This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.MyAmeriBen.com** or by calling **1-866-365-9198**.

Important Questions	Answers		Why this Matters:
What is the overall deductible?	**In-Network:** Individual: **$900** Family: **$1,800**	**Out-of-Network:** Individual: **$2,250** Family: **$4,500**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document/SPD to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
	Does not apply to amounts in excess of UCR, services not covered, preventive care		
Are there other deductibles for specific services?	**No.**		You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**In-Network:** Individual: **$6,350** Family: **$12,700**	**Out-of-Network:** Individual: **$10,000** Family: **$10,000 per person**	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, penalties for failing to follow precertification, amounts in excess of UCR, expenses not covered by the plan		Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No.**		The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	**Yes, for medical.** See **www.azblue.com/chsnetwork** for a list of in-network providers.		If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.		You can see the **specialist** you choose without permission from this plan.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	50% coinsurance/visit	In-network: Deductible does not apply; includes lab work.
	Specialist visit	$35 copayment/visit	50% coinsurance/visit	----------none----------
	Other practitioner office visit	$35 copayment/visit	$35 copayment/visit	Spinal Manipulation Services Deductible does not apply both in-network and out-of-network. Covered services are for back-related care only, for adults 18 years or older. Limited to 16 visits per person, per year.
	Preventive care/screening/immunization	No Charge	50% coinsurance/visit	Deductible does not apply in-network.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance/test	50% coinsurance/test	Covered only when ordered by a physician.
	Imaging (CT/PET scans, MRIs)	25% coinsurance/test	50% coinsurance/test	Covered only when ordered by a physician.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.mycatamaranrx.com**.	Generic drugs	$10 co-payment/prescription, or cost of the drug if less than $10 (30-day supply, retail) $20 co-payment/ prescription (90 day supply, mail order)		There is no charge for FDA-approved generic contraceptives. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at **www.mycatamaranrx.com**.
	Formulary brand drugs	$10 copayment/prescription or 30%, whichever is greater, to a maximum of $150/prescription (30 day supply, retail) $40 copayment/ prescription (90 day supply, mail order)		
	Non-formulary brand drugs	$10 co-payment/prescription (retail) or 40%, whichever is greater to a maximum of $150/prescription PLUS the difference between the cost of the brand vs generic drug (30 day supply, retail) $60 co-payment/ prescription (90 day supply, mail order)		
	Specialty drugs	25% coinsurance/ prescription	25% coinsurance/prescription	Maximum benefit of $150 per 30 day supply. Specialty drugs may be subject to dispensing limits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance/visit	50% coinsurance/visit	**Precertification is required.** Payment for the service may not be covered if precertification is not obtained.
	Physician/surgeon fees	25% coinsurance/visit	50% coinsurance/visit	----------none----------
If you need immediate medical attention	Emergency room services	$100 co-payment after deductible then 25% coinsurance/visit	$100 co-payment after deductible then 25% coinsurance/visit	Copayment is waived if admitted.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Emergency medical transportation	25% coinsurance	25% coinsurance	Includes emergency air transportation. Paid at in-network level if true emergency. Air transportation only as medically necessary due to inaccessibility by ground transport and/or if medically necessary.
	Urgent care	$50 copayment/visit	$50 copayment and 50% coinsurance/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance/visit	50% coinsurance/visit	**Precertification is required.** Payment for the service may not be covered if precertification is not obtained.
	Physician/surgeon fee	25% coinsurance/visit	50% coinsurance/visit	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copayment/visit	50% coinsurance/visit	Deductible does not apply in-network.
	Mental/Behavioral health inpatient services	25% coinsurance/visit	50% coinsurance/visit	**Precertification is required.** Payment for the service may not be covered if precertification is not obtained.
	Substance use disorder outpatient services	$25 copayment/visit	50% coinsurance/visit	Deductible does not apply in-network.
	Substance use disorder inpatient services	25% coinsurance/visit	50% coinsurance/visit	**Precertification is required.** Payment for the service may not be covered if precertification is not obtained.
If you are pregnant	Prenatal and postnatal care	No charge for office visits. All other services 25% coinsurance	50% coinsurance/visit	In Network: Copayments are waived if OB/GYN care begins in first trimester of pregnancy.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	25% coinsurance/visit	50% coinsurance/visit	**Precertification is required for extended stay.** Payment for the service may not be covered if precertification is not obtained.
If you need help recovering or have other special health needs	Home health care	25% coinsurance/visit	50% coinsurance/visit	Limited to 60 visits per person, per year. **Precertification is required.** Payment for the service may not be covered if precertification is not obtained. Part-time, intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion services. Home services other than skilled nursing care are not covered.
	Rehabilitation services	25% coinsurance/visit	50% coinsurance/visit	Check with plan for limitations that may apply based on type of therapy.
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	25% coinsurance/visit	50% coinsurance/visit	**Precertification is required.** Payment for the service may not be covered if precertification is not obtained. Limited to 60 days per person, per year.
	Durable medical equipment	25% coinsurance	50% coinsurance	**Pre-certification is required for durable medical equipment in excess of $5,000 per person.** Payment for DME may not be covered if precertification is not obtained.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Hospice service	25% coinsurance/visit	50% coinsurance/visit	**Precertification is required.** Payment for the service may not be covered if precertification is not obtained.
If your child needs dental or eye care	Eye exam	No Charge	50% coinsurance/visit	Deductible is waived in-network. Covered if provided during a well-child visit only.
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	Dental benefits are a separate election.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture (for rehabilitation purposes)
- Cosmetic surgery
- Dental care (Adult or Child)
- Routine eye care (Adult or Child)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Long-term care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-866-365-9198**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact a plan representative at: (866) 365-9198 or visit us at www.MyAmeriBen.com. You may also 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
1-866-365-9198

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-365-9198.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-365-9198.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-365-9198.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-365-9198.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,740
- **Patient pays** $2,800

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$900
Copays	$100
Coinsurance	$1,400
Limits or exclusions	$400
Total	**$2,800**

These amounts assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not notified the plan, your costs may be higher. For more information, contact (866) 365-9198 or visit us at www.MyAmeriBen.com.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,400
- **Patient pays** $1,000

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$800
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,000**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact (866) 365-9198 or visit us at www.MyAmeriBen.com.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.