Cochise Combined Trust: EPO Plan

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,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:**	$600	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:	$1,800	
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 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?	**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:	$9,100	
	Per family:	$18,200	

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. **Yes**, **for Prescription Drugs:** For a list of retail and mail pharmacies, log on to www.optumRx.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. Mayo Clinic is non-network.
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 AZBlue Telehealth at $30 per visit. To access this service log on to www.AZBluetelehealth.com.
	Specialist visit	$45 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: $45 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
		In-Network Provider (You will pay the least)	Out-of-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.	Generic drugs	**30 day supply** $10 copay **90 day supply** $20 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.optumRx.com.
	Preferred brand drugs	**30 day supply** $30 copay **90 day supply** $60 copay	Not Covered	
	Non-preferred brand drugs	**30 day supply** $60 copay **90 day supply** $120 copay	Not Covered	
	Specialty drugs	**30 day supply** 20% copay up to $150	Not Covered	

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: $45 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	$45 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	

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: $45 copay/visit	Not Covered	**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 calendar year. CCT also provides coverage for telephonic consultations through AZBlue Telehealth at www.azbluetelehealth.com at $30 per visit. CCT also offers an Employee Assistance Program through ComPsych, which provides up to five (5) 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	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	

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, 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.
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 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:

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.

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.

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	**$600**
Specialist copayment	**$45**
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	$600
Copayments	$40
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	**$600**
Specialist copayment	**$45**
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	$600
Copayments	$500
Coinsurance	$60
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,360**

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

The plan's overall deductible	**$600**
Specialist copayment	**$45**
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	$600
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma
sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID
卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của
tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각
장애인이신가요? 다른 형식으로
된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga
format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи
на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы
со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու
ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua
lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi
di vista? È possibile richiedere anche altri formati di
questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache
zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert?
Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei
ID Card. Hoscht Druwwel fer sehne? Du kannscht des
do Schreiwes in en differnter Weg griege so as du's
besser sehne kannscht.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications-as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language

assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 7186 Boise, ID 83707, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf