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 1-877-768-7182. 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 1-877-768-7182 or 1-602-231-8855 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	None	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Yes.** There is no deductible.	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**	No. You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Per participant:** $5,000 HonorHealth and BCBSAZ In-Network Provider/ Unlimited non-network **Per family:** $10,000 HonorHealth and BCBSAZ In-Network Provider/ Unlimited non-network There is a $2,500/person cost-sharing limit on specialty drugs that also accumulates to this Out-of-Pocket Limit.	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.
What is not included in the out–of–pocket limit?	For the Medical Plan including outpatient drugs: 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 out-of-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.

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

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	**Yes. for medical:** HonorHealth network providers see www.honorhealth.com/locations Innovation Care Partners see www.innovationcarepartners.com/physiciansearch Blue Cross Blue Shield of Arizona in-network providers, see www.azblue.com/chsnetwork or call (602) 231-8855. **Yes, for behavioral:** Magellan Behavioral Health in-network providers, see www.magellanhealth.com/member or call (800) 424-4138. **Yes, for prescription drugs:** OptumRx. For a list of retail and mail pharmacies, log on to www.optumrx.com or call 1-844-368-9854	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 you need a referral to see a specialist?	**No.**	You can see the specialist you choose without permission from this plan.

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
		HonorHealth Network Provider (You will pay the least)	BCBSAZ 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	$20 co-payment/visit	Not covered	Not covered	Primary care = family/general practitioner, internist, pediatrician
	Specialist visit	$50 co-payment/visit	BCBSAZ: $50 co-payment/ visit. If specialty in HonorHealth network: $125 co-payment/ visit	Not covered	——————none——————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HonorHealth Network Provider (You will pay the least)	BCBSAZ 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	Preventive care/screening/ immunization	No charge	Not covered. Lab fees 100% when ordered by an HonorHealth physician	Not covered	Plan covers preventive services and supplies required by the Health Reform law, with age and frequency guidelines applied.
If you have a test	Diagnostic test (x-ray, blood work)	$10 co-payment	Lab: $10 co-payment X-ray: 50% coinsurance	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$100 co-payment then you pay 20% co-insurance	Not covered	Not covered	Imaging tests require precertification.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or call 1-844-368-9854	Generic drugs	**Retail Maintenance Generic Drugs:** $0 co-payment after deductible/30 days **Retail Generic Drugs:** $4 co-payment after deductible /30 days **Mail Order Maintenance Generic Drugs:** $0 co-payment after deductible /90 days **Mail Order Generic Drugs:** $10 co-payment after deductible /90 days Prescription contraceptives: No charge for generic drugs.		Not covered	**Generic drugs:** Maintenance drug benefit is limited to drugs to treat asthma, diabetes, hypertension, and cardiac conditions. If drug cost is less than copayment, you pay just the drug cost. Some prescriptions need preapproval, quantity limits or step therapy requirements. Not all prescription drugs are covered.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HonorHealth Network Provider (You will pay the least)	BCBSAZ 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.optumrx.com or call 1-844-368-9854.	Preferred brand drugs	**Retail Preferred Brand Drugs:** 30% co-insurance after deductible/30 days Minimum: $30/Maximum: $80 **Mail Order Preferred Brand Drugs:** 30% co-insurance after deductible/90 days Minimum: $75/Maximum: $200 No charge for brand drug if generic drug is medically inappropriate.		Not covered	**Preferred and Non-preferred drugs:** If drug cost is less than copayment, you pay just the drug cost. Some prescriptions need pre-approval, quantity limits or step therapy requirements. Dispense as Written (DAW) penalty: If you purchase a brand drug when a generic drug is available you pay the brand drug cost-sharing plus the difference in cost between the brand drug and generic drug, and the difference is a penalty that does not apply toward your out-of-pocket maximum. Not all prescription drugs are covered. Specialty Drugs available only at Avella Specialty Pharmacy. Call 1-877-546-5779 for prior approval.
	Non-preferred brand drugs	**Retail Non-preferred Brand Drugs:** 60% co-insurance after deductible/30 days Minimum: $100 **Mail Order Non-preferred Brand Drugs:** Not covered		Not covered	
	Specialty drugs	**Specialty Drugs:** 30% co-insurance after deductible/30 days Minimum: $50/Maximum: $100 Specialty drugs have a co-payment maximum of $2,500 per year per covered member.		Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HonorHealth Network Provider (You will pay the least)	BCBSAZ Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 co-payment, then no charge	Not covered	Not covered	Outpatient surgery requires precertification.
	Physician/surgeon fees	20% co-insurance	30% co-insurance	Not covered	——————none——————
If you need immediate medical attention	Emergency room care	$250 co-payment/visit	$250 co-payment/visit	$250 co-payment/visit	Co-payment waived if hospitalized as in-patient after 24 hours.
	Emergency medical transportation	25% co-insurance	25% co-insurance	25% co-insurance, applies to out-of-pocket limit.	——————none——————
	Urgent care	Not available	$25 co-payment/visit	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 co-payment per day for up to 5 days, then no charge.	$400 co-payment per day/ admission for up to 5 days plus 10% coinsurance if emergency. Not covered if elective.	Only emergency admit covered: $400 co-payment per day/admission for up to 5 days plus 10% coinsurance.	Elective hospital admission requires precertification. Inpatient rehab max 120 days/year.
	Physician/surgeon fees	20% co-insurance	30% co-insurance	Not covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Using a Magellan Health Provider:** $20 co-payment/visit. **Intensive Outpatient:** $30 co-payment/visit **Outpatient Therapy with PhD or MD:** $40 co-payment/visit		Not covered	——————none——————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HonorHealth Network Provider (You will pay the least)	BCBSAZ 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	Inpatient services	**Using a Magellan Health :** $150 co-payment per day per admission for up to 5 days, then no charge.		Only emergency admit covered: $400 co-payment per day/per admission for up to 5 days plus 10% co-insurance if emergency.	Elective hospital admission, partial hospitalization and residential facility requires precertification.
If you are pregnant	Office visits	Initial visit: $50 co-payment All subsequent prenatal and postnatal visits: No charge	Initial visit: $125 co-payment/visit All subsequent prenatal and postnatal visits: No charge	Not covered	——————none——————
	Childbirth/delivery professional services	20% co-insurance	30% co-insurance	Not covered	——————none——————
	Childbirth/delivery facility services	$150 co-payment per day per admit for up to 5 days, then no charge	Not covered	Not covered	Preapproval required if admit is longer than 48 hours for vaginal delivery or 96 hours for C-section
If you need help recovering or have other special health needs	Home health care	20% co-insurance	25% co-insurance	Not covered	Max benefit 60 visits/year. Precertify if not using an HonorHealth provider.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HonorHealth Network Provider (You will pay the least)	BCBSAZ Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Rehabilitation services	**Outpatient visits:** $20 co-payment per visit for physical, occupational and speech therapy **Inpatient rehab:** $150 co-payment per day/admit for up to 5 days, then no charge	Outpatient visits $20 co-payment per visit for physical, occupational therapy and speech therapy. Inpatient rehab Not covered	Not covered	Outpatient physical, occupational. & speech therapy max. 40 visit/year combined. Speech therapy requires precertification.
	Habilitation services	Not covered	Not covered	Not covered	You pay 100% of the expenses.
	Skilled nursing care	25% co-insurance	25% co-insurance	Not covered	Max benefit 120 days per year.
	Durable medical equipment	Supplies for Diabetic DME 10% co-insurance DME 25% co-insurance	Supplies for Diabetic DME 10% co-insurance DME 25% co-insurance	Not covered	Certain equipment requires precertification. Breast pumps/supplies, no charge.
	Hospice services	25% co-insurance	25% co-insurance	Not covered	Covered if terminally ill.
If your child needs dental or eye care	Children's eye exam	No charge during a PCP preventive care visit.	No charge during a PCP preventive care visit.	Not covered	Covered for child up to 26 years.
	Children's glasses	Not covered	Not covered	Not covered	You pay 100% of the expense.
	Children's dental check-up	Not covered	Not covered	Not covered	You pay 100% of the expense.

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 (Adult) (Child)
- Eyeglasses
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult) (Child)

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

- Acupuncture, chiropractic and naturopathic (you pay 25%, once the plan pays $1,000/year then you pay 90% coinsurance as part of combined Alternative Healthcare services).
- Bariatric Surgery (payable only if using the HonorHealth Bariatric Center).
- Hearing aids (you pay 25%, once the plan pays $2,000/ear every 3 years, then you pay 90% coinsurance).
- Infertility treatment (payable at usual cost-sharing to $1,500/person per year then you pay 90% coinsurance, plus for fertility drugs the plan pays four 30-day fills/person/year).
- Routine foot care payable when treating diabetic (metabolic) or vascular insufficiency of the feet.

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. For more information on your rights to continue coverage, contact the plan at (480) 323-4667 or toll-free at (877) 898-6569 or (602) 231-8855. 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
1-855-779-9044

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 1-877-891-7109.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-891-7109.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-891-7109.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-891-7109.

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)

The plan's overall deductible	**$0**
Specialist coinsurance	**$30**
Hospital (facility) coinsurance	**$10**
Other coinsurance	**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	$0
Copayments	$300
Coinsurance	$500
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$810**

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

The plan's overall deductible	**$0**
Specialist coinsurance	**$30**
Hospital (facility) coinsurance	**$10**
Other coinsurance	**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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$500
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,530**

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

The plan's overall deductible	**$0**
Specialist coinsurance	**$30**
Hospital (facility) coinsurance	**$10**
Other coinsurance	**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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$230
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$630**

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