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?		**Network**	**Non-Network**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
	Per participant:	$500	$1,500	
Are there services covered before you meet your deductible?	Yes. Preventive services, prescription drugs, urgent care, non-complex lab and x-ray, and office visits.			This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?		**Network**	**Non-Network**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
	Per participant:	$5,500	Unlimited	
	Per family:	$14,300	Unlimited	
What is not included in the out-of-pocket limit?	Cost-containment penalties, items not covered under the plan, charges in excess of the plan's maximum benefits, amounts over the maximum allowable charges			Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. **Medical**: BCBSAZ. See www.azblue.com/chsnetwork or call 1-877-635-2912 for a list of network providers. **Prescription drugs**: NavitusRX. See www.navitus.com or call 1-480-498-6268 for a list of prescription drugs. Contact Navitus Specialty Rx			This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

	at www.lumicera.com or 1-855-847-3553 for specialty drugs. **Medical (Apache entity only)**: New Mexico Health. See www.multiplan.com or call 1-888-342-7427 for a list of network providers.	
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-payment per provider/day	50% co-insurance after deductible	The office visit co-payment will apply to the office visit and all other office services, including lab and x-rays, performed and billed by the physician for the same date of service. If the physician's office is inside a hospital, the co-payment applies to the office visit only. All other services rendered during the physician's office visit are paid at the hospital benefit level.
	Specialist visit	$45 co-payment per provider/day	50% co-insurance after deductible	
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Non-Complex Lab:** $30 co-payment per provider/day **Complex Lab:** 20% co-insurance after deductible	50% co-insurance after deductible	Services in excess of $500 per episode of care are considered complex lab.
	Imaging (CT/PET scans, MRIs)	20% 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.

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	**Preferred Retail:** $15 co-payment **Non-Preferred Retail:** $20 co-payment **Preferred Mail Order:** $30 co-payment **Non-Preferred Mail Order:** $40 co-payment	Not Covered	**Retail**: Limited to a thirty (30) day supply. **Mail Order**: Limited to a ninety (90) day supply. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.navitus.com or call 1-480-498-6268. If you obtain prescription drugs from a non-preferred pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement.
	Preferred brand drugs	**Preferred Retail:** $40 co-payment **Non-Preferred Retail:** $45 co-payment **Preferred Mail Order:** $100 co-payment **Non-Preferred Mail Order:** $112.50 co-payment	Not Covered	
	Non-preferred brand drugs	**Preferred Retail:** $80 co-payment **Non-Preferred Retail:** $85 co-payment **Preferred Mail Order:** $200 co-payment **Non-Preferred Mail Order:** $212.50 co-payment	Not Covered	

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)	
	Specialty drugs	**Navitus Specialty RX:** $100 co-payment	Not Covered	Specialty drugs 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% 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	20% co-insurance after deductible	50% co-insurance after deductible	
If you need immediate medical attention	Emergency room care	$100 co-payment per provider/day, then 20% co-insurance after deductible		Co-payment waived if admitted to inpatient services.
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible	Charges for inter-facility transports are covered when the medically necessary level of care is not available at the current location. Ambulances response charges when the plan participant is not transported to the hospital is not covered.
	Urgent care	$45 co-payment per provider/day	50% co-insurance after deductible	The Urgent Care co-payment includes all covered services rendered. Retail clinics are covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% 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	20% co-insurance after deductible	50% co-insurance after deductible	

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 mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visits:** PCP: $30 co-payment per provider/day SPC: $45 co-payment per provider/day **Other Outpatient:** 20% 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	20% 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	20% co-insurance after deductible	50% co-insurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a co-payment, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% co-insurance after deductible	50% co-insurance after deductible	
	Childbirth/delivery facility services	20% co-insurance after deductible	50% co-insurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% 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.
	Rehabilitation services	20% 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 home health care benefit level. Cardiac therapy is limited to Phase I and Phase II.
	Habilitation services	20% co-insurance after deductible	50% co-insurance after deductible	

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)	
				Services are limited to progressive therapy only.
	Skilled nursing care	20% 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.
	Durable medical equipment	20% 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.
	Hospice services	20% 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	

Excluded Services & Other Covered Services:

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

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

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

- Bariatric Surgery (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)

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, kwiijigo holne' 1-877-635-2912.

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

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.

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	$500
Specialist copayment	$45
Hospital (facility) cost sharing	20%
Other cost sharing	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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$250
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,960**

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

The plan's overall deductible	$500
Specialist copayment	$45
Hospital (facility) cost sharing	20%
Other cost sharing	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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

The plan's overall deductible	$500
Specialist copayment	$45
Hospital (facility) cost sharing	20%
Other cost sharing	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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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