




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 1-866-365-9198. 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](http://www.MyAmeriBen.com) or call 1-866-365-9198 to request a copy.

Important Questions	Answers			Why This Matters:
<b>What is the overall deductible?</b>		In-Network	Out-of-Network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, 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:	\$750	\$1,500	
	Per family:	\$1,500	\$3,000	
<b>Are there services covered before you meet your deductible?</b>	Yes. Some services such as office visits require a co-payment while <u>preventive care</u> is provided at no cost.			This plan 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 plan 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>	No			No. You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>		In-Network	Out-of-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 plan, 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:	\$5,750	\$9,000	
	Per family:	\$11,500	\$9,000 per person	

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

Important Questions	Answers	Why This Matters:
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this plan doesn't cover, penalties for failing to follow pre-certification, amounts in excess of <u>UCR</u> , expenses covered under the dental and vision plans, and expenses not covered by the Plan.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	<p><b>Yes, for medical:</b> Blue Cross Blue Shield of Arizona. For a list of <u>network providers</u>, call AmeriBen, at 1-866-365-9198 or visit <a href="http://www.azblue.com/chsnetwork">www.azblue.com/chsnetwork</a>.</p> <p><b>Yes, for medical services rendered in Mexico:</b> International Medical Solutions (IMS). For a list of <u>network providers</u>, call IMS at 1-928-446-6179 (United States) or 1-653-690-1874 (Mexico), or visit <a href="http://www.internationalmedsolutions.com/">www.internationalmedsolutions.com/</a>.</p> <p><b>Yes, for <u>prescription drugs</u>:</b> MagellanRx. For a list of retail and mail pharmacies, log on to <a href="http://www.magellanrx.com">www.magellanrx.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</u> network. You will pay the most if you use an out-of-network provider, 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 out-of-network provider 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	<u>Co-payment</u> includes lab work. All other services performed during the office visit are paid at the applicable benefit level.
	<u>Specialist</u> visit	\$25 co-payment/visit, deductible waived	50% co-insurance after deductible	
	<u>Preventive care/screening/immunization</u>	No Charge	50% co-insurance after deductible	<u>Deductible</u> does not apply for <u>preventive services</u> rendered in-network. 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.

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 test	<u>Diagnostic test</u> (x-ray, blood work)	<b>Laboratory</b> \$25 co-payment <b>Pre-Admission Test</b> No charge <b>Radiology</b> 20% co-insurance after deductible <b>Sleep Study</b> 20% co-insurance After deductible	<b>Laboratory</b> 50% co-insurance <b>Pre-Admission Test</b> No charge <b>Radiology</b> 50% co-insurance after deductible <b>Sleep Study</b> Not Covered	Covered only when ordered by a physician. Lab tests obtained and performed within the physician's office are payable under the office visit <u>co-payment</u> when an office visit is billed on the same date of service.
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	50% co-insurance after deductible	Covered only when ordered by a physician.
<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.magellanrx.com">www.magellanrx.com</a> .	Generic drugs	<b>Retail</b> \$10 co-payment/prescription, or cost of the drug if less than \$10 <b>Mail Order</b> \$20 co-payment/prescription	<b>Retail</b> \$10 co-payment/prescription, or 30%, whichever is greater, to a maximum of \$150 <b>Mail Order</b> \$40 co-payment/prescription	Covers up to a thirty (30) day supply for retail prescriptions and up to a ninety (90) day supply for mail order prescriptions. Direct member reimbursement for use of an out-of-network retail pharmacy. There is no charge for FDA-approved generic contraceptives received in <u>network</u> .
	<u>Formulary</u> brand drugs	<b>Retail</b> \$10 co-payment/prescription, or 30%, whichever is greater, to a maximum of \$150 <b>Mail Order</b> \$40 co-payment/prescription	<b>Retail</b> \$10 co-payment/prescription, or 40%, whichever is greater, to a maximum of \$150 plus the difference between the cost of the brand vs generic drug <b>Mail Order</b> \$60 co-payment/prescription	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 <a href="http://www.magellanrx.com">www.magellanrx.com</a> .
	Non-formulary brand drugs	<b>Retail</b> \$10 co-payment/prescription, or 40%, whichever is greater, to a maximum of \$150 plus the difference between the cost of the brand vs generic drug <b>Mail Order</b> \$60 co-payment/prescription	<b>Retail</b> \$10 co-payment/prescription, or 40%, whichever is greater, to a maximum of \$150 plus the difference between the cost of the brand vs generic drug <b>Mail Order</b> \$60 co-payment/prescription	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 <a href="http://www.magellanrx.com">www.magellanrx.com</a> .
	<u>Specialty drugs</u>	25% co-insurance/prescription	25% co-insurance/prescription	Maximum benefit of \$150 per thirty (30) day supply. <u>Specialty drugs</u> may be subject to dispensing limits.

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	<b>Pre-certification is required.</b> Payment for the service may not be covered if pre-certification is not obtained.
	Physician/surgeon fees	20% co-insurance after deductible	50% co-insurance after deductible	_____none_____
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 co-payment/visit then 20% co-insurance after deductible	\$150 co-payment/visit then 20% co-insurance after deductible	In-network <u>deductible</u> applies to out-of-network ER services. <u>Co-payment</u> is waived if admitted.
	<u>Emergency medical transportation</u>	20% co-insurance after deductible	<b>True Emergency:</b> 20% co-insurance after deductible  <b>Non-Emergency:</b> 50% co-insurance after deductible	_____none_____
	<u>Urgent care</u>	\$50 co-payment/visit, deductible waived	\$50 co-payment/visit then 50% co-insurance, deductible waived	_____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	For inpatient rehabilitation admissions, refer to <u>Rehabilitation services</u> . <b>Pre-certification is required.</b> Payment for the service may not be covered if pre-certification is not obtained.
	Physician/surgeon fees	20% co-insurance after deductible	50% co-insurance after deductible	_____none_____
<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	_____none_____
	Inpatient services	20% co-insurance after deductible	50% co-insurance after deductible	<b>Pre-certification is required.</b> Payment for the service may not be covered if pre-certification is not obtained.
<b>If you are pregnant</b>	Office visits	No Charge	50% co-insurance after deductible	<u>Network co-payments</u> are waived if OB/GYN care begins in first trimester of pregnancy. Maternity care may include tests and services described elsewhere in the SBC. Depending on the type of services, a <u>co-insurance</u> or

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>deductible</u> may apply
	Childbirth/delivery professional services	20% co-insurance after deductible	50% co-insurance after deductible	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery facility services	20% co-insurance after deductible	50% co-insurance after deductible	<b>Pre-certification is required for extended stay.</b> Payment for the service may not be covered if pre-certification is not obtained.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% co-insurance after deductible	50% co-insurance after deductible	Includes part-time, intermittent <u>skilled nursing care</u> services and <u>medically necessary</u> supplies to provide <u>home health care</u> or home infusion services. Home services other than <u>skilled nursing care</u> are not covered. <b>Annual Maximum:</b> Sixty (60) visits per plan participant. <b>Pre-certification is required.</b> Payment for the service may not be covered if pre-certification is not obtained.
	<u>Rehabilitation services</u>	20% co-insurance after deductible	No coverage for inpatient rehabilitation facility admission.  All other services 50% co-insurance after deductible	<b>Benefit Maximum:</b> Outpatient rehabilitation benefit (any combination of physical, occupational, or speech therapy) is payable to fifty (50) visits per person per injury or illness. Inpatient rehabilitation admission is limited to sixty (60) consecutive days per person per injury or illness. <b>Pre-certification is required for inpatient admissions.</b> Payment for the service may not be covered if pre-certification is not obtained.
	<u>Habilitation services</u>	Not Covered	Not Covered	—————none—————
	<u>Skilled nursing care</u>	20% co-insurance after deductible	Not Covered	<b>Annual Maximum:</b> Sixty (60) days per plan participant. <b>Pre-certification is required.</b> Payment for the service may not be covered if pre-certification is not obtained.

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>Durable medical equipment</u>	20% co-insurance after deductible	50% co-insurance after deductible	<b>Pre-certification is required for <u>durable medical equipment</u> in excess of \$5,000 per item.</b> Payment for the equipment may not be covered if pre-certification is not obtained.
	<u>Hospice services</u>	20% co-insurance after deductible	50% co-insurance after deductible	<b>Pre-certification is required.</b> Payment for the service may not be covered if pre-certification is not obtained.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	50% co-insurance after deductible	Covered only if provided during a well-child visit.
	Children's glasses	Not Covered	Not Covered	_____none_____
	Children's dental check-up	Not Covered	Not Covered	Dental benefits are a separate election.

## 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                       | • <u>Habilitation services</u>                                  |                        |
| • Cosmetic surgery                  | • Hearing aids  | • Private duty nursing |
| • Dental care (Adult or Child)      | • Infertility treatment   | • Routine foot care    |
| • Routine eye care (Adult or Child) | • Non-emergency care when traveling outside the U.S. and Mexico | • 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 | • Long-term care | • Non-emergency care when traveling in Mexico |
| • Chiropractic care |                  |   |

**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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). You may also contact the Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise ID 83707, 1-866-365-9198.

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. For more information about your rights, this notice, or assistance, contact the Plan Administrator at 1-928-344-7515.

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 plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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 1-866-365-9198.

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, kwijigo holne' 1-866-365-9198.

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

## 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)

■ <u>The Plan's overall deductible</u>	\$750
■ <u>Specialist co-payment</u>	\$25
■ <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:

Cost Sharing	
Deductibles	\$750
Copayments	\$100
Coinsurance	\$1,900
What isn't covered	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$2,760</b>

### Managing Joe's type 2 Diabetes

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

■ <u>The Plan's overall deductible</u>	\$750
■ <u>Specialist co-payment</u>	\$25
■ <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>\$7,400</b>
---------------------------	----------------

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

Cost Sharing	
Deductibles	\$750
Copayments	\$500
Coinsurance	\$1,300
What isn't covered	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$2,580</b>

### Mia's Simple Fracture

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

■ <u>The Plan's overall deductible</u>	\$750
■ <u>Specialist co-payment</u>	\$25
■ <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>\$1,900</b>
---------------------------	----------------

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

Cost Sharing	
Deductibles	\$750
Copayments	\$200
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,150</b>