**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, call 1-855-961-5370 or visit www.MyAmeriBen.com. 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 1-855-961-5370 to request a copy.

| Important Questions | Answers | | | Why This Matters: |
|---|---|---|---|---|
| **What is the overall deductible?** | | **Tier 1 and BCBSAZ** | **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:** | $2,800 | $3,600 | |
| | **Per family:** | $5,600 | $7,200 | |
| **Are there services covered before you meet your deductible?** | **Yes.** Preventive services and breast pumps/supplies. | | | 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?** | | **Tier 1 and BCBSAZ** | **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:** | $6,450 | Unlimited | |
| | **Per family:** | $12,900 | Unlimited | |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, health care expenses this plan does not cover, charges in excess of annual maximum benefits, a penalty for failure to obtain precertification, and non-network cost sharing (except for emergency) do not count toward the out-of-pocket limit. | | | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | **Yes. for medical:**<br>Tier 1- network providers see www.honorhealth.com/locations<br>Innovation Care Partners see www.innovationcarepartners.com/physiciansearch.<br>Blue Cross Blue Shield of Arizona network providers, see www.azblue.com/chsnetwork or call 1-855 961 5370.<br>**Yes, for prescription drugs:**<br>Navitus. For a list of retail and mail pharmacies, log on to www.navitus.com or call 1-844 268 9789.<br>Specialty Pharmacy: Lumicera Health Services. Call 1-855-847-3553. | 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. |
| **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 |
|---|---|---|---|---|---|
| | | Tier 1 Network Provider (You will pay the least) | BCBSAZ Network Provider | 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 | 10% co-insurance after deductible | 20% co-insurance after deductible | Not covered | Primary care providers include family/general practitioners, internists, and pediatricians. |
| | Specialist visit | 10% co-insurance after deductible | 20% co-insurance after deductible | Not covered | ——————none—————— |
| | Preventive care/screening/ immunization | No charge, deductible waived | No charge, deductible waived* | 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.<br>**Calendar Year Maximum:** One (1) exam per adult plan participant.<br>*Wellness exams for children are only covered without cost sharing at a BCBSAZ provider when performed by a pediatrician. |

* 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 |
|---|---|---|---|---|---|
| | | Tier 1 Network Provider (You will pay the least) | BCBSAZ Network Provider | Non-Network Provider (You will pay the most) | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% co-insurance after deductible | 10% co-insurance after deductible | Not covered | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 10% co-insurance after deductible | 50% co-insurance after deductible | Not covered | **Pre-certification is required for MRI/MRA and PET scans.** |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.navitus.com | Generic drugs | **Retail Generic Preventive Drugs, 30-Day Supply:** No charge after deductible<br>**Retail Generic Drugs, 30-Day Supply:** $15 co-payment after deductible<br>**Mail Generic Preventive Drugs, 90-Day Supply:** No charge after deductible<br>**Retail 90 Program and Mail Order Generic Drugs, 90-Day Supply:** $37.50 co-payment after deductible | | Not Covered | 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 1-844 268 9789.<br>Your pharmacy benefit plan includes special coverage for **preventive medications.** These medications help protect against or manage medical conditions such as diabetes, hypertension, asthma, and depression.<br>Prior authorizations, quantity limits and step therapy may apply to certain drugs.<br>Dispense as Written (DAW) penalty: If you choose a brand drug when a generic equivalent drug is available you may pay the applicable brand copay or coinsurance plus the difference in cost between the brand drug and generic drug. The penalty does not apply toward your out-of-pocket limit. If drug cost is less than co-payment, you pay just the drug cost.<br>Retail 90 Program: 90-day maintenance medications will only be covered when filled at participating retail pharmacy or Navitus Mail Order. Maintenance medications are those you take regularly. |
| | Preferred brand drugs | **Retail Preferred Brand Drugs, 30-Day Supply:** 35% co-insurance after deductible Minimum: $40 Maximum: $100<br>**Retail 90 Program and Mail Order Preferred Brand Drugs, 90-Day Supply:** 35% co-insurance after deductible Minimum: $100 Maximum: $250 | | Not Covered | |
| | Non-preferred brand drugs | **Retail Non-Preferred Brand Drugs, 30-Day Supply:** 60% co-insurance after deductible Minimum: $125 | | Not Covered | |

* 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 |
|---|---|---|---|---|---|
| | | Tier 1 Network Provider (You will pay the least) | BCBSAZ Network Provider | Non-Network Provider (You will pay the most) | |
| | | **Retail 90 Program and Mail Order Non-Preferred Brand Drugs, 30-Day Supply:**<br>Retail: 100% after deductible<br>Mail order: Not covered | | | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.navitus.com | Specialty drugs | **30-Day Supply:**<br>30% co-insurance after deductible<br>Minimum: $60<br>Maximum: $150 | | Not Covered | Specialty Drugs are not covered unless obtained through Lumicera Health Services. Call 1-855-847-3553 for more information.<br>**Pre-certification is required** for specialty drugs over $1,000. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% co-insurance after deductible | 50% co-insurance after deductible | Not Covered | **Pre-certification is required.** |
| | Physician/ surgeon fees | 10% co-insurance after deductible | 30% co-insurance after deductible | Not Covered | ——————none—————— |
| **If you need immediate medical attention** | Emergency room care | 20% co-insurance after deductible | 20% co-insurance after deductible | 20% co-insurance after deductible | ——————none—————— |
| | Emergency medical transportation | **Initial Transport:**<br>25% co-insurance after deductible<br>**Inter-Facility Transport:**<br>No charge | **Initial Transport:**<br>25% co-insurance after deductible<br>**Inter-Facility Transport:**<br>No charge | **Initial Transport:**<br>25% co-insurance after deductible<br>**Inter-Facility Transport:** | Non-network ambulance charges apply to network out-of-pocket limit. |

* 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 |
|---|---|---|---|---|---|
| | | Tier 1 Network Provider (You will pay the least) | BCBSAZ Network Provider | Non-Network Provider (You will pay the most) | |
| | | | | No charge | |
| | Urgent care | 20% co-insurance after deductible | 20% co-insurance after deductible | Not covered | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% co-insurance after deductible | **Emergency Admission:** 20% co-insurance after deductible<br>**Elective Admission:** 50% co-insurance after deductible | 20% co-insurance after deductible<br>Not covered if elective | **Calendar Year Maximum:** Inpatient rehabilitation services one hundred twenty (120) days per plan participant.<br>**Pre-certification is required.** |
| | Physician/ surgeon fees | 10% co-insurance after deductible | 30% co-insurance after deductible | Not covered | ——————none—————— |

* 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 |
|---|---|---|---|---|---|
| | | Tier 1 Network Provider (You will pay the least) | BCBSAZ Network Provider | Non-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% co-insurance after deductible | | 60% co-insurance after deductible | Outpatient visits to a non-network provider may be subject to retrospective review for medical necessity.<br>**Pre-certification is required** for partial hospitalization and intensive outpatient treatment in excess of eighteen (18) visits per calendar year. |
| | Inpatient services | 10% co-insurance after deductible | | 60% co-insurance after deductible | **Pre-certification is required** for inpatient admissions and residential treatment. |
| **If you are pregnant** | Office visits | No charge after deductible | No charge after deductible | Not covered | Cost sharing does not apply for preventive services. Depending on the type of services, a co-insurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).<br>**Benefit Maximum:** One (1) breast pump per pregnancy.<br>**Pre-certification is required** for breast pumps in excess of $1,000. |
| | Childbirth/delivery professional services | 10% co-insurance after deductible | 30% co-insurance after deductible | Not covered | |
| | Childbirth/delivery facility services | 10% co-insurance after deductible | 50% co-insurance after deductible | Not covered | **Pre-certification is required** if admission is longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for C-section. |
| **If you need help recovering or have other** | Home health care | 10% co-insurance after deductible | 20% co-insurance after deductible | Not covered | **Pre-certification is required.** |

* 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 |
|---|---|---|---|---|---|
| | | Tier 1 Network Provider (You will pay the least) | BCBSAZ Network Provider | Non-Network Provider (You will pay the most) | |
| **special needs** | Rehabilitation services | 20% co-insurance after deductible | 20% co-insurance after deductible | Not covered | **Pre-certification is required** for speech therapy. **Pre-certification is required** for physical and occupational therapy in excess of twenty (20) visits. |
| **If you need help recovering or have other special needs** | Habilitation services | 20% co-insurance after deductible | Not covered | Not covered | Habilitation services are covered only for Applied Behavioral Analysis (ABA) Therapy for autism.<br>**Pre-certification is required** for speech therapy. **Pre-certification is required** for physical and occupational therapy in excess of twenty (20) visits. |
| | Skilled nursing care | 10% co-insurance after deductible | 25% co-insurance after deductible | Not covered | **Calendar Year Maximum:** One hundred twenty (120) days per plan participant.<br>**Pre-certification is required.** |
| | Durable medical equipment | **DME:** 25% co-insurance after deductible | **DME:** 25% co-insurance after deductible | Not covered | Some diabetic supplies are covered under the pharmacy benefits.<br>**Pre-certification is required** for durable medical equipment in excess of $1,000. |
| | | **Diabetic Equipment:** 10% co-insurance after deductible | **Diabetic Equipment:** 10% co-insurance after deductible | | |
| | Hospice services | 20% co-insurance after deductible | 20% co-insurance after deductible | Not covered | Covered if terminally ill.<br>**Pre-certification is required.** |
| **If your child needs dental or eye care** | Children's eye exam | No charge during a preventive care office visit. | No charge during a PCP preventive care office visit. | Not covered | Covered for dependent children up to twenty-six (26) years. |
| | Children's glasses | Not covered | Not covered | Not covered | ——————none—————— |
| | Children's dental check-up | Not covered | Not covered | Not covered | ——————none—————— |

* 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.)**

- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- 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.)**

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment

**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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise, ID 83707, 1-855-961-5370. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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
1-855-961-5370

**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 1-855-961-5370.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-961-5370.
* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-855-961-5370.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-961-5370.

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

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

## 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 | $2,800 |
| Specialist cost sharing | 10% |
| Hospital (facility) cost sharing | 10% |
| Other cost sharing | 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** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,800 |
| Copayments | $10 |
| Coinsurance | $800 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$3,630** |

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

| | |
|---|---|
| The plan's overall deductible | $2,800 |
| Specialist cost sharing | 10% |
| Hospital (facility) cost sharing | 10% |
| Other cost sharing | 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** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,800 |
| Copayments | $0 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,880** |

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

| | |
|---|---|
| The plan's overall deductible | $2,800 |
| Specialist cost sharing | 10% |
| Hospital (facility) cost sharing | 10% |
| Other cost sharing | 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** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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.