

Cochise Combined Trust: EPO Plan

Coverage for: Single + Family Plan Type: 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, 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](http://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:  | \$500    | 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.<br>If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
|   | Per family:   | \$1,500  |   |
| Are there services covered before you meet your deductible? | Yes. Preventive care, office visit copayments, ambulance, and prescription drug copayments. |          | 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> . |
| Are there other deductibles for specific services?          | No.   |          | No. You don't have to meet <u>deductibles</u> for specific services.  |
| What is the out-of-pocket limit for this plan?              | Medical Out-of-Pocket Limit   |          | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.<br>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.  |
|   | Per participant:  | \$6,000  |   |
|   | Per family:   | \$14,300 |   |

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| <p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p> | <p>The Medical Out-of-Pocket Limit does not include premiums, pre-certification penalty amounts, balance-billed charges, and health care this plan doesn't cover.</p>   | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>  |
| <p><b>Will you pay less if you use a <u>network provider</u>?</b></p> | <p>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.</p> <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>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 <a href="http://www.multiplan.com/search">www.multiplan.com/search</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> | <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.</p> |
| <p><b>Do you need a referral to see a <u>specialist</u>?</b></p>      | <p>No.</p>  | <p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.MyAmeriBen.com](http://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<br>(You will pay the least)  | Out-of-Network Provider<br>(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 | \$25 copay/visit   | Not Covered  | <p><u>Copay</u> applies per visit regardless of what services are rendered.</p> <p>CCT also provides coverage for telephonic consultations through Teladoc. For Teladoc consultations, you pay \$0 for the first two (2) consultations. Thereafter, you pay \$35/consultation. To access this service logon to your Teladoc account or call 1-800-Teladoc.</p> <p>Includes all <u>preventive services</u> as well as routine well care [routine physicals, gynecological exams, routine laboratory tests/x-rays, mammograms (includes 3D mammograms), cancer screenings, biometric on-site screenings, body scans, bone density scans, and flu shots.</p> <p><b>Wellness care (not defined by PPACA) plan year maximum:</b> \$500 per plan participant for services not covered by healthcare reform. Biometric on-site screenings are not deducted from the plan year maximum.</p> |
|  | <u>Specialist</u> visit                          | \$35 copay/visit   | Not Covered  |   |
|  | <u>Preventive care/screening/immunization</u>    | No Charge  | Not Covered  |   |
| If you have a test                                     | <u>Diagnostic test</u> (x-ray, blood work)       | <p><b>Charges Under \$500</b><br/>           PCP: \$25 copay/visit<br/>           Specialist: \$35 copay/visit<br/>           All Other Locations: \$25 copay/visit</p> <p><b>Single test over \$500 allowable</b><br/>           20% coinsurance after deductible</p> | Not Covered  | <p><b><u>Pre-certification</u> is required</b> for procedures in excess of \$1,000. Failure to <u>pre-certify</u> will result in a \$300 penalty.</p>   |

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| Common Medical Event   | Services You May Need        | What You Will Pay   |   |  | Limitations, Exceptions, & Other Important Information  |
|--|------------------------------|---|---|--|---|
|  |                              | In-Network Provider<br>(You will pay the least)                               |   | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you have a test</b>  | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible  |   | Not Covered  | <b>Pre-certification is required.</b> Failure to <u>pre-certify</u> will result in a \$300 penalty.   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.navitus.com">www.navitus.com</a> . | Generic drugs                | <b>30 day supply</b><br>\$10 copay<br><br><b>90 day supply</b><br>\$20 copay  | <b>30 day supply</b><br>\$15 copay<br><br><b>90 day supply</b><br>\$25 copay  | Not Covered  | <p><u>Prescription drug</u> charges apply to the <u>out-of-pocket</u> limit.</p> <p>The <u>Plan</u> requires that retail pharmacies dispense generic drugs when available. If you or your <u>physician</u> specifies that a brand name drug should be dispensed when a generic drug is available, you will pay the appropriate brand <u>copayment</u> 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 <u>Plan's out-of-pocket</u> limit.</p> <p>Not all <u>prescription drugs</u> 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>.</p> <p>*Specialty drugs must be obtained through the Navitus Specialty Pharmacy Program.</p> |
|  | Preferred brand drugs        | <b>30 day supply</b><br>\$30 copay<br><br><b>90 day supply</b><br>\$60 copay  | <b>30 day supply</b><br>\$35 copay<br><br><b>90 day supply</b><br>\$65 copay  | Not Covered  |   |
|  | Non-preferred brand drugs    | <b>30 day supply</b><br>\$60 copay<br><br><b>90 day supply</b><br>\$120 copay | <b>30 day supply</b><br>\$65 copay<br><br><b>90 day supply</b><br>\$125 copay | Not Covered  |   |
|  | <u>Specialty drugs</u>       | <b>30 day supply*</b><br>\$100 copay  | Not Covered   | Not Covered  |   |

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| Common Medical Event                    | Services You May Need                          | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|---|--|---|--|---|
|   |  | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |   |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible  | Not Covered  | <b>Pre-certification is required</b> for procedures in excess of \$1,000. Failure to <u>pre-certify</u> will result in a \$300 penalty.                               |
|   | Physician/surgeon fees                         | <b>Office Surgery Charges under \$500</b><br>PCP: \$25 copay/visit<br>Specialist: \$35 copay/visit<br>All Other Locations:<br>20% coinsurance after deductible<br><br><b>Surgery Charges over \$500</b><br>20% coinsurance after deductible | Not Covered  |   |
| If you need immediate medical attention | <u>Emergency room care</u>                     | \$250 copay/occurrence plus 20% coinsurance after deductible  |  | <u>Emergency room</u> services for a non-emergency are not covered.<br>Copay waived if you are admitted to <u>hospital</u> .<br>The <u>deductible</u> does not apply. |
|   | <u>Emergency medical transportation</u>        | 20% coinsurance   |  | Transportation for a non-medical emergency is not covered.<br><b>Pre-certification is required</b> for fixed wing ambulance.  |
|   | <u>Urgent care</u>                             | \$35 copay/occurrence   | Not Covered  | —————none—————  |
| If you have a hospital stay             | Facility fee (e.g., hospital room)             | 20% coinsurance after deductible  | Not Covered  | <b>Pre-certification is required.</b> Failure to <u>pre-certify</u> will result in a \$300 penalty.   |
|   | Physician/surgeon fees                         | 20% coinsurance after deductible  | Not Covered  |   |

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| Common Medical Event   | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|--|---|---|--|--|
|  |   | In-Network Provider<br>(You will pay the least)           | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | PCP: \$25 copay/visit<br><br>Specialist: \$35 copay/visit | Not Covered  | For psychological & neuropsychological testing, you pay 50% coinsurance after <u>deductible</u> . These services are not covered <u>out-of-network</u> .<br><br><b><u>Pre-certification is required</u></b> for psychological and neuropsychological testing. Failure to <u>pre-certify</u> will result in a \$300 penalty.<br><br><b><u>Pre-certification is required</u></b> for partial hospitalization and intensive outpatient programs in excess of eighteen (18) visits per calendar year.<br><br>CCT also offers an Employee Assistance Program through Alliance Work Partners (AWP) which provides up to three (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                        | 20% coinsurance after deductible                          | Not Covered  | <b><u>Pre-certification is required</u></b> . Failure to <u>pre-certify</u> will result in a \$300 penalty.  |
| <b>If you are pregnant</b>   | Office visits                             | \$25 copay for initial visit only                         | Not Covered  | Includes <u>preventive</u> 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.  |
|  | Childbirth/delivery facility services     | 20% coinsurance after deductible                          | Not Covered  | <b><u>Pre-certification is required</u></b> for inpatient hospital stays in excess of forty eight (48) hours (vaginal delivery) or ninety six (96) hours (C-section). Failure to <u>pre-certify</u> will result in a \$300 penalty.  |

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| Common Medical Event   | Services You May Need            | What You Will Pay                               |  | Limitations, Exceptions, & Other Important Information  |
|--|----------------------------------|---|--|---|
|  |                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | 20% coinsurance after deductible                | Not Covered  | <p><b>Plan year maximum:</b> Sixty (60) visits per plan participant.</p> <p><b>Pre-certification is required</b> for <u>home health care</u>, as well as for injectable medications in excess of \$1,000. Failure to <u>pre-certify</u> will result in a \$300 penalty.</p>   |
|  | <u>Rehabilitation services</u>   | 20% coinsurance after deductible                | Not Covered  | <p>Includes physical, speech, and occupational therapy.</p> <p><b>Speech therapy plan year maximum:</b> Twenty (20) visits per plan participant.</p> <p><b>Inpatient therapy plan year maximum:</b> Sixty (60) days per plan participant.</p> <p><b>Pre-certification is required</b> for occupational, speech, and physical therapy treatment programs. Failure to <u>pre-certify</u> will result in a \$300 penalty. Penalty will be applied per condition.</p> |
|  | <u>Habilitation services</u>     | Not Covered                                     | Not Covered  | _____none_____  |
|  | <u>Skilled nursing care</u>      | 20% coinsurance after deductible                | Not Covered  | <p><b>Plan year maximum:</b> Ninety (90) days per plan participant.</p> <p><b>Pre-certification is required.</b> Failure to <u>pre-certify</u> will result in a \$300 penalty.</p>  |
|  | <u>Durable medical equipment</u> | 20% coinsurance after deductible                | Not Covered  | <p><b>Pre-certification is required</b> for any item in excess of \$1,000. Failure to <u>pre-certify</u> will result in a \$300 penalty.</p>  |
|  | <u>Hospice services</u>          | 20% coinsurance after deductible                | Not Covered  | <p><b>Benefit maximum:</b> Sixty (60) days per twelve (12) consecutive months per plan participant.</p> <p><b>Pre-certification of inpatient services is required.</b> Failure to <u>pre-certify</u> will result in a \$300 penalty.</p>  |

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| Common Medical Event                          | Services You May Need      | What You Will Pay                                     |  | Limitations, Exceptions, & Other Important Information  |
|---|----------------------------|---|--|---|
|   |                            | In-Network Provider<br>(You will pay the least)       | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | PCP: \$25 copay/visit<br>Specialist: \$35 copay/visit | Not Covered  | <b>Routine eye exam plan year maximum:</b> One (1) routine eye exam per plan participant.<br><br>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](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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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 \$500
- Specialist copayment \$35
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> |         |
|---------------------|---------|
| Deductibles         | \$500   |
| Copayments          | \$40    |
| Coinsurance         | \$2,400 |

| <i>What isn't covered</i> |      |
|---------------------------|------|
| Limits or exclusions      | \$20 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$2,960</b> |
|-----------------------------------|----------------|

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

- The plan's overall deductible \$500
- Specialist copayment \$35
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> |       |
|---------------------|-------|
| Deductibles         | \$500 |
| Copayments          | \$400 |
| Coinsurance         | \$80  |

| <i>What isn't covered</i> |       |
|---------------------------|-------|
| Limits or exclusions      | \$200 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$1,180</b> |
|-----------------------------------|----------------|

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

- The plan's overall deductible \$500
- Specialist copayment \$35
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> |       |
|---------------------|-------|
| Deductibles         | \$500 |
| Copayments          | \$400 |
| Coinsurance         | \$400 |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$1,300</b> |
|-----------------------------------|----------------|