
 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.MyAmeriBen.com or call 1-855-350-8699. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.MyAmeriBen.com or call 1-855-350-8699 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall <u>deductible</u> ?		Network	Non-Network	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:	\$300	N/A	
	Per family:	\$600	N/A	
Are there services covered before you meet your <u>deductible</u> ?	Yes. <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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.			You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?		Network	Non-Network	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:	\$2,750	N/A	
	Per family:	\$5,500	N/A	
	For Prescription Drugs			
	Per participant:	\$4,100	N/A	
Per family:	\$8,200	N/A		
What is not included in the <u>out-of-pocket limit</u> ?	<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>Yes, for medical: BlueCross® BlueShield® of Arizona. For a list of <u>network providers</u>, call BCBSAZ at 1-800-232-2345 or visit www.azblue.com/CHSNetwork.</p> <p>Yes, for prescription drugs: Navitus. For a list of retail and mail pharmacies, log on to www.navitus.com.</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	\$20 co-payment/visit, deductible waived	Not Covered	_____none_____
	<u>Specialist</u> visit	\$40 co-payment/visit, deductible waived	Not Covered	_____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)	10% co-insurance after deductible	Not Covered	There is no charge when labs are received at a free-standing facility.
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible	Not Covered	Pre-certification is required. Benefits will be reduced by \$300 per paid <u>claim</u> for non-

* For more information about limitations and exceptions, see the plan or policy document at 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)	
				compliance.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.navitus.com	Generic drugs	\$15 co-payment/ 30-day supply	You pay the network pharmacy co-payment plus the difference between the non-network and network pharmacy cost.	<u>Prescription drug charges</u> apply to the <u>Prescription Drug out-of-pocket limit</u> . Preventive prescription medications (including contraceptives) when purchased from a <u>network pharmacy</u> are paid at 100% and the <u>co-payment/deductible</u> (if applicable) is waived. Members who elect a brand name drug when a generic is available will be subject to a penalty equivalent to the cost difference between the brand and generic. Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>Plan</u> , log into your account at www.navitus.com . Note: <u>Specialty drugs</u> are only available through the Navitus SpecialtyRx Program Pharmacy.
	Preferred brand drugs	\$30 co-payment/ 90-day supply		
	Non-preferred brand drugs	\$35 co-payment/ 30-day supply \$80 co-payment/ 90-day supply		
	<u>Specialty drugs</u>	\$55 co-payment/ 30-day supply \$130 co-payment/ 90-day supply		
		20% co-payment to a maximum of \$300/30-day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance after deductible	Not Covered	<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. Pre-certification is required. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	Physician/surgeon fees	10% co-insurance after deductible	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$300 co-payment/visit, plus 20% co-insurance after deductible		Co-payment waived if admitted.
	<u>Emergency medical transportation</u>	10% co-insurance after deductible		EPO only offers non-network coverage in the case of a life threatening emergency.

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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>Urgent care</u>	\$50 co-pay/visit, deductible waived	Not Covered	_____none_____

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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 have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance after deductible	Not Covered	Limited to the semi-private room rate. Pre-certification is required. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	Physician/surgeon fees	10% co-insurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 co-payment/visit PCP or \$40 co-pay/visit specialist, deductible waived	Not Covered	Pre-certification is required for partial hospitalization and intensive <u>outpatient</u> programs in excess of eighteen (18) visits, and psychiatric day treatment. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	Inpatient services	10% co-insurance, after deductible	Not Covered	Pre-certification is required. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
If you are pregnant	Office visits	10% co-insurance, after deductible	Not Covered	First visit to confirm pregnancy is subject to a \$20 co-pay for a PCP or a \$40 co-pay for a <u>specialist</u> , <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	10% co-insurance, after deductible	Not Covered	—————none—————
	Childbirth/delivery facility services	10% co-insurance, after deductible	Not Covered	—————none—————

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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>Home health care</u>	10% co-insurance, after deductible	Not Covered	Benefit year maximum: Sixty (60) visits per plan participant.
	<u>Rehabilitation services</u>	10% co-insurance, after deductible	Not Covered	Services include speech, occupational, or physical therapy provided on an inpatient or outpatient basis. Combined benefit year maximum: Twenty (20) visits per plan participant. Pre-certification is required for services in excess of the twenty (20) visit limit. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	<u>Habilitation services</u>	Covered as any other illness depending on <u>provider</u> type, service performed, and place of service.	Not Covered	Coverage for Autism Spectrum Disorder – Behavior Therapy Services ONLY. Behavioral therapy services for the treatment of Autism spectrum disorder are available for plan participants who have been diagnosed with autism spectrum disorder. Pre-certification is required. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	<u>Skilled nursing care</u>	10% co-insurance, after deductible	Not Covered	Benefit year maximum: Sixty (60) days per plan participant. Pre-certification is required. Benefits will be reduced by \$300 per paid <u>claim</u> for non-compliance.
	<u>Durable medical equipment</u>	10% co-insurance, after deductible	Not Covered	—————none—————
	<u>Hospice services</u>	10% co-insurance, after deductible	Not Covered	Lifetime maximum: Six (6) months per plan participant. Services include bereavement counseling;

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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)	
				limited to \$300 per plan participant.

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

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

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, kwijjigo 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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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 <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> co-payment	\$40
■ Hospital (facility) <u>cost sharing</u>	10%
■ Other <u>cost sharing</u>	10%

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$10
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$1,530

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> co-payment	\$40
■ Hospital (facility) <u>cost sharing</u>	10%
■ Other <u>cost sharing</u>	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$600
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$910

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> co-payment	\$40
■ Hospital (facility) <u>cost sharing</u>	10%
■ Other <u>cost sharing</u>	10%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$400
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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