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 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 or call 1-866-365-9198 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		**In-Network**	**Out-of-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:	**$1,000**	**$2,250**	
	Per family:	**$2,000**	**$4,500**	
	Does not apply to amounts in excess of the allowed amount, services not covered, outpatient prescription drugs, or preventive care. The deductible restarts on July 1, 2024 and applies until June 30, 2025.			
Are there services covered before you meet your deductible?	**Yes.** Some services such as office visits require a co-payment while preventive care is provided at no cost.			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?		**In-Network**	**Out-of-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:	**$6,600**	**$10,000**	
	Per family:	**$13,200**	**$10,000 per person**	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, penalties for failing to follow pre-certification, amounts in excess of the allowed amount, 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 out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	**Yes, for medical:** Blue Cross Blue Shield of Arizona. For a list of network providers, call AmeriBen, at 1-866-365-9198 or visit www.azblue.com/chsnetwork. **Yes, for medical services rendered in Mexico:** International Medical Solutions (IMS). For a list of network providers, call IMS at 1-928-446-6179 (United States) or 1-653-690-1874 (Mexico), or visit www.internationalmedsolutions.com/. **Yes, for prescription drugs:** MagellanRx. For a list of retail and mail pharmacies, log on to www.magellanrx.com.	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
		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	$30 co-payment/visit, deductible waived	50% co-insurance after deductible	Co-payment includes lab work. All other services performed during the office visit are paid at the applicable benefit level.
	Specialist visit	$50 co-payment/visit, deductible waived	50% co-insurance after deductible	
	Preventive care/screening/ immunization	No Charge	50% co-insurance after deductible	Deductible does not apply for preventive services rendered in-network. 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.

* 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
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	**Laboratory** $30 co-payment/visit, deductible waived **Pre-Admission Test** No charge **Radiology** 25% co-insurance after deductible **Sleep Study** 25% co-insurance after deductible	**Laboratory** 50% co-insurance after deductible **Pre-Admission Test** No charge **Radiology** 50% co-insurance after deductible **Sleep Study** 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 co-payment when an office visit is billed on the same date of service.
	Imaging (CT/PET scans, MRIs)	25% co-insurance after deductible	50% co-insurance after deductible	Covered only when ordered by a physician.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com.	Generic drugs	**Retail** $10 co-payment/prescription, or cost of the drug if less than $10 **Mail Order** $20 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 network. Not all prescription drugs are covered. To determine if a specific drug is covered under your Plan, log into your account at www.magellanrx.com.
	Formulary brand drugs	**Retail** $10 co-payment/prescription, or 30%, whichever is greater, to a maximum of $150 **Mail Order** $40 co-payment/prescription		
	Non-formulary brand drugs	**Retail** $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 **Mail Order** $60 co-payment/prescription		

* 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
		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.magellanrx.com.	Specialty drugs	25% co-insurance/prescription, to a maximum of $150 per 30 day supply		Specialty drugs may be subject to dispensing limits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% co-insurance after deductible	50% co-insurance after deductible	**Pre-certification is required.** Payment for the service may not be covered if pre-certification is not obtained.
	Physician/surgeon fees	25% co-insurance after deductible	50% co-insurance after deductible	——————————none——————————
If you need immediate medical attention	Emergency room care	$150 co-payment/visit after deductible then 25% coinsurance	$150 co-payment/visit then 25% co-insurance after deductible	In-network deductible applies to out-of-network ER services. Co-payment is waived if admitted.
	Emergency medical transportation	25% co-insurance after deductible	**True Emergency:** 25% co-insurance after deductible **Non-Emergency:** 50% co-insurance after deductible	——————————none——————————
	Urgent care	$50 co-payment/visit, deductible waived	$50 co-payment/visit then 50% co-insurance, deductible waived	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	25% co-insurance after deductible	50% co-insurance after deductible	For inpatient rehabilitation admissions, refer to Rehabilitation services. **Pre-certification is required.** Payment for the service may not be covered if pre-certification is not obtained.
	Physician/surgeon fees	25% co-insurance after deductible	50% co-insurance after deductible	——————————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
		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	Outpatient services	$30 co-payment/visit, deductible waived	50% co-insurance after deductible	——————————none——————————
	Inpatient services	25% co-insurance after deductible	50% co-insurance after deductible	**Pre-certification is required.** Payment for the service may not be covered if pre-certification is not obtained.
If you are pregnant	Office visits	No Charge	50% co-insurance after deductible	Network co-payments 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 co-insurance or deductible may apply
	Childbirth/delivery professional services	25% co-insurance after deductible	50% co-insurance after deductible	Cost sharing does not apply for preventive services.
	Childbirth/delivery facility services	25% co-insurance after deductible	50% co-insurance after deductible	**Pre-certification is required for extended stay.** Payment for the service may not be covered if pre-certification is not obtained.
If you need help recovering or have other special needs	Home health care	25% co-insurance after deductible	50% co-insurance after deductible	Includes part-time, intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion services. Home services other than skilled nursing care are not covered. **Annual Maximum:** Sixty (60) visits per plan participant. **Pre-certification is required.** Payment for the service may not be covered if pre-certification is not obtained.

* 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
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special needs	Rehabilitation services	25% co-insurance after deductible	No coverage for inpatient rehabilitation facility admission. **All other services** 50% co-insurance after deductible	**Benefit Maximum:** 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. **Pre-certification is required for inpatient admissions.** Payment for the service may not be covered if pre-certification is not obtained.
	Habilitation services	Not Covered	Not Covered	——————————none——————————
	Skilled nursing care	25% co-insurance after deductible	Not Covered	**Annual Maximum:** Sixty (60) days per plan participant. **Pre-certification is required.** Payment for the service may not be covered if pre-certification is not obtained.
	Durable medical equipment	25% co-insurance after deductible	50% co-insurance after deductible	**Pre-certification is required for durable medical equipment in excess of $5,000 per item.** Payment for the equipment may not be covered if pre-certification is not obtained.
	Hospice services	25% co-insurance after deductible	50% co-insurance after deductible	**Pre-certification is required.** Payment for the service may not be covered if pre-certification is not obtained.
If your child needs dental or eye care	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.

* 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult or Child)
- Routine eye care (Adult or Child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. and Mexico
- Private duty nursing
- 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.)

- Bariatric surgery
- Chiropractic care
- Long-term care
- Non-emergency care when traveling in Mexico

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. 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 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**
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.

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

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

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	$1,000
Specialist co-payment	$30
Hospital (facility) cost sharing	25%
Other cost sharing	25%

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	$1,000
Copayments	$100
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,520**

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

The plan's overall deductible	$1,000
Specialist co-payment	$30
Hospital (facility) cost sharing	25%
Other cost sharing	25%

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	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,500**

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

The plan's overall deductible	$1,000
Specialist co-payment	$30
Hospital (facility) cost sharing	25%
Other cost sharing	25%

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	$1,000
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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