




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, [insert contact information]. 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](http://www.MyAmeriBen.com) or call 1-855-258-6455 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>Yes:</b> <b>Per participant:</b> \$1,300 In-Network/ \$5,000 Out-of-Network <b>Per family:</b> \$2,600 In-Network/ \$10,000 Out-of-Network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	<b>Yes.</b> Preventive care services, performed by a network provider, are not subject to the deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	<b>No</b>	No. You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<b>Yes, Medical Out-of-Pocket Limit:</b> <b>Per participant:</b> \$3,000 In-Network/ \$10,000 Out-of-Network <b>Per family:</b> \$6,000 In-Network/ \$20,000 Out-of-Network <b>Health Savings Account:</b> Access to an HSA is available for eligible participants when enrolled on this plan. Funding may be used for reimbursements of eligible health expenses. Employee only level coverage has access to up to \$3,400/annual HSA funding. Employee plus one or more coverage tiers have access to up to \$6,750/annual HSA funding. You may contribute an extra \$1,000 annually for each person covered under the HDHP option who is age 55 or older at the end of the plan year in which you enroll in the HSA.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).]

Important Questions	Answers	Why This Matters:
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, pre-certification penalty amounts, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	<p><b>Yes, for Medical:</b> BlueCross® BlueShield® of Arizona. For a list of in-network providers, call BCBSAZ at 1-800-232-2345 or visit <a href="http://www.azblue.com/CHSnetwork">www.azblue.com/CHSnetwork</a>.</p> <p><b>Yes, for Prescription Drugs:</b> For a list of retail and mail pharmacies, log on to <a href="http://www.navitus.com">www.navitus.com</a>.</p>	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an out-of-network provider for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	10% coinsurance after deductible	50% coinsurance after deductible	CCT also provides coverage for telephonic consultations through Teladoc. For Teladoc consultations, you pay \$45/consultation until the deductible is met and 10% coinsurance after the deductible is met. To access this service logon to your Teladoc account or call 1-800-Teladoc.
	<u>Specialist</u> visit	10% coinsurance after deductible	50% coinsurance after deductible	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	The deductible does not apply. Includes all preventive services as well as routine well care (routine physicals, gynecological exams, routine laboratory tests/ x-rays, mammograms (includes 3D mammograms), cancer screenings, body scans, bone density scans, and flu shots). Wellness care (not defined by PPACA) plan year maximum: \$500 per plan participant for services not covered by healthcare reform.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information	
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification required for procedures in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.	
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification required. Failure to pre-certify will result in a \$300 penalty.	
Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Pharmacy (You will pay the least)	Non-Preferred Pharmacy	Out-of-Network Pharmacy (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.navitus.com">www.navitus.com</a> .	Generic drugs	10% coinsurance after deductible/ 30-day supply or 90-day supply		50% coinsurance after deductible	Covers up to a 30-day or 90-day supply (retail prescription); 90-day supply (mail order prescription). For proton pump inhibitors, you pay 50% copay.
	Preferred brand drugs	10% coinsurance after deductible/ 30-day supply or 90-day supply		50% coinsurance after deductible	The Plan requires that retail pharmacies dispense generic drugs when available. If you or your physician specifies that a brand name drug should be dispensed when a generic drug is available, you will pay the difference in cost between the brand name and generic drugs.
	Non-preferred brand drugs	10% coinsurance after deductible/ 30-day supply or 90-day supply		50% coinsurance after deductible	The plan participant's share of this cost difference does not apply toward the Plan's out-of-pocket limit.
	<u>Specialty drugs</u>	10% coinsurance after deductible/ 30-day supply or 90-day supply		50% coinsurance after deductible	Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at <a href="http://www.navitus.com">www.navitus.com</a> . *Specialty drugs must be obtained through the Navitus Specialty Pharmacy Program.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification required for procedures in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	10% coinsurance after deductible		Emergency room services for a non-emergency are not covered. Copay waived if you are admitted to hospital.
	<u>Emergency medical transportation</u>	10% coinsurance after deductible		Transportation for a non-medical emergency is not covered.
	<u>Urgent care</u>	10% coinsurance after deductible	50% coinsurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification required. Failure to pre-certify will result in a \$300 penalty.
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% coinsurance after deductible	50% coinsurance after deductible	<b>Plan year maximum:</b> Limited to thirty (30) days per plan participant. For psychological & neuropsychological testing, you pay 50% coinsurance after deductible (pre-certification required – failure to pre-certify will result in a \$300 penalty). CCT also offers an Employee Assistance Program through Alliance Work Partners (AWP) which provides up to 3 free counseling sessions each plan year (July 1 through June 30) for each type of problem you may encounter along with work-life assistance for financial and/or legal problems.
	Inpatient services	10% coinsurance after deductible	50% coinsurance after deductible	<b>Plan year maximum:</b> Thirty (30) days per plan participant [sixty (60) days lifetime maximum]. Pre-certification required. Failure to pre-certify will result in a \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	10% coinsurance after deductible	50% coinsurance after deductible	Includes preventive prenatal care and certain breastfeeding support and supplies.
	Childbirth/delivery professional services	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification required for inpatient hospital stays in excess of 48 hours (vaginal delivery) or 96 hours (C-section). Failure to pre-certify will result in a \$300 penalty. Routine newborn care counts towards the mother's expense.
	Childbirth/delivery facility services	10% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% coinsurance after deductible	50% coinsurance after deductible	<b>Plan year maximum:</b> One hundred (100) visits per plan participant. Pre-certification required for injectable medications in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.
	<u>Rehabilitation services</u>	10% coinsurance after deductible	50% coinsurance after deductible	Includes physical, speech, and occupational therapy. <b>Speech therapy plan year maximum:</b> Twenty (20) visits per plan participant. <b>Inpatient therapy plan year maximum:</b> Sixty (60) days per plan participant. Pre-certification is required for occupational, speech, and physical therapy treatment programs (penalty applied per condition). Failure to pre-certify will result in a \$300 penalty.
	<u>Habilitation services</u>	Not Covered	Not Covered	_____none_____
	<u>Skilled nursing care</u>	10% coinsurance after deductible	50% coinsurance after deductible	<b>Plan year maximum:</b> Sixty (60) days per plan participant. Pre-certification required. Failure to pre-certify will result in a \$300 penalty.
	<u>Durable medical equipment</u>	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification required for any item in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.
	<u>Hospice services</u>	10% coinsurance after deductible	50% coinsurance after deductible	<b>Benefit maximum:</b> Sixty (60) days per 12 consecutive months per plan participant. Pre-certification of inpatient services required. Failure to pre-certify will result in a \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If your child needs dental or eye care</b>	Children's eye exam	10% coinsurance after deductible	50% coinsurance after deductible	<b>Routine eye exam plan year maximum:</b> One (1) routine eye exam per plan participant. This describes benefits provided by your medical plan. CCT 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.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b>		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Ambulance transportation for a non-medical emergency</li> <li>Cosmetic surgery (except for reconstructive surgery and correction of congenital defects)</li> <li>Dental care (covered under stand-alone dental plan)</li> </ul>	<ul style="list-style-type: none"> <li>Emergency room services for a non-medical emergency</li> <li>Glasses (covered under stand-alone vision plan)</li> <li>Habilitation services</li> <li>Infertility treatment (except diagnosis)</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (except for routine eye exam) All other eye care is covered under stand-alone vision plan.</li> <li>Routine foot care (except as medically necessary)</li> <li>Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b>		
<ul style="list-style-type: none"> <li>Bariatric surgery (for the treatment of morbid obesity only)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care (20 visits per plan year)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (Limited to one aid every three years. Subject to a maximum benefit payable of \$1,000)</li> </ul>

**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](http://www.dol.gov/ebsa/healthreform). You may also contact the Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise ID 83707, 1-855-258-6455.

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](http://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 Cochise Combined Trust at 1-928-753-4700 or 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  
1-855-258-6455

**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 1-855-258-6455.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6455.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-258-6455.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-258-6455.

—————*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 <u>deductible</u> /family	\$2,600
■ <u>Specialist cost sharing</u>	0%
■ <u>Hospital (facility) cost sharing</u>	0%
■ <u>Other cost sharing</u>	0%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,600
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$600
<b>The total Peg would pay is</b>	<b>\$3,200</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u> /person	\$1,300
■ <u>Specialist cost sharing</u>	0%
■ <u>Hospital (facility) cost sharing</u>	0%
■ <u>Other cost sharing</u>	0%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,300
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$1,330</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u> /person	\$1,300
■ <u>Specialist cost sharing</u>	0%
■ <u>Hospital (facility) cost sharing</u>	0%
■ <u>Other cost sharing</u>	0%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,300
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

This coverage example assumes that the mother and newborn must meet the family deductible and out-of-pocket limit.