Cochise Combined Trust: Buy-Up EPO

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 1-855-258-6455. 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 1-855-258-6455 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	**Per participant:**	$300	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 family:	$900	
Are there services covered before you meet your deductible?	**Yes**. Preventive care, office visit copayments, ambulance, and prescription drug copayments.		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 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?	**Medical 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.
	Per participant:	$5,500	
	Per family:	$11,000	

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	The Medical Out-of-Pocket Limit does not include premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	This plan only provides coverage when you use an in-network provider. There is no coverage under the plan if you use an out-of-network provider, unless due to a medical emergency. **Yes, for Medical:** BlueCross® BlueShield® of Arizona. For a list of in-network providers, call BCBSAZ at 1-800-232-2345 or visit www.azblue.com/CHSnetwork. PHCS Healthy Directions is available to members living or traveling outside AZ. For a list of in-network providers, call PHCS at 1-800-678-7427 or visit www.multiplan.com/search. **Yes**, **for Prescription Drugs:** For a list of retail and mail pharmacies, log on to www.navitus.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.

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

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	Not Covered	Copay applies per visit regardless of what services are rendered. CCT also provides coverage for telephonic consultations through Teladoc. For Teladoc consultations, you pay $40. To access this service logon to your Teladoc account or call 1-800-Teladoc.
	Specialist visit	$40 copay/visit	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes all preventive services as well as routine well care [routine physicals, gynecological exams, pap smears, routine laboratory tests/ x-rays, mammograms (includes 3D mammograms), cancer screenings, biometric on-site screenings, body scans, bone density scans, and flu shots]. **Wellness care (not defined by PPACA) plan year maximum:** $750 per plan participant for services not covered by healthcare reform. Biometric on-site screenings are not deducted from the plan year maximum.
If you have a test	Diagnostic test (x-ray, blood work)	**Charges Under $500** PCP: $30 copay/visit Specialist: $40 copay/visit All Other Locations: $30 copay/visit **Single test over $500 allowable** 20% coinsurance after deductible	Not Covered	**Pre-certification is required** for procedures in excess of $1,000.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	**Pre-certification is required.**

* 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
		Preferred Pharmacy (You will pay the least)	Non-Preferred Pharmacy	Out-of-Network Pharmacy (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.navitus.com.	Generic drugs	**30 day supply** $10 copay **90 day supply** $20 copay	**30 day supply** $15 copay **90 day supply** $25 copay	Not Covered	Prescription drug charges apply to the out-of-pocket limit. The Plan works with the Copay Max Plus Program to obtain copayment assistance on your behalf. This program applies to certain prescription drugs that have manufacturer-funded copayment assistance programs available. 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 appropriate brand copayment plus the difference in cost between the brand name and generic drugs. The plan participant's share of this cost difference does not apply toward the Plan's out-of-pocket limit. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.navitus.com. *Specialty drugs must be obtained through the Navitus Specialty Pharmacy Program.
	Preferred brand drugs	**30 day supply** $30 copay **90 day supply** $60 copay	**30 day supply** $35 copay **90 day supply** $65 copay	Not Covered	
	Non-preferred brand drugs	**30 day supply** $60 copay **90 day supply** $120 copay	**30 day supply** $65 copay **90 day supply** $125 copay	Not Covered	
	Specialty drugs	**30 day supply*** 20% copay up to $150	Not Covered	Not Covered	

* 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	**Pre-certification is required** for procedures in excess of $1,000 (except colonoscopies and sigmoidoscopies [both screening and diagnostic]).
	Physician/surgeon fees	**Office Surgery Charges under $500** PCP: $30 copay/visit Specialist: $40 copay/visit All Other Locations: 20% coinsurance after deductible **Surgery Charges over $500** 20% coinsurance after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	$250 copay/occurrence plus 20% coinsurance after deductible		Emergency room services for a non-emergency are not covered. Copay waived if you are admitted to hospital.
	Emergency medical transportation	20% coinsurance		The deductible does not apply. Transportation for a non-medical emergency is not covered. **Pre-certification is required** for fixed wing ambulance.
	Urgent care	$40 copay/occurrence	Not Covered	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not Covered	**Pre-certification is required.**
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	

* 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	PCP: $30 copay/visit Specialist: $40 copay/visit	Not Covered	For psychological & neuropsychological testing, you pay 50% coinsurance after deductible. These services are not covered out-of-network. **Pre-certification is required** for psychological and neuropsychological testing**.** **Pre-certification is required** for partial hospitalization and intensive outpatient programs in excess of eighteen (18) visits per year. CCT also offers an Employee Assistance Program through CuraLinc, which provides up to five (5) free counseling sessions each plan year for each type of problem you may encounter along with work-life assistance for financial and/or legal problems.
	Inpatient services	20% coinsurance after deductible	Not Covered	**Pre-certification is required.**
If you are pregnant	Office visits	$30 copay for initial visit only	Not Covered	Includes preventive prenatal care and certain breastfeeding support and supplies.
	Childbirth/delivery professional services	20% coinsurance after deductible	Not Covered	Routine newborn care counts towards the mother's expense. **Pre-certification is required** for inpatient hospital stays in excess of forty eight (48) hours (vaginal delivery) or ninety six (96) hours (C-section).
	Childbirth/delivery facility services	20% coinsurance after deductible	Not Covered	

* 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	**Plan year maximum:** Sixty (60) visits per plan participant. **Pre-certification is required** for home health care services, as well as for injectable medications in excess of $1,000.
	Rehabilitation services	Non-Hospital Based Occupational Therapy/Physical Therapy: $10 copay/visit All Other: 20% coinsurance after deductible	Not Covered	Includes physical, speech, and occupational therapy. **Speech therapy plan year maximum:** Twenty (20) visits per plan participant. **Inpatient therapy plan year maximum:** Sixty (60) days per plan participant. **Pre-certification is required** for occupational, speech, and physical therapy treatment programs.
	Habilitation services	Not Covered	Not Covered	——————————none——————————
	Skilled nursing care	20% coinsurance after deductible	Not Covered	**Plan year maximum:** Ninety (90) days per plan participant. **Pre-certification is required.**
	Durable medical equipment	20% coinsurance after deductible	Not Covered	**Pre-certification is required** for any item in excess of $1,000.
	Hospice services	20% coinsurance after deductible	Not Covered	**Benefit maximum:** Sixty (60) days per twelve (12) consecutive months per plan participant. **Pre-certification of inpatient services is required.**
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	**Routine eye exam plan year maximum:** One (1) routine eye exam per plan participant. This describes benefits provided by your medical plan. CCT provides Dental and Vision coverage
	Children's glasses	Not Covered	Not Covered	

* 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered	Not Covered	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.

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
- Ambulance transportation for a non-medical emergency
- Cosmetic surgery (except for reconstructive surgery and correction of congenital defects)
- Dental care (covered under stand-alone dental plan)
- Emergency room services for a non-medical emergency
- Glasses (covered under stand-alone vision plan)
- Habilitation services
- Infertility treatment (except diagnosis)
- Long-term care
- Non-emergency care provided by an out-of-network provider
- Non-emergency care when traveling outside the U.S.
- Prescription drugs purchased from a non-network pharmacy
- Private-duty nursing
- Routine eye care (except for routine eye exam) All other eye care is covered under stand-alone vision plan.
- Routine foot care (except as medically necessary)
- 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 (for the treatment of morbid obesity only)
- Chiropractic care (limited to twenty (20) visits per plan year)
- Hearing aids (Limited to two (2) aids every three (3) years. Subject to a maximum benefit payable of $2,000)

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. 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 or call 1-800-318-2596.

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

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, kwiijigo holne' 1-855-258-6455.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* 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 /family	**$300**
Specialist copayment	**$40**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**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	$300
Copayments	$40
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,760**

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

The plan's overall deductible	**$300**
Specialist copayment	**$40**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,100**

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

The plan's overall deductible	**$300**
Specialist copayment	**$40**
Hospital (facility) cost sharing	**20%**
Other cost sharing	**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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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