
 **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 1-877-635-2912. 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 1-877-635-2912 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		<u>Network</u>	<u>Non-Network</u>	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:	\$3,750	\$7,000	
	Per family:	\$7,500	\$14,000	
Are there services covered before you meet your deductible?	Yes. <u>Preventive services</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 deductibles for specific services?	No.			You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?		<u>Network</u>	<u>Non-Network</u>	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:	\$3,750	\$14,000	
	Per family:	\$7,500	\$28,000	
What is not included in the out-of-pocket limit?	Cost-containment penalties, items not covered under the <u>plan</u> , charges in excess of the <u>plan's</u> maximum benefits, amounts over the <u>maximum</u>			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

	<u>allowable charges</u>	
Will you pay less if you use a <u>network provider</u>?	<p>Yes. Medical: BCBSAZ. See www.azblue.com/chsnetwork or call 1-877-635-2912 for a list of <u>network providers</u>.</p> <p>Prescription drugs: NavitusRX. See www.navitus.com or call 1-480-498-6268 for a list of <u>prescription drugs</u>. Contact Navitus Specialty Rx at www.lumicera.com or 1-855-847-3553 for <u>specialty drugs</u>.</p> <p>Medical (Apache entity only): New Mexico Health. See www.multiplan.com or call 1-888-342-7427 for a list of <u>network providers</u>.</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	0% co-insurance after deductible	50% co-insurance after deductible	_____none_____
	<u>Specialist</u> visit	0% co-insurance after deductible	50% co-insurance after deductible	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% co-insurance after deductible	50% co-insurance after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	0% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required for services in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.

* 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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.navitus.com and www.lumicera.com for specialty drugs	Generic drugs	0% co-insurance after deductible	Not Covered	Retail: Limited to a thirty (30) day supply. Mail Order: Limited to a ninety (90) day supply. 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 or call 1-877-635-2912. If you obtain <u>prescription drugs</u> from a non-preferred pharmacy, you will be required to pay the full cost of the <u>prescription</u> and then submit for reimbursement. <u>Specialty drugs</u> are limited to a thirty (30) day supply and are only covered through Navitus Specialty Rx Program. Contact Navitus Specialty Rx Program at www.lumicera.com or call 1-855-847-3553.
	Preferred brand drugs	0% co-insurance after deductible	Not Covered	
	Non-preferred brand drugs	0% co-insurance after deductible	Not Covered	
	<u>Specialty drugs</u>	0% co-insurance after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required for services in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.
	Physician/surgeon fees	0% co-insurance after deductible	50% co-insurance after deductible	
If you need immediate medical attention	<u>Emergency room care</u>	0% co-insurance after deductible		_____none_____
	<u>Emergency medical transportation</u>	0% co-insurance after deductible	0% co-insurance after deductible	Charges for inter-facility transports are covered when the <u>medically necessary</u> level of care is not available at the current location. Ambulance response charges when the <u>plan</u> participant is not transported to the hospital is not covered.
	<u>Urgent care</u>	0% co-insurance after deductible	50% co-insurance after deductible	Retail clinics are covered.

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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)	0% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required. Failure to pre-certify will result in a \$300 penalty. Room and board is limited to the semi-private room rate.
	Physician/surgeon fees	0% co-insurance after deductible	50% co-insurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required for certain outpatient services. Failure to pre-certify will result in a \$300 penalty. Services include partial hospitalization and intensive psychiatric day treatment.
	Inpatient services	0% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required. Failure to pre-certify will result in a \$300 penalty. Services include residential treatment.
If you are pregnant	Office visits	0% co-insurance after deductible	50% co-insurance after deductible	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>co-insurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% co-insurance after deductible	50% co-insurance after deductible	
	Childbirth/delivery facility services	0% 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.

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 health needs	<u>Home health care</u>	0% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required in excess of sixty (60) visits. Failure to pre-certify will result in a \$300 penalty.
	<u>Rehabilitation services</u>	0% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required for inpatient stays in excess of sixty (60) days and for physical, speech, and occupational therapy services in excess of sixty (60) visits. Therapy rendered in the home applies to the <u>home health care</u> benefit level. Cardiac therapy is limited to Phase I and Phase II. Services are limited to progressive therapy only.
	<u>Habilitation services</u>	0% co-insurance after deductible	50% co-insurance after deductible	
	<u>Skilled nursing care</u>	0% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required in excess of sixty (60) days. Failure to pre-certify will result in a \$300 penalty.
	<u>Durable medical equipment</u>	0% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required in excess of \$2,500. Failure to pre-certify will result in a \$300 penalty. Repair and/or replacement is covered once every five (5) years.
	<u>Hospice services</u>	0% co-insurance after deductible	50% co-insurance after deductible	Benefit Maximum: one-hundred (100) visits per lifetime, including bereavement counseling. Respite care is not covered.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	—————none—————
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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

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.)

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|--|--|----------------------------|
| • Acupuncture | • Infertility Treatment (infertility testing is covered) | • Private-Duty Nursing |
| • Cosmetic Surgery (except for accidental injury or anomaly) | • Long-Term Care | • Routine Eye Care (adult) |
| • Dental Care (adult) | • Non-Emergency Care When Traveling Outside the U.S. | • Routine Foot Care |
| | | • Weight Loss Programs |

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

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|--|--|---|
| • Bariatric Surgery (for morbid obesity) | • Chiropractic Care (annual maximum: twenty-six (26) visits) | • Hearing Aids (limited to one (1) hearing aid up to \$1,000 per three (3) year period) |
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise, ID 83707, 1-877-635-2912. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the third party administrator (TPA) to assist the plan administrator with claims adjudication. The TPA's name, address, and telephone number are:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-877-635-2912

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 1-877-635-2912.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-635-2912.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-635-2912.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-635-2912.

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 plan's overall deductible **\$3,750**
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$3,750
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,750

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

- The plan's overall deductible **\$3,750**
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$3,750
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,750

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

- The plan's overall deductible **\$3,750**
- 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*)

Total Example Cost	\$2,800
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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
The total Mia would pay is	\$2,800

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