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 1-866-955-1485.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**NETWORK** $750/ person $1,500/ family of two $2,250/ family of three or more **OUT-OF-NETWORK** $1,500/ person $3,000/ family of two $4,500/ family of three or more The in-network and out-of-network deductible amounts **do not** accumulate towards each other.	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**.
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?	**Yes** **NETWORK** $5,000/ person $10,000/family of two or more **OUT-OF-NETWORK** No limit on out-of-network, out-of-pocket maximums. The in-network and out-of-network out-of-pocket amounts **do not** accumulate towards each other.	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.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, applicable and penalties for failure to comply with the Utilization Management Programs. Also all charges in excess of the allowed charges, Plan's maximum benefits, or in excess of any other limitation of the Plan.	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?	**Yes, Medical:** BlueCross® BlueShield® of Arizona. For a list of preferred providers, call BCBSAZ visit http://www.azblue.com . Mayo Clinic Arizona is considered an in-network provider. Visit online at www.mayoclinic.org/arizona. **Yes Prescription Drugs:** A list of retail and mail pharmacies, is available from CVS/Caremark at www.caremark.com.	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 6. 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 an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge after $20 co-pay / visit	50% co-insurance	——————none——————
	Specialist visit	No charge after $40 co-pay / visit	50% co-insurance	——————none——————
	Other practitioner office visit	**Acupuncture, Naturopathic and Homeopathic Services** 20% co-insurance	20% co-insurance	Combined Maximum: Eight (8) visits per person per plan year.
		Chiropractic Services 20% co-insurance	50% co-insurance	Maximum: Eight (8) visits per person per plan year after the deductible is met.
If you visit a health care provider's office or clinic	Preventive care/screening/immunization	No Charge	**Immunizations**: No Charge **All other services:** 50%, no deductible	Please refer to the SPD, SCHEDULE OF MEDICAL BENEFITS, Wellness (Preventive) Program, for a further description and limitations to this benefit.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	50% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% co-insurance	50% co-insurance	Elective MRI and CT scans require precertification.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$10 co-payment / 30 day supply $25 co-payment / 90 day supply	You will be reimbursed (for eligible prescriptions) at the network discount rate minus your applicable prescription co-pay/co-insurance payment.	Co-payments for drugs are not applied to the Plan's deductible. Certain over the counter (OTC) drugs are paid at 100%, no co-pay or deductible applies when purchased from a network pharmacy with a prescription. Refer to the SPD, Medical Expense Coverage, COVERAGE OF CERTAIN OVER THE COUNTER (OTC) DRUGS for details on this benefit. Generic contraceptives are paid at 100%, no co-pay or deductible applies. Normal cost-sharing applies to preferred brand and non-preferred brand contraceptives. No charge for brand prescription contraceptive drug only if a generic contraceptive is unavailable or medically inappropriate. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your CVS/Caremark account at www.caremark.com.
	Preferred brand drugs	The greater of $20 or 30% of the drug cost, to a maximum payment of $45 per fill / 30 day supply. $50 co-payment / 90 day supply		
	Non-preferred brand drugs	The greater of $30 or 50% of the drug cost; to a maximum payment of $90 per fill / 30 day supply. $90 co-payment / 90 day supply		
	Specialty drugs	Subject to the normal co-pays/co-insurance as listed above, dependent upon the classification of the drug. Only available in thirty day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	50% co-insurance	——————none——————
	Physician/surgeon fees	20% co-insurance	50% co-insurance	
If you need immediate medical attention	Emergency room services	20% co-insurance		Emergency room treatment is limited to emergency medical conditions having sudden and unexpected onset requiring immediate care to safeguard the life of the plan participant.
	Emergency medical transportation	20% co-insurance	50% co-insurance	Expenses for Ambulance services are covered only when those services are for an Emergency as defined in the SPD
	Urgent care	No charge after $40 co-pay / visit	50% co-insurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	50% co-insurance	Elective Hospitalization is subject to precertification. Note the $300 penalty for failure to follow the Plan's precertification requirements.
	Physician/surgeon fee	20% co-insurance	50% co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after $20 co-pay / visit	50% co-insurance	EAP Program offers up to 6 free counseling visits per situation. Psychological Testing is paid at 20% co-insurance when received in-network.
	Mental/Behavioral health inpatient services	20% co-insurance	50% co-insurance	Behavioral Health elective inpatient services and in-network residential treatment require precertification. Benefits will be reduced by $300 for non-compliance. Out-of-network residential treatment is not covered.
	Substance use disorder outpatient services	No charge after $20 co-pay / visit	50% co-insurance	EAP Program offers up to 6 free counseling visits per situation. Psychological Testing is paid at 20% co-insurance when received in-network.
	Substance use disorder inpatient services	20% co-insurance	50% co-insurance	Behavioral Health elective inpatient services and in-network residential treatment require precertification. Benefits will be reduced by $300 for non-compliance. Out-of-network residential treatment is not covered.
If you are pregnant	Prenatal and postnatal care	No Charge	50% co-insurance	Ultrasounds and other lab/radiology tests are payable with normal cost-sharing. When a provider submits a bill to the plan with one global CPT code for the combination of prenatal visits and delivery expenses, the Plan's claims administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal visit expenses, and normal cost-sharing to 60% of the charges representing the delivery expenses. Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.
	Delivery and all inpatient services	20% co-insurance	50% co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-insurance	50% co-insurance	Annual Maximum Plan Benefit for Skilled Nursing Care services and supplies to provide Home Health Care and Home Infusion Services is 100 visits per person.
	Rehabilitation services	20% co-insurance	50% co-insurance	Services include speech, occupational, or physical therapy provided on an inpatient or outpatient basis. Combined outpatient maximum: 60 visits per person per plan year. Inpatient rehabilitation services are payable up to 60 days per person per plan year.
If you need help recovering or have other special health needs	Habilitation services	20% co-insurance	50% co-insurance	Speech delays excluded.
	Skilled nursing care	20% co-insurance	Not Covered	Skilled Nursing Facility confinement payable up to 60 days per plan year.
	Durable medical equipment	20% co-insurance	50% co-insurance	All requests for DME exceeding $1,000/item must be precertified. Benefits will be reduced by $300 for non-compliance.
	Hospice service	20% co-insurance	50% co-insurance	Hospice services are for terminally ill persons assessed to have a life expectancy of 6 months or less.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	———none———
	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 excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- Hearing aids
- Infertility (except for the diagnosis of infertility)
- Long-term care (except for a facility licensed to provide long term acute care)
- Non-emergency care when traveling outside the U.S.
- Out-of-network residential treatment
- Out-of-network skilled nursing care
- Private duty nursing (except when medically necessary)
- Routine eye care (Adult)
- Routine foot care (except when medically necessary)
- 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.)	
• Acupuncture	• Chiropractic care

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, 1-866-955-1485. 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:

Medical: AmeriBen at 1-866-955-1485

Prescription Drug: CVS/Caremark at 1-800-237-2767

Department of Labor's Employee Benefits Security Administration: 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 1-866-955-1485.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-955-1485.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-955-1485.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-955-1485.

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** $4,830
- **Patient pays** $2,710

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	$1,500
Copays	$80
Coinsurance	$1,100
Limits or exclusions	$30
Total	**$2,710**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,660
- **Patient pays** $740

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	$40
Copays	$700
Coinsurance	$0
Limits or exclusions	$0
Total	**$740**

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.