</li> </ul>	Up to \$60

BENEFIT	DESCRIPTION	COPAY
<b>Premium Coverage with a VSP Provider</b>		
<b>WELLVISION EXAM</b>	<ul style="list-style-type: none"> <li>Focuses on your eyes and overall wellness</li> <li>Routine retinal screening</li> <li>Every plan year*</li> </ul>	\$10 Up to \$39
<b>ESSENTIAL MEDICAL EYE CARE</b>	<ul style="list-style-type: none"> <li>Retinal imaging for members with diabetes covered-in-full</li> <li>Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.</li> <li>Coordination with your medical coverage may apply. Ask your VSP network doctor for details.</li> <li>Available as needed</li> </ul>	\$20 per exam
<b>PRESCRIPTION GLASSES \$10</b>		
<b>FRAME*</b>	<ul style="list-style-type: none"> <li>\$245 Featured Frame Brands allowance</li> <li>\$225 frame allowance</li> <li>20% savings on the amount over your allowance</li> <li>\$225 Walmart/Sam's Club frame allowance</li> <li>\$120 Costco frame allowance</li> <li>Every plan year</li> </ul>	Included in Prescription Glasses
<b>LENSES</b>	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Every plan year</li> </ul>	Included in Prescription Glasses
<b>LENS ENHANCEMENTS</b>	<ul style="list-style-type: none"> <li>Standard progressive lenses</li> <li>Impact-resistant lenses</li> <li>Premium progressive lenses</li> <li>Custom progressive lenses</li> <li>Average savings of 30% on other lens enhancements</li> <li>Every plan year</li> </ul>	\$0 \$0 \$25 \$25
<b>CONTACTS (INSTEAD OF GLASSES)</b>	<ul style="list-style-type: none"> <li>\$175 allowance for contacts; copay does not apply</li> <li>Contact lens exam (fitting and evaluation)</li> <li>Every plan year</li> </ul>	Up to \$60

<b>ADDITIONAL SAVINGS</b>	<b>Glasses and Sunglasses</b>	<ul style="list-style-type: none"> <li>Discover all current eyewear offers and savings at <a href="https://vsp.com/offers">vsp.com/offers</a>.</li> <li>20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.</li> </ul>
	<b>Laser Vision Correction</b>	<ul style="list-style-type: none"> <li>Average of 15% off the regular price; discounts available at contracted facilities.</li> </ul>
	<b>Exclusive Member Extras for VSP Members</b>	<ul style="list-style-type: none"> <li>Contact lens rebates, lens satisfaction guarantees, and more offers at <a href="https://vsp.com/offers">vsp.com/offers</a>.</li> <li>Save up to 60% on digital hearing aids with TruHearing®. Visit <a href="https://vsp.com/offers/special-offers/hearing-aids">vsp.com/offers/special-offers/hearing-aids</a> for details.</li> <li>Enjoy everyday savings on health, wellness, and more with VSP Simple Values.</li> </ul>

## YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to [vsp.com](https://vsp.com) to find an in-network provider.

\*Plan year begins in July

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.

‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on [vsp.com](https://vsp.com).

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VSP, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare and VSP Premier Edge are trademarks of Vision Service Plan. Flexon and Dragon are registered trademarks of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners. 102898 VCCM



## AzMT - Town of Wickenburg Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance

Insurance products issued by Minnesota Life Insurance Company or Securian Life Insurance Company and administered by Ochs.

### **Life and AD&D Insurance Coverage Available - No Health Questions!**

There are many reasons to consider Life and AD&D Insurance and there are certain times in which you can enroll for coverage without answering health questions. **Below is a summary of those options.**

#### INITIAL ELIGIBILITY OPPORTUNITY

Initial eligibility refers to the first time an employee is eligible for coverage.

- ✓ **Employee** - up to **\$300,000**
- ✓ **Spouse** - up to **\$30,000**
- ✓ **Child** - **all coverage**
- ✓ **Voluntary AD&D** - **all coverage**

#### ANNUAL ENROLLMENT OPPORTUNITY

Available during your employer's annual enrollment period.

- ✓ **Employee** - add or increase by **\$10,000** provided the resulting amount does not exceed \$300,000 of total coverage
- ✓ **Child** - **all coverage**
- ✓ **Voluntary AD&D** - **all coverage**

#### QUALIFIED FAMILY STATUS CHANGE

If you experience a family status change, check with your employer within 31 days to confirm guaranteed coverage availability.

#### LOOKING FOR A HIGHER AMOUNT OF COVERAGE?

A full list of your Life Insurance coverage options is outlined on the following pages. To apply for coverage other than the above, health questions and underwriting approval is required.



## Your Basic and Supplemental Life and Voluntary AD&D Insurance Coverages:

### Basic Life Coverage - 100% employer paid & automatically enrolled

<b>Basic term life</b>	<b>Non-Key Employees:</b> <b>\$20,000</b>	✓ Includes a matching AD&D benefit
	<b>Key Employees:</b> <b>\$50,000</b>	✓ Includes a Line of Duty benefit ✓ Coverage reduces beginning at age 75

### Supplemental Life Coverage - 100% employee paid

<b>Supplemental term life</b>	Elect in <b>\$10,000</b> increments Maximum <b>\$750,000</b>	
<b>Spouse term life</b>	Elect in <b>\$5,000</b> increments Maximum <b>\$250,000</b>	✓ Not to exceed 100% of the employee's basic and supplemental coverages combined
<b>Child term life</b>	<b>\$2,500, \$5,000, \$7,500, \$10,000 or \$15,000</b>	
<b>Voluntary AD&amp;D (employee or family)</b>	Elect in <b>\$10,000</b> increments Maximum <b>\$500,000</b>	✓ Family benefit is a percentage of the employee's elected AD&D amount: Spouse w/children - 40%; Spouse no children - 50% Each child w/spouse - 10%; Each child no spouse - 15%

If your spouse or child is eligible for employee coverage, they cannot be covered as a dependent. Only one employee may cover a dependent child. It is the employee's responsibility to notify their employer when dependents are no longer eligible.

## Monthly Cost:

Employee or Spouse Supplemental Life		
Age	Employee Rate per \$1,000	Spouse Rate per \$1,000
<25	\$0.060	\$0.049
25-29	\$0.060	\$0.049
30-34	\$0.080	\$0.050
35-39	\$0.090	\$0.066
40-44	\$0.124	\$0.093
45-49	\$0.201	\$0.141
50-54	\$0.307	\$0.214
55-59	\$0.496	\$0.356
60-64	\$0.660	\$0.538
65-69	\$1.270	\$0.914
70-74	\$2.060	\$1.624
75*	\$7.532	\$3.340

\*Rates beyond age 75 are available upon request. Rates increase with age and all rates are subject to change.

### Here's how to calculate your monthly premium:

Total supplemental term life coverage amount	\$ _____
÷ 1,000	\$ _____
× your rate (based on your age)	\$ _____
<b>= Monthly premium</b>	<b>\$ _____</b>

### Here's how Riley calculated their monthly premium:

Riley elected a total supplemental term life coverage amount of	\$150,000
÷ 1,000	\$150.00
× Riley's rate (based on their age of 42)	\$0.124
<b>= Riley's monthly premium</b>	<b>\$18.60</b>

Child Life				
\$2,500	\$5,000	\$7,500	\$10,000	\$15,000
\$0.325	\$0.650	\$0.975	\$1.300	\$1.950

One premium covers all eligible children from live birth to age 26

Voluntary AD&D	
Employee	Family*
\$0.030 per \$1,000	\$0.045 per \$1,000

\*One premium covers all eligible children from live birth to age 26



## Why Life Insurance?

No matter where you are in life, there are many reasons to consider Life Insurance. Group Life Insurance protects you and your family from the unexpected loss of life and income during working years. AD&D Insurance provides additional financial protection if the insured's death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere. Life and AD&D Insurance benefits are disbursed to you and/or your beneficiaries to help pay for things like:

- ✓ Your mortgage or rent
- ✓ Childcare or education costs
- ✓ Medical bills or other expenses
- ✓ Funeral and burial costs

## How much Life Insurance do I need?

To estimate the amount of Life Insurance you need, you'll want to determine what you must protect in the event of your death. Determine your needs today.

Check out our Life Insurance calculator: [click here.](#)

Or scan here:



## Naming a Beneficiary:

Naming a beneficiary is an important right of Life Insurance ownership; this determines who receives the death benefit. It is recommended that you review and update your beneficiaries periodically. Events such as marriage, birth/adoption of children, divorce or death may change how you want your Life Insurance benefit paid.

## Continuation:

If you are no longer eligible for coverage as an active employee, you may be eligible to continue your coverage after employment. No health questions are needed and rates are generally higher than active rates. If you would like to continue your coverage, be sure to enroll within 31 days of your current coverage ending.

**Questions? Contact Ochs. Email: [ochs@ochsinc.com](mailto:ochs@ochsinc.com) Phone: 800-392-7295**

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Insurance products are issued by Minnesota Life Insurance Company or Securian Life Insurance Company, a New York authorized insurer. Minnesota Life Insurance Company is not an authorized New York insurer and does not do insurance business in New York. Both companies are headquartered in St. Paul, MN. Product availability and features may vary by state. Each insurer is solely responsible for the financial obligations under the policies or contracts it issues.

Products are offered under policy form series MHC-96-13180.2 and 02-30428.

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### Ochs, Inc.

A Securian Financial Company

400 Robert Street N, Ste. 1880, St. Paul, MN 55101



## HEALTH SAVINGS ACCOUNT (HSA)

# Save now — and for your future

If you're on a high-deductible health plan (HDHP), you can use an HSA to pay your required deductible with pretax funds.

With an HSA, you may be able to contribute up to \$4,300\* per individual or \$8,550\* per family (pretax) annually. If you are 55 or older, you can contribute an extra \$1,000.

## Check HSA eligibility

You're eligible if you're enrolled in a qualified high-deductible health plan, with a few exceptions. They include:

- Other health plan coverage that pays out-of-pocket expenses before you meet your plan deductible, such as Medicare or TriCare coverage
- A general-purpose health care flexible spending account or health reimbursement arrangement in the same year
- Veterans Affairs medical benefits used in the last three months, unless the hospital care or medical services were for a service-connected disability
- Someone claiming you as a dependent on their tax return

## Use your HSA to save

Adding an HSA to your health plan can help grow your savings after meeting immediate health care expenses.

### → Triple tax benefit

Your contributions are tax-free, and remain completely tax-free when used for qualified health care expenses.

### → Invest tax-free

You can invest your HSA funds in an investment account, where your money may grow tax-free.\*\*

### → Take it with you

Your HSA isn't tied to an employer, health plan, or retirement. If you have an HSA elsewhere, you can transfer the balance to your new one. And your unused funds roll over from year to year.



## Helpful HSA tips

- 1 Check IRS contribution limits and eligible expense items on your employer's plan document or at [inspirafinancial.com](https://www.inspirafinancial.com).
- 2 Access the record of your HSA expense payments on the Inspira website.
- 3 If you use your HSA for ineligible expenses, you'll need to pay income taxes. Plus, a 20% penalty tax on that amount, unless you're age 65 or older or disabled at the time.

## Choose your way to pay

Once funds are available in your HSA, Inspira makes it easy to pay for your eligible expenses.

### → Pay with your Inspira Card™

When you use it, your expense is automatically paid from your account.

### → Pay yourself back

Pay for eligible expenses with cash, a check, or your personal credit card. Then withdraw funds from your HSA to pay yourself back and have your payment deposited directly into your checking or savings account.

### → Pay expenses online

Use our digital tools to set up easy repeat payments.

## Use the Inspira Mobile™ app

It's the easiest way to manage your account and view alerts; make payments, withdrawals, and deposits; use our barcode scanner to see if an item is an eligible expense.

An HSA allows tax-free payment of medical expenses, many over-the-counter products, and prescriptions, as well as vision and dental expenses. Find a list of which expenses may not be covered on the Inspira website.

## ⇒ Realize the savings potential of an HSA

For more information visit [inspirafinancial.com](https://www.inspirafinancial.com) or scan the QR code.



\*The maximum contribution limits are subject to change annually. 2025 IRS limits included.

\*\*Please note that not all states provide favorable income tax treatment for HSAs.

Inspira Financial Health, Inc. does not provide legal, tax, or financial advice. Please contact a professional for advice on eligibility, tax treatment, and other restrictions. Inspira and Inspira Financial are trademarks of Inspira Financial Trust, LLC.

This material is for informational purposes only. It is not an offer of coverage and it does not constitute a contract. Health savings accounts (HSAs) are individual accounts administered by Inspira Financial Health. There may be fees associated with your HSA. HSAs are subject to eligibility requirements and restrictions. State taxes may apply.

In case of a conflict between your plan documents and the information in this material, the plan documents will govern. Eligible expenses may vary from employer to employer. Please refer to your employer's Summary Plan Description ("SPD") for more information about your covered benefits. Information is believed to be accurate as of the production date; however, it is subject to change.

# Emotional wellbeing and work-life balance resources to keep you at your best

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues



## In-the-moment support

Reach a licensed clinician by phone 24/7/365 when you call for assistance.



## Short-term counseling

Access no-cost in-person or virtual (video) counseling sessions to resolve emotional concerns such as stress, anxiety, depression, burnout or substance use.



## Coaching

Get assistance from a Coach to boost your emotional fitness, learn healthy habits, establish new routines, build your resilience and more.



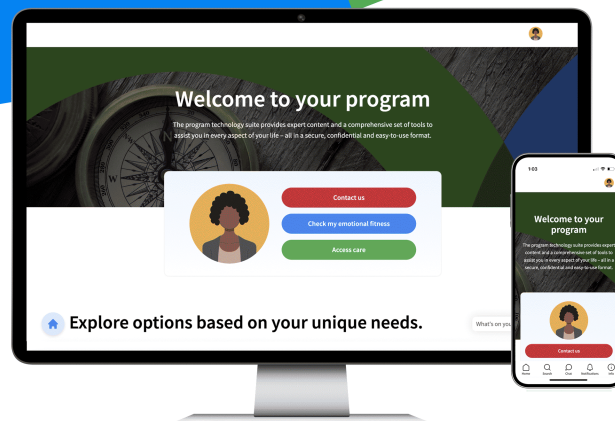
## Work-life benefits

Receive expert consultations for financial and legal issues. Work-life specialists also provide convenience referrals for everyday needs such as child or elder care, pet care, home improvement or auto repair.



## Confidentiality

Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.



## Your web portal and mobile app

- Create a personal profile to quickly access support from a licensed clinician
- Receive recommendations and care options based on your unique needs
- Exchange text messages with a Coach
- Attend anonymous group support sessions on a variety of topics
- Strengthen your mental health and wellbeing at your own pace with self-guided digital therapy
- Discover flash courses, self-assessments, financial calculators, career resources, articles, tip sheets and videos



## Start with Mental Health Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator assessment. You'll instantly receive personalized guidance to access care and support.



Download the mobile app today!



1-888-881-5462



supportlinc.com  
group code: azmt



# Save Money with Gallagher Marketplace

Clients saved \$400+ on auto insurance in 2024.\*

Get a free, no-obligation quote and save on your home and auto insurance with over 40 carriers nationwide.

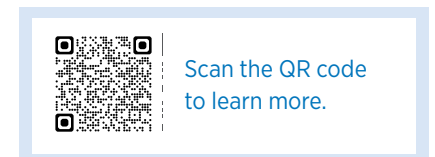
Looking for more savings? Our program offers significant savings on things you are already buying — like pre-paid legal services, identity theft protection, pet insurance, renters insurance and boat or RV insurance, as well as extended vehicle warranties and an employee discount program — all in one centralized hub.

## Discover what benefits your organization offers through Gallagher Marketplace.

The value	The convenience
<ul style="list-style-type: none"> <li>• Whether full-time, part-time or contract workers, all employees and their families are eligible.</li> <li>• Compare real, no-obligation quotes from multiple carriers on one site.</li> <li>• Potential cost savings compared to shopping on your own.</li> <li>• Call and talk to licensed insurance advisors to help understand and find the policy that meets your needs.</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll any time of the year, not just during open enrollment.</li> <li>• Monthly, quarterly and annual payment option available.</li> <li>• Schedule a callback from licensed insurance advisors for a time that's most convenient.</li> <li>• All programs are portable so you can keep the coverage no matter where life takes you.</li> </ul>

## How it works

- 1 Visit [Gallagher Marketplace](#) to see your available benefits.
- 2 Select a product to view more details.
- 3 Click on the partner link to learn more, get a free no-obligation quote or apply for coverage.
- 4 Enter your employer name when prompted.



**AJG.com** The Gallagher Way. Since 1927.

\*Insurance is subject to availability and individual eligibility. Savings based on 2024 Insuramatch customer survey.

Consulting and insurance brokerage services to be provided by Gallagher Benefit Services, Inc. and/or its affiliate Gallagher Benefit Services (Canada) Group Inc. Gallagher Benefit Services, Inc. is a licensed insurance agency that does business in California as "Gallagher Benefit Services of California Insurance Services" and in Massachusetts as "Gallagher Benefit Insurance Services." Neither Arthur J. Gallagher & Co., nor its affiliates provide accounting, legal or tax advice.



## Welcome to Your Discount Program!

### What is the PerkSpot+ Marketplace Discount Program?

Your PerkSpot+ Marketplace Discount Program is a one-stop-shop for thousands of exclusive discounts in more than 25 different categories. That means there's something for everyone!

#### How to Navigate Your Discount Program



##### Perks Near You

Located in the New & Featured section, Perks Near You allows you to use your location to see all of the discounts near you, wherever you are! Discounts can be filtered by category and distance.



##### Personalized Savings

Let us know what you're interested in so we can ensure you're seeing the perks you'll most enjoy, front and center on your Discount Program Home Page.



##### Brands Fit For Every Lifestyle

Looking for something specific? The Brands page, found in the Popular Perks section, is an easy and quick way to search for all of the discounts available to you.



##### Suggest a Business

Don't see what you're looking for? Head to the Suggest a Business page, found in the upper right-hand corner of your Home Page under Account Options, to suggest your favorite brands and local spots be added to your Discount Program.



##### Dedicated Support

PerkSpot's customer support team is here to help with any questions. We've included important information regarding our availability should you need assistance!

#### We're Here to Help



##### Hours

Monday - Friday  
8:00 AM - 6:00 PM CST



##### Phone Number

866-606-6057



##### Email

[cs@perkspot.com](mailto:cs@perkspot.com)



##### Help Center\*

[support.perkspot.com](https://support.perkspot.com)

*\*Our bilingual Customer Service team can answer any questions in both English and Spanish*

Ready to save? Head to [gallaghermarketplace.perkspot.com](https://gallaghermarketplace.perkspot.com) to get started!

# Telehealth from AZ Blue

Formerly known as BlueCare Anywhere<sup>SM</sup>



## Discover convenience, comfort, and savings

If you don't have a regular doctor, or if your primary care provider isn't available, you can visit with a board-certified doctor in the privacy and comfort of home. See a doctor, counselor, or psychiatrist from your phone, computer, or tablet. Plus, **Telehealth from AZ Blue** visits often cost less than an urgent care visit.

## What services are offered?



### Medical Care 24/7

Get treated for minor injuries and illnesses and non-emergency health issues like cold and flu symptoms, fevers, rashes, and stomach bugs. Doctors can also prescribe medications from your pharmacy of choice, if needed.



### Counseling

You can get the benefits of an in-person counseling session online. Schedule an appointment with a board-certified counselor or psychologist to get help for depression and anxiety, as well as stress caused by grief, divorce, parenting challenges, job loss, and other major life changes.



### Psychiatry

A board-certified psychiatrist is available by appointment. Experienced psychiatrists can help you address common mental health challenges, and provide assessments and treatments, as well as assist with medication management.

## Care is available now!

Visit [AZBlueTelehealth.com](https://AZBlueTelehealth.com) to start a visit.

**Customer service line: 1-844-606-1612.**

# Quick Tips

Telehealth puts you **face to face** with a board-certified doctor for your sick care needs **any time, day or night**, and board-certified counselors, psychologists, and psychiatrists are available by appointment. These tips can help you start a visit using your computer, tablet, or smartphone.

*Helpful Hint:* If prompted to add your member ID, use the entire series of numbers and letters shown on your member ID.

## 1 Sign up to get started.

**Create your account right away for quick access when you need an appointment!**

- Visit [AZBlueTelehealth.com](https://AZBlueTelehealth.com) and click **Sign Up**.
- Click **Create Account**.
- Enter your email address. Telehealth will send you an email to this account to verify for your account security.
- After you verify your email, create a password for your account.
- Use your email address and password to log in.
- Verify your account using one of the options. We suggest SMS or Phone.
- Follow the prompts to provide your information.

## 2 Know when to use it.

Visit with a doctor, counselor, or psychiatrist for help with:

- Cold, flu, fever
- Cough, bronchitis
- Diarrhea, vomiting
- Headache
- Pink eye
- Rashes
- Insomnia
- Anxiety
- Depression, and more



*This is not a complete list. Telehealth from AZ Blue should not be used for burns, wounds, broken bones, or life-threatening conditions. In an identified or probable emergency, the virtual visit provider will direct you to seek emergency care. For more information, visit [azbluetelehealth.com](https://azbluetelehealth.com).*

## 3 Make an appointment.

- Follow the steps to choose a provider for immediate care, or schedule an appointment for counseling or psychiatry.
- You can see the fees, and add or change your payment information.



If you are traveling out of state, you'll need to change your profile setting to show the state you're visiting. That way, you can choose a doctor who is licensed to practice in that state.

## 4 Get treated.



You will talk with the doctor about your health concern just like you would at a regular office visit.



The doctor will give you treatment options and may send a prescription to the pharmacy you've selected, if needed.



Need a "sick slip" or other document to go back to work or school? The doctor can provide one as appropriate.



After your visit you'll receive a report that you can share with your PCP or other healthcare provider.


**Care is available now!**

Visit [AZBlueTelehealth.com](https://AZBlueTelehealth.com) to start a visit.




An Independent Licensee of the Blue Cross Blue Shield Association

Virtual visits do not provide emergency care. In an identified or probable emergency call 911, or the virtual visit provider will direct the patient to seek emergency care. Blue Cross, Blue Shield, and the Cross and Shield Symbols are registered service marks, and BlueCare Anywhere is a service mark, of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Other logos are the property of their respective owners. ©2026 Blue Cross Blue Shield of Arizona, Inc. All rights reserved.

 **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](http://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 <https://www.healthcare.gov/sbc-glossary/> or call 1-855-350-8699 to request a copy.

Important Questions	Answers			Why This Matters:
<b>What is the overall deductible?</b>		<b>Network</b>	<b>Non-Network</b>	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> .
	<b>Per participant:</b>	\$750	\$2,000	
	<b>Per family:</b>	\$1,500	\$4,000	
<b>Are there services covered before you meet your deductible?</b>	<b>Yes.</b> <u>Network preventive care</u> services, wellness care services not defined by PPACA (limited), services which require a <u>co-payment</u> .			This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	<b>No.</b>			You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>		<b>Network</b>	<b>Non-Network</b>	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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
	<b>Per participant:</b>	\$3,500	\$5,000	
	<b>Per family:</b>	\$7,000	\$10,000	
	<b>For Prescription Drugs</b>			
	<b>Per participant:</b>	\$3,600		
<b>Per family:</b>	\$7,200			
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, pre-certification penalties, and medical food charges.			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	<p><b>Yes, for medical:</b> BlueCross® BlueShield® of Arizona. For a list of <u>network providers</u>, call BCBSAZ at 1-844-995-2583 or visit <a href="http://www.azblue.com">www.azblue.com</a>.</p> <p><b>Yes, for prescription drugs:</b> SmithRx. For a list of retail and mail pharmacies, log on to <a href="http://www.member.mysmithrx.com">www.member.mysmithrx.com</a>.</p>	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 co-payment/visit, deductible waived	50% co-insurance after deductible	_____none_____
	<u>Specialist</u> visit	\$45 co-payment/visit, deductible waived	50% co-insurance after deductible	_____none_____
	<u>Preventive care/screening/immunization</u>	No charge, deductible waived	Not Covered	<p>AzMT L.I.V.E. on-site wellness screenings and programs will be covered at no charge.</p> <p>Please refer to the Routine Preventive Care provision listed in the plan document for a further description and limitations to this benefit.</p> <p>You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>Plan</u> will pay for.</p>
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% co-insurance after deductible	50% co-insurance after deductible	There is no charge when labs are received at a free-standing facility.
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	50% co-insurance after deductible	<b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.member.mysmithrx.com">www.member.mysmithrx.com</a></p>	Generic drugs	<p><b>Deductible does not apply:</b></p> <p><b>Retail 30-day supply:</b> \$15</p> <p><b>Retail 90-day supply:</b> \$30</p> <p><b>Mail Order 90-day supply:</b> \$30</p>	<p>Reimbursed at the SmithRx calculated rate minus co-pay/co-insurance.</p> <p>Specialty drugs: Out of Network is not covered.</p>	<p><u>Prescription drug charges apply to the Prescription drug out-of-pocket limit.</u></p> <p>Retail: up to a 90-day supply Mail Order: up to a 90-day supply Specialty: up to a 30-day supply</p> <p>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by SmithRx.</p> <p>Certain drugs may have a pre-authorization requirement or may result in a higher cost.</p> <p>Dispense as written (DAW) provision applies.</p>
	Preferred brand drugs	<p><b>Deductible applies:</b></p> <p><b>Retail 30-day supply:</b> \$35</p> <p><b>Retail 90-day supply:</b> \$80</p> <p><b>Mail Order 90-day supply:</b> \$80</p>		
	Non-preferred brand drugs	<p><b>Deductible applies:</b></p> <p><b>Retail 30-day supply:</b> \$55</p> <p><b>Retail 90-day supply:</b> \$130</p> <p><b>Mail Order 90-day supply:</b> \$130</p>		
	<u>Specialty drugs</u>	<p><b>Deductible applies:</b></p> <p><b>Tier 4 &amp; Tier 5 30-day supply:</b> 20% of cost up to a \$300 maximum co-payment</p>		

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	50% co-insurance after deductible	<p><u>Providers</u> who do not typically contract (e.g. anesthesiologist, pathologists, and assistant surgeons) are to be paid based on the <u>network</u> status of the facility in which the services were rendered.</p> <p><b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.</p>
	Physician/surgeon fees	20% co-insurance after deductible	50% co-insurance after deductible	
<b>If you need immediate medical attention</b>	Emergency room care	\$300 co-payment/visit, plus 20% co-insurance after deductible		Co-payment waived if admitted.
	<u>Emergency medical transportation</u>	20% co-insurance after deductible	20% co-insurance after deductible	_____none_____
	<u>Urgent care</u>	\$50 co-pay/visit, deductible waived	50% co-insurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% co-insurance after deductible	50% co-insurance after deductible	<p>Limited to the semi-private room rate.</p> <p><b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.</p>
	Physician/surgeon fees	20% co-insurance after deductible	50% co-insurance after deductible	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 co-payment/visit deductible waived	50% co-insurance after deductible	<p><b>Pre-certification is required</b> for partial hospitalization and intensive outpatient treatment in excess of twenty (20) visits. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.</p> <p><b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.</p>
	Inpatient services	20% co-insurance after deductible	50% co-insurance after deductible	
<b>If you are pregnant</b>	Office visits	20% co-insurance after deductible	50% co-insurance after deductible	<p>First visit to confirm pregnancy is subject to a \$25 co-payment, <u>deductible</u> waived.</p> <p><u>Cost sharing</u> does not apply for <u>preventive services</u>. Depending on the type of services, a <u>co-payment</u>, <u>co-insurance</u>, or <u>deductible</u> may apply.</p>
	Childbirth/delivery professional services	20% co-insurance after deductible	50% co-insurance after deductible	

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
If you are pregnant	Childbirth/delivery facility services	20% co-insurance after deductible	50% co-insurance after deductible	_____none_____
If you need help recovering or have other special needs	<u>Home health care</u>	20% co-insurance after deductible	50% co-insurance after deductible	Benefit year maximum: Sixty (60) visits per plan participant.
	<u>Rehabilitation services</u>	20% co-insurance after deductible	50% co-insurance after deductible	Services include speech, occupational, or physical therapy provided on an inpatient or outpatient basis. Combined benefit year maximum: Twenty (20) visits per plan participant. <b>Pre-certification is required</b> for services in excess of the twenty (20) visit limit. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	<u>Habilitation services</u>	Covered as any other illness depending on provider type, service performed, and place of service.	50% co-insurance after deductible	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. <b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	<u>Skilled nursing care</u>	20% co-insurance after deductible	50% co-insurance after deductible	Benefit year maximum: Sixty (60) days per plan participant. <b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
If you need help recovering or have other special needs	<u>Durable medical equipment</u>	20% co-insurance after deductible	50% co-insurance after deductible	<b>Pre-certification is required</b> for durable medical equipment (DME) in excess of \$3,000. Benefits will be reduced by \$300 per paid claim for non-compliance.
	<u>Hospice services</u>	20% co-insurance after deductible	50% co-insurance after deductible	Lifetime maximum: Six (6) months per plan participant. Services include bereavement counseling; 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 <u>Plan</u> . 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.
	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.)

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (adult and children covered under stand-alone dental plan)</li> <li>• Glasses (adult and children)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care (except for a facility licensed to provide long term acute care)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care (except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg)</li> <li>• Weight loss programs</li> </ul> |
|---|--|--|

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery [limited to one (1) procedure per lifetime]</li> <li>• Chiropractic care [limited to thirty (30) visits per benefit year]</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids [limited to \$1,000 per lifetime]</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (children)</li> </ul> |
|---|--|---|

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

**Your Rights to Continue Coverage:** You may 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](http://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.

You may 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**

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 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, kwijigo holne' 1-855-350-8699.

*To see examples of how this plan 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.

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

## 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 <u>deductible</u>	\$750
■ <u>Specialist co-payment</u>	\$45
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other cost sharing</u>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$10
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$3,080</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$750
■ <u>Specialist co-payment</u>	\$45
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other cost sharing</u>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,000</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$750
■ <u>Specialist co-payment</u>	\$45
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other cost sharing</u>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$400
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,450</b>

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

## We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

### Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

### Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

### Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

### Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

### Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

### Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

### French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

### Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

### French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

### Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

### Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

### Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害を

お持ちですか？他の形式でこの文書を要求することもできます。

### Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

### German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

### Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.


### Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kanschtt des do Schreiwes in en differnter Weg griege so as du's besser sehne kanschtt.

## It's important we treat you fairly


We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications—as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the

Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 7186 Boise, ID 83707, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

 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](http://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 <https://www.healthcare.gov/sbc-glossary/> or call 1-855-350-8699 to request a copy.

Important Questions	Answers			Why This Matters:
<b>What is the overall deductible?</b>		<b>Network</b>	<b>Non-Network</b>	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> .
	Per participant:	\$250	\$500	
	Per family:	\$500	\$1,000	
<b>Are there services covered before you meet your deductible?</b>	<b>Yes.</b> <u>Network preventive care</u> services, wellness care services not defined by PPACA (limited), services which require a <u>co-payment</u> .			This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	<b>No.</b>			You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>		<b>Network</b>	<b>Non-Network</b>	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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
	Per participant:	\$3,000	\$5,000	
	Per family:	\$6,000	\$10,000	
	<b>For Prescription Drugs</b>			
	Per participant:	\$4,100		
Per family:	\$8,200			
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, pre-certification penalties, and medical food charges.			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	<p><b>Yes, for medical:</b> BlueCross® BlueShield® of Arizona. For a list of <u>network providers</u>, call BCBSAZ at 1-844-995-2583 or visit <a href="http://www.azblue.com">www.azblue.com</a>.</p> <p><b>Yes, for prescription drugs:</b> SmithRx. For a list of retail and mail pharmacies, log on to <a href="http://www.member.mysmithrx.com">www.member.mysmithrx.com</a>.</p>	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$25 co-payment/visit, deductible waived	50% co-insurance after deductible	_____none_____
	<u>Specialist</u> visit	\$45 co-payment/visit, deductible waived	50% co-insurance after deductible	_____none_____
	<u>Preventive care/screening/immunization</u>	No charge, deductible waived	Not Covered	<p>AzMT L.I.V.E. on-site wellness screenings and programs will be covered at no charge.</p> <p>Please refer to the Routine Preventive Care provision listed in the plan document for a further description and limitations to this benefit.</p> <p>You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>Plan</u> will pay for.</p>
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% co-insurance after deductible	50% co-insurance after deductible	There is no charge when labs are received at a free-standing facility.
If you have a test	Imaging (CT/PET scans, MRIs)	20% co-insurance after	50% co-insurance after	<b>Pre-certification is required.</b> Benefits will be

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
		deductible	deductible	reduced by \$300 per paid <u>claim</u> for non-compliance.
<p><b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.member.mysmithrx.com">www.member.mysmithrx.com</a></p>	Generic drugs	<b>Deductible does not apply:</b> <b>Retail 30-day supply:</b> \$15 <b>Retail 90-day supply:</b> \$30 <b>Mail Order 90-day supply:</b> \$30	Reimbursed at the SmithRx calculated rate minus co-pay/co-insurance.  Specialty drugs: Out of Network is not covered.	<u>Prescription drug charges apply to the Prescription drug out-of-pocket limit.</u> Retail: up to a 90-day supply Mail Order: up to a 90-day supply Specialty: up to a 30-day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by SmithRx. Certain drugs may have a pre-authorization requirement or may result in a higher cost. Dispense as written (DAW) provision applies.
	Preferred brand drugs	<b>Deductible applies:</b> <b>Retail 30-day supply:</b> \$35 <b>Retail 90-day supply:</b> \$80 <b>Mail Order 90-day supply:</b> \$80		
	Non-preferred brand drugs	<b>Deductible applies:</b> <b>Retail 30-day supply:</b> \$55 <b>Retail 90-day supply:</b> \$130 <b>Mail Order 90-day supply:</b> \$130		

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.member.mysmithrx.com">www.member.mysmithrx.com</a>	<u>Specialty drugs</u>	<b>Deductible applies:</b> <b>Tier 4 &amp; Tier 5 30-day supply:</b> 20% of cost up to a \$300 maximum co-payment		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	50% co-insurance after deductible	<u>Providers</u> who do not typically contract (e.g. anesthesiologist, pathologists, and assistant surgeons) are to be paid based on the <u>network</u> status of the facility in which the services were rendered.  <b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	Physician/surgeon fees	20% co-insurance after deductible	50% co-insurance after deductible	
<b>If you need immediate medical attention</b>	Emergency room care	\$300 co-payment/visit, plus 20% co-insurance after deductible		Co-payment waived if admitted.
	<u>Emergency medical transportation</u>	20% co-insurance after deductible	20% co-insurance after deductible	_____none_____
	<u>Urgent care</u>	\$50 co-pay/visit, deductible waived	50% co-insurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% co-insurance after deductible	50% co-insurance after deductible	Limited to the semi-private room rate.  <b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	Physician/surgeon fees	20% co-insurance after deductible	50% co-insurance after deductible	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 co-payment/visit deductible waived	50% co-insurance after deductible	<b>Pre-certification is required</b> for partial hospitalization and intensive outpatient treatment in excess of twenty (20) visits. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	Inpatient services	20% co-insurance after deductible	50% co-insurance after deductible	<b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
<b>If you are pregnant</b>	Office visits	20% co-insurance	50% co-insurance after deductible	First visit to confirm pregnancy is subject to a

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
		after deductible	deductible	\$25 co-payment , <u>deductible</u> waived.  <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>co-payment</u> , <u>co-insurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	20% co-insurance after deductible	50% co-insurance after deductible	_____none_____
	Childbirth/delivery facility services	20% co-insurance after deductible	50% co-insurance after deductible	_____none_____
<b>If you need help recovering or have other special needs</b>	<u>Home health care</u>	20% co-insurance after deductible	50% co-insurance after deductible	Benefit year maximum: Sixty (60) visits per plan participant.
	<u>Rehabilitation services</u>	20% co-insurance after deductible	50% co-insurance after deductible	Services include speech, occupational, or physical therapy provided on an inpatient or outpatient basis.  Combined benefit year maximum: Twenty (20) visits per plan participant.  <b>Pre-certification is required</b> for services in excess of the twenty (20) visit limit. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
<b>If you need help recovering or have other special needs</b>	<u>Habilitation services</u>	Covered as any other illness depending on provider type, service performed, and place of service.	50% co-insurance after deductible	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.  <b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
	<u>Skilled nursing care</u>	20% co-insurance after deductible	50% co-insurance after deductible	Benefit year maximum: Sixty (60) days per plan participant. <b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	<u>Durable medical equipment</u>	20% co-insurance after deductible	50% co-insurance after deductible	<b>Pre-certification is required</b> for durable medical equipment (DME) in excess of \$3,000. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	<u>Hospice services</u>	20% co-insurance after deductible	50% co-insurance after deductible	Lifetime maximum: Six (6) months per plan participant. Services include bereavement counseling; limited to \$300 per plan participant.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge, deductible waived	Not Covered	This describes benefits provided by your medical <u>Plan</u> . 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.
	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.)

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (adult and children covered under stand-alone dental plan)</li> <li>• Glasses (adult and children)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care (except for a facility licensed to provide long term acute care)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care (except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg)</li> <li>• Weight loss programs</li> </ul> |
|---|--|--|

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery [limited to one (1) procedure per lifetime]</li> <li>• Chiropractic care [limited to thirty (30) visits per</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids [limited to \$1,000 per lifetime]</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (children)</li> </ul> |
|---|--|---|

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

**Your Rights to Continue Coverage:** You may 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](http://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.

You may 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**

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 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, kwijigo holne' 1-855-350-8699.

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

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\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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## 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 <u>deductible</u>	\$250
■ <u>Specialist co-payment</u>	\$45
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other cost sharing</u>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$10
Coinsurance	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$2,680</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist co-payment</u>	\$45
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other cost sharing</u>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$600
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$890</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist co-payment</u>	\$45
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other cost sharing</u>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$400
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,050</b>

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

## We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

### Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

### Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

### Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

### Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

### Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

### Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

### French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

### Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

### French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

### Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

### Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

### Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害を

お持ちですか？他の形式でこの文書を要求することもできます。

### Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

### German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

### Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.


### Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kanschtt des do Schreiwes in en differnter Weg griege so as du's besser sehne kanschtt.

## It's important we treat you fairly


We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications—as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the

Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 7186 Boise, ID 83707, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

 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](http://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 <https://www.healthcare.gov/sbc-glossary/> or call 1-855-350-8699 to request a copy.

Important Questions	Answers			Why This Matters:
<b>What is the overall <u>deductible</u>?</b>		<b>Network</b>	<b>Non-Network</b>	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> .
	<b>Per participant:</b>	\$3,400	\$5,000	
	<b>Per family:</b>	\$6,800	\$10,000	
<b>Are there services covered before you meet your <u>deductible</u>?</b>	<b>Yes.</b> <u>Network preventive care</u> services, wellness care services not defined by PPACA (limited).			This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>co-payment</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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	<b>No.</b>			You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>		<b>Network</b>	<b>Non-Network</b>	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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
	<b>Per participant:</b>	\$3,400	\$10,000	
	<b>Per family:</b>	\$6,800	\$20,000	
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, pre-certification penalties, and medical food charges.			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	<b>Yes, for medical:</b> BlueCross® BlueShield® of Arizona. For a list of <u>network providers</u> , call BCBSAZ at 1-844-995-2583 or visit <a href="http://www.azblue.com">www.azblue.com</a> . <b>Yes, for prescription drugs:</b> SmithRx. For a list of retail and mail pharmacies, log on to <a href="http://www.member.mySmithRx.com">www.member.mySmithRx.com</a> .			This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	No charge after deductible	50% co-insurance after deductible	_____none_____
	<u>Specialist</u> visit	No charge after deductible	50% co-insurance after deductible	_____none_____
	<u>Preventive care/screening/immunization</u>	No charge, deductible waived	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 <u>provider</u> if the services you need are preventive. Then check what your <u>Plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge after deductible	50% co-insurance after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	No charge after deductible	50% co-insurance after deductible	<b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
<p><b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.member.mysmithrx.com">www.member.mysmithrx.com</a></p>	Generic drugs (Tier 1)	<b>Deductible applies:</b> <b>Retail 30-day supply:</b> \$0 <b>Retail 90-day supply:</b> \$0 <b>Mail Order 90-day supply:</b> \$0	Reimbursed at the SmithRx calculated rate minus co-pay/co-insurance.  Specialty drugs: Out of Network is not covered.	Retail: up to a 90-day supply Mail Order: up to a 90-day supply Specialty: up to a 30-day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by SmithRx. Certain drugs may have a pre-authorization requirement or may result in a higher cost. Dispense as written (DAW) provision applies.
	Preferred brand drugs (Tier 2)	<b>Deductible applies:</b> <b>Retail 30-day supply:</b> \$0 <b>Retail 90-day supply:</b> \$0 <b>Mail Order 90-day supply:</b> \$0		
	Non-preferred brand drugs (Tier 3)	<b>Deductible applies:</b> <b>Retail 30-day supply:</b> \$0 <b>Retail 90-day supply:</b> \$0 <b>Mail Order 90-day supply:</b> \$0		
	<u>Specialty drugs (Tier 4 &amp; Tier 5)</u>	<b>Deductible applies:</b> <b>Tier 4 &amp; Tier 5 30-day supply:</b> \$0		

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	50% co-insurance after deductible	<p><u>Providers</u> who do not typically contract (e.g. anesthesiologist, pathologists, and assistant surgeons) are to be paid based on the <u>network</u> status of the facility in which the services were rendered.</p> <p><b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.</p>
	Physician/surgeon fees	No charge after deductible	50% co-insurance after deductible	
<b>If you need immediate medical attention</b>	Emergency room care	No charge after deductible		_____none_____
	<u>Emergency medical transportation</u>	No charge after deductible	50% co-insurance after deductible	_____none_____
	<u>Urgent care</u>	No charge after deductible	50% co-insurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge after deductible	50% co-insurance after deductible	<p>Limited to the semi-private room rate.</p> <p><b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.</p>
	Physician/surgeon fees	No charge after deductible	50% co-insurance after deductible	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge after deductible	50% co-insurance after deductible	<p><b>Pre-certification is required</b> for partial hospitalization and intensive outpatient treatment in excess of twenty (20) visits. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.</p> <p><b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.</p>
	Inpatient services	No charge after deductible	50% co-insurance after deductible	
<b>If you are pregnant</b>	Office visits	No charge after deductible	50% co-insurance after deductible	<u>Cost sharing</u> does not apply for <u>preventive services</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
<b>If you are pregnant</b>	Childbirth/delivery professional services	No charge after deductible	50% co-insurance after deductible	_____none_____
	Childbirth/delivery facility services	No charge after deductible	50% co-insurance after deductible	_____none_____
<b>If you need help recovering or have other special needs</b>	<u>Home health care</u>	No charge after deductible	50% co-insurance after deductible	Benefit year maximum: Sixty (60) visits per plan participant.
	<u>Rehabilitation services</u>	No charge after deductible	50% co-insurance after deductible	Services include speech, occupational, or physical therapy provided on an inpatient or outpatient basis.  Combined benefit year maximum: Twenty (20) visits per plan participant.  <b>Pre-certification is required</b> for services in excess of the twenty (20) visit limit. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	<u>Habilitation services</u>	No charge after deductible	50% co-insurance after deductible	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.  <b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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)	
If you need help recovering or have other special needs	<u>Skilled nursing care</u>	No charge after deductible	50% co-insurance after deductible	Benefit year maximum: Sixty (60) days per plan participant. <b>Pre-certification is required.</b> Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	<u>Durable medical equipment</u>	No charge after deductible	50% co-insurance after deductible	<b>Pre-certification is required</b> for durable medical equipment (DME) in excess of \$3,000. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	<u>Hospice services</u>	No charge after deductible	50% co-insurance after deductible	Lifetime maximum: Six (6) months per plan participant. Services include bereavement counseling; 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 <u>Plan</u> . 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.
	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.)**

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (adult and children covered under stand-alone dental plan)</li> <li>• Glasses (adult and children)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care (except for a facility licensed to provide long term acute care)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care (except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg)</li> <li>• Weight loss programs</li> </ul> |
|---|--|--|

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery [limited to one (1) procedure per lifetime]</li> <li>• Chiropractic care [limited to thirty (30) visits per benefit year]</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids [limited to \$1,000 per lifetime]</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (children)</li> </ul> |
|---|--|---|

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

**Your Rights to Continue Coverage:** You may 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](http://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.

You may 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**

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 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, kwijigo holne' 1-855-350-8699.

*To see examples of how this plan 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.

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

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 **\$3,400**
- Specialist cost sharing **0%**
- Hospital (facility) cost sharing **0%**
- Other cost sharing **0%**

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,400
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$3,420</b>

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

- The plan's overall deductible **\$3,400**
- Specialist cost sharing **0%**
- Hospital (facility) cost sharing **0%**
- Other cost sharing **0%**

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,200
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,200</b>

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

- The plan's overall deductible **\$3,400**
- Specialist cost sharing **0%**
- Hospital (facility) cost sharing **0%**
- Other cost sharing **0%**

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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

## We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

### Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

### Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

### Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

### Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

### Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

### Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

### French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

### Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

### French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

### Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

### Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

### Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害を

お持ちですか？他の形式でこの文書を要求することもできます。

### Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

### German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

### Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

### Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kanschtt des do Schreiwes in en differnter Weg griege so as du's besser sehne kanschtt.

## It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications—as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the

Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 7186 Boise, ID 83707, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>