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?		**HonorHealth 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:	$5,000	Unlimited	
	Per family:	$10,000	Unlimited	
	There is a $2,500/plan participant cost sharing limit on specialty drugs that also accumulates to this out-of-pocket limit.			
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 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.

* 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 network providers, see www.azblue.com/chsnetwork or call 1-602-231-8855. **Yes, for behavioral:** Magellan Behavioral Health network providers, see www.MagellanAscend.com or call 1-800-424-4138. **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	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
		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	Not covered	Not covered	The co-payment applies to the office visit and office consultations only. Co-payments are applied per visit. Primary care providers include family/general practitioners, internists, and pediatricians.
	Specialist visit	$50 co-payment	**If Specialty Not in HonorHealth Network:** $50 co-payment **If Specialty in HonorHealth Network:** $125 co-payment	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 visit a health care provider's office or clinic	Preventive care/screening/ immunization	No charge	No charge for lab fees ordered by an HonorHealth physician Otherwise not covered	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. **Calendar Year Maximum:** One (1) exam per adult plan participant.
If you have a test	Diagnostic test (x-ray, blood work)	$10 co-payment	**Lab:** $10 co-payment **X-ray:** 50% co-insurance	Not covered	Co-payments are applied per visit.
	Advanced imaging (CT/PET scans, MRIs)	$100 co-payment, then 20% co-insurance	Not covered	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.optumrx.com or call 1-844-368-9854	Generic drugs	**Retail Maintenance Generic Drugs:** No charge /30 days **Retail Generic Drugs:** $4 co-payment /30 days **Mail Order Maintenance Generic Drugs:** No charge/90 days **Mail Order Generic Drugs:** $10 co-payment/90 days **Prescription Contraceptives:** No charge for generic drugs		Not covered	Not all prescription drugs are covered. **Generic drugs:** Maintenance drug benefit is limited to drugs to treat asthma, diabetes, hypertension, and cardiac conditions. If drug cost is less than co-payment, you pay just the drug cost. Some prescriptions need preapproval, quantity limits or step therapy requirements.

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.	Formulary (preferred) brand and single source generic drugs	**Retail Preferred Brand Drugs:** 30% co-insurance/30 days Minimum: $30 Maximum: $80 **Mail Order Preferred Brand Drugs:** 30% co-insurance/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 co-payment, 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 limit. Specialty Drugs available only at Avella Specialty Pharmacy. Call 1-877-546-5779 for prior approval.
	Non-formulary (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		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 co-payment	Not covered	Not covered	**Pre-certification is required.**
	Physician/surgeon fees	20% co-insurance	30% co-insurance	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 immediate medical attention	Emergency room care	$250 co-payment	$250 co-payment	$250 co-payment	Co-payments are applied per visit. Co-payment waived if hospitalized as inpatient after twenty-four (24) hours.
	Emergency medical transportation	**Initial Transport:** 25% co-insurance **Inter-Facility Transport:** No charge	**Initial Transport:** 25% co-insurance **Inter-Facility Transport:** No charge	**Initial Transport:** 25% co-insurance **Inter-Facility Transport:** No charge	Non-network ambulance charges apply to network out-of-pocket limit.
	Urgent care	$25 co-payment	$25 co-payment	Not covered	Co-payments are applied per visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 co-payment per day per admission for up to five (5) days, then no charge	$400 co-payment per day per admission for up to five (5) days plus 10% co-insurance if emergency Not covered if elective	$400 co-payment per day per admission for up to five (5) days plus 10% co-insurance if emergency Not covered if elective	**Calendar Year Maximum:** Inpatient rehabilitation services one hundred twenty (120) days per plan participant. **Pre-certification is required.**
	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	**Behavioral Network Provider:** $20 co-payment **Intensive Outpatient:** $30 co-payment **Outpatient Therapy with PhD or MD:** $40 co-payment		Not covered	Co-payments are applied per visit.

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	**Behavioral Network Facility:** $150 co-payment per day per admission for up to five (5) days, then no charge		Not covered	**Pre-certification is required** for inpatient admissions, partial hospitalization, and residential treatment.
If you are pregnant	Office visits	**Initial Visit:** $50 co-payment **All Subsequent Prenatal and Postnatal Visits:** No charge	**Initial Visit:** $125 co-payment **All Subsequent Prenatal and Postnatal Visits:** No charge	Not covered	**Benefit Maximum:** One (1) breast pump per pregnancy. **Pre-certification is required** for breast pumps in excess of $1,000.
	Childbirth/delivery professional services	20% co-insurance	30% co-insurance	Not covered	
	Childbirth/delivery facility services	$150 co-payment per day per admission for up to five (5) days, then no charge	Not covered	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 special health needs	Home health care	20% co-insurance	25% co-insurance	Not covered	**Calendar Year Maximum:** Sixty (60) visits per plan participant. **Pre-certification is required.**
If you need help recovering or have other special health needs	Rehabilitation services	**Outpatient Visits:** $20 co-payment **Inpatient Rehab:** $150 co-payment per day per admission for up to five (5) days, then no charge	**Outpatient Visits:** $20 co-payment **Inpatient Rehab:** Not covered	Not covered	Co-payments are applied per visit for outpatient services. **Combined Calendar Year Maximum:** Forty (40) visits per plan participant for outpatient physical, occupational, and speech therapy.

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)	
					Pre-certification is required for speech therapy.
	Habilitation services	$20 co-payment	Not covered	Not covered	Habilitation services are covered only for Applied Behavioral Analysis (ABA) Therapy for autism. **Pre-certification is required** for speech therapy.
	Skilled nursing care	25% co-insurance	25% co-insurance	Not covered	**Calendar Year Maximum:** One hundred twenty (120) days per plan participant. **Pre-certification is required.**
	Durable medical equipment	**Diabetic Supplies:** 10% co-insurance **Other DME:** 25% co-insurance	**Diabetic Supplies:** 10% co-insurance **Other DME:** 25% co-insurance	Not covered	Some diabetic supplies are covered under the pharmacy benefits. **Pre-certification is required** for insulin pumps in excess of $1,000. **Pre-certification is required** for durable medical equipment in excess of $1,000.
	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 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——————

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	• Habilitation services	• Private-duty nursing

• Dental care • Eyeglasses	• Long-term care • Non-emergency care when traveling outside the U.S.	• 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. 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 co-payment	$30
Hospital (facility) co-payment	$150
Other coinsurance	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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$210**

This coverage example assumes the baby is enrolled in the Plan.

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 co-payment	$30
Hospital (facility) co-payment	$150
Other coinsurance	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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,930**

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

The plan's overall deductible	$0
Specialist co-payment	$30
Hospital (facility) co-payment	$150
Other coinsurance	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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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