



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 1-855-350-8699.

Important Questions	Answers	Why this Matters:						
What is the overall deductible?	<table border="0"> <tr> <td>NETWORK</td> <td>NON-NETWORK</td> </tr> <tr> <td>\$0 per person</td> <td>\$500 per person</td> </tr> <tr> <td>\$500 per family</td> <td>\$1,000 per family</td> </tr> </table> <p>The network and non-network deductible amounts do not accumulate towards each other.</p>	NETWORK	NON-NETWORK	\$0 per person	\$500 per person	\$500 per family	\$1,000 per family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document 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 .
NETWORK	NON-NETWORK							
\$0 per person	\$500 per person							
\$500 per family	\$1,000 per family							
Are there other deductibles for specific services?	No. There are no other specific deductibles.	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?	<p>Yes, Medical Out-of-Pocket Limit</p> <table border="0"> <tr> <td>NETWORK</td> <td>NON-NETWORK</td> </tr> <tr> <td>\$2,500 per person</td> <td>\$5,000 per person</td> </tr> <tr> <td>\$5,000 per family</td> <td>\$10,000 per family</td> </tr> </table> <p>The network and non-network out-of-pocket amounts do not accumulate towards each other.</p> <p>Prescription Drug Out-of-Pocket Limit</p> <p>\$4,100 per person \$8,200 per family</p>	NETWORK	NON-NETWORK	\$2,500 per person	\$5,000 per person	\$5,000 per family	\$10,000 per family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
NETWORK	NON-NETWORK							
\$2,500 per person	\$5,000 per person							
\$5,000 per family	\$10,000 per family							
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, pre-certification penalties, prescription drug co-payments, and medical food charges do not apply to the Medical out-of-pocket limit.	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?	<p>Yes, Medical: BlueCross[®] BlueShield[®] of Arizona. For a list of preferred providers, call BCBSAZ at 1-800-232-2345 or visit www.azblue.com/provider-directory.</p> <p>Yes, Prescription Drugs: A list of retail and mail pharmacies is available from Navitus Health Solutions at https://www.navitus.com/Pages/default.aspx.</p>	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 .						

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. 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 **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a-		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay/visit, deductible waived	50% co-insurance, after deductible	_____none_____
	Specialist visit	\$40 co-pay/visit, deductible waived	50% co-insurance, after deductible	_____none_____
	Other practitioner office visit	Chiropractic Treatment		Benefit year maximum: Thirty (30) visits per plan participant.
		\$20 co-pay/visit, deductible waived	50% co-insurance, after deductible	
	Preventive care/screening/immunization	No Charge	Not Covered	Wellness care (not defined by PPACA) maximum: \$500 per plan participant per benefit year for services not covered by healthcare reform. Please refer to the Routine Preventive Care provision listed in the plan document MEDICAL BENEFITS, Covered Medical Charges section, for a further description and limitations to this benefit.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance, after deductible	50% co-insurance, after deductible	There is no charge when labs are received at a free standing facility.
	Imaging (CT/PET scans, MRIs)	20% co-insurance, after deductible	50% co-insurance, after deductible	_____none_____

Common Medical Event	Services You May Need	Your Cost If You Use a-			Limitations & Exceptions
		Preferred Pharmacy	Non-Preferred Pharmacy	Non-Network Pharmacy	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.navitus.com/Pages/default.aspx .	Formulary Generics and Certain Low Cost Brand Name Drugs	\$10 co-payment/ 30 day supply \$25 co-payment/ 90 day supply	\$15 co-payment/ 30 day supply \$30 co-payment/ 90 day supply	You pay the full price of the prescription minus the network price of the prescription	Prescription drug charges apply to the Prescription Drug out-of-pocket limit. Preventive prescription medications (including contraceptives) when purchased from a network pharmacy, are paid at 100% and the co-payment/deductible (if applicable) is waived. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your Navitus Health Solutions account at https://www.navitus.com/Pages/default.aspx . Note: Specialty drugs are only available through the Navitus SpecialtyRx Program Pharmacy.
	Formulary Brand Name Drugs and Certain Higher Cost Generic Drugs	\$30 co-payment/ 30 day supply \$75 co-payment/ 90 day supply	\$35 co-payment/ 30 day supply \$80 co-payment/ 90 day supply		
	Non-Formulary Drugs and Compound Medications	\$50 co-payment/ 30 day supply \$125 co-payment/ 90 day supply	\$55 co-payment/ 30 day supply \$130 co-payment/ 90 day supply		
	Specialty drugs	\$100 co-payment/ 30 day supply Only available in 30 day supply	Specialty drugs are only available through the Navitus SpecialtyRx Program Pharmacy.		
Common Medical Event	Services You May Need	Your Cost If You Use a-		Limitations & Exceptions	
		Network Provider	Non-Network Provider		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance, after deductible	50% co-insurance, after deductible	Providers who do not typically contract (e.g. anesthesiologist, pathologists, and assistant surgeons) are to be paid based on the network status of the facility in which the services were rendered.	
	Physician/surgeon fees	20% co-insurance, after deductible	50% co-insurance, after deductible		
If you need immediate medical attention	Emergency room services	\$250 co-pay/visit, plus deductible and co-insurance Co-payment waived if admitted		_____none_____	
	Emergency medical transportation	20% co-insurance, after deductible	20% co-insurance, after deductible	_____none_____	
	Urgent care	\$50 co-pay/visit, deductible waived	50% co-insurance, after deductible	_____none_____	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance, after deductible	50% co-insurance, after deductible	Limited to the semi-private room rate. Pre-certification is required. Benefits will be reduced by \$300 per paid claim for non-compliance.	
	Physician/surgeon fee	20% co-insurance, after deductible	50% co-insurance, after deductible		

Common Medical Event	Services You May Need	Your Cost If You Use a-		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 co-pay/visit, deductible waived	50% co-insurance, after deductible	Psychiatric Day Treatment requires pre-certification. Benefits will be reduced by \$300 per paid claim for non-compliance.
	Mental/Behavioral health inpatient services	20% co-insurance, after deductible	50% co-insurance, after deductible	Pre-certification is required. Benefits will be reduced by \$300 per paid claim for non-compliance.
	Substance use disorder outpatient services	\$20 co-pay/visit, deductible waived	50% co-insurance, after deductible	Psychiatric Day Treatment requires pre-certification. Benefits will be reduced by \$300 per paid claim for non-compliance.
	Substance use disorder inpatient services	20% co-insurance, after deductible	50% co-insurance, after deductible	Pre-certification is required. Benefits will be reduced by \$300 per paid claim for non-compliance.
If you are pregnant	Prenatal and postnatal care	20% co-insurance, after deductible	50% co-insurance, after deductible	First visit to confirm pregnancy is subject to a \$20 co-pay for a PCP or \$40 co-pay for a specialist, deductible waived.
	Delivery and all inpatient services	20% co-insurance, after deductible	50% co-insurance, after deductible	_____none_____
If you need help recovering or have other special health needs	Home health care	20% co-insurance, after deductible	50% co-insurance, after deductible	Benefit year maximum: Sixty (60) visits per plan participant.
	Rehabilitation services	20% co-insurance, after deductible	50% co-insurance, after deductible	Services include speech, occupational, or physical therapy provided on an inpatient or outpatient basis. Combined benefit year maximum: Twenty (20) visits per plan participant.
	Habilitation services	Covered as any other illness depending on provider type, service performed, and place of service.	50% co-insurance, after deductible	Coverage for Autism Spectrum Disorder — Behavior Therapy Services ONLY. Behavioral therapy services for the treatment of Autism spectrum disorder are available for plan participants who have been diagnosed with autism spectrum disorder. Pre-certification is required. Benefits will be reduced by \$300 per paid claim for non-compliance.

Common Medical Event	Services You May Need	Your Cost If You Use a-		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you need help recovering or have other special health needs	Skilled nursing care	20% co-insurance, after deductible	50% co-insurance, after deductible	Benefit year maximum: Sixty (60) days per plan participant. Pre-certification is required. Benefits will be reduced by \$300 per paid claim for non-compliance.
	Durable medical equipment	20% co-insurance, after deductible	50% co-insurance, after deductible	—————none—————
	Hospice service	20% co-insurance, after deductible	50% co-insurance, after deductible	Lifetime maximum: Six (6) months per plan participant. Services include Bereavement Counseling; limited to \$300 per plan participant.
If your child needs dental or eye care	Eye exam	\$40 co-pay/visit, deductible waived	50% co-insurance, after deductible	This describes benefits provided by your medical plan. AzMT provides Dental and Vision coverage through stand-alone plans at a low monthly cost. If this is elected, please refer to your vision and/or dental administrator for additional benefits.
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care (Adult covered under stand-alone dental plan) Dental check-up (Child covered under stand-alone dental plan) Glasses (Child) 	<ul style="list-style-type: none"> Hearing aids Infertility treatment Long-term care (except for a facility licensed to provide long term acute care) Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private duty nursing Routine foot care (except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg) 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.)		
<ul style="list-style-type: none"> Bariatric surgery 	<ul style="list-style-type: none"> Chiropractic care 	<ul style="list-style-type: none"> Routine eye care (Adult and children)

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 AmeriBen, P.O. Box 7186, Boise, ID 83707, 1-855-350-8699. 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 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
1-855-350-8699

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 1-855-350-8699.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-350-8699.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-350-8699.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-855-350-8699.

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 \$5,820
- Patient pays \$1,720

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	\$0
Copays	\$20
Coinsurance	\$1,400
Limits or exclusions	\$300
Total	\$1,720

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

- Amount owed to providers: \$5,400
- Plan pays \$4,300
- Patient pays \$1,100

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	\$600
Coinsurance	\$300
Limits or exclusions	\$200
Total	\$1,100

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.

Questions: Call 1-855-350-8699 or visit us at www.MyAmeriBen.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.MyAmeriBen.com or www.dol.gov/ebsa/healthreform or call 1-866-4-USA-DOL to request a copy.