

Cochise Combined Trust: EPO Plan

Coverage Period: 07/01/2016 – 06/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family

Plan Type: EPO



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 1-855-258-6455.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$350 per person \$1,050 per family Applies to all services, except as specified below.	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. Medical Out-of-Pocket Limit: \$3,000 per person \$13,700 per family Prescription Drug Out-of-Pocket Limit: \$3,850 per person Prescription drug charges for family coverage apply to the Medical Family Out-of-Pocket Limit.	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?	The Medical Out-of-Pocket Limit does not include premiums, pre-certification penalty amounts, balance-billed charges, prescription drug copayments (for individual coverage), charges for mental health and substance use disorder treatment, and health care this plan doesn't cover.	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?	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 . Yes, for Prescription Drugs: For a list of retail and mail pharmacies, log on to www.navitus.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 .
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 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-855-258-6455 or visit us at www.MyAmeriBen.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.MyAmeriBen.com or www.dol.gov/ebsa/healthreform or call 1-866-4-USA-DOL to request a copy. **1 of 8**



- **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 **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider Note* EPO only offers coverage out-of-network in the case of a medical emergency.	Out-of-Network Provider	
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	Copay applies per visit regardless of what services are rendered. The deductible does not apply. CCT also provides coverage for telephonic consultations through Teladoc. For Teladoc consultations, you pay \$0 for the first two consultations. Thereafter, you pay \$45/consultation. To access this service logon to your Teladoc account or call 1-800-Teladoc (835-2362). Plan year maximum: Twenty (20) visits per plan participant (\$40 maximum payable per visit). The deductible does not apply.
	Specialist visit	\$35 copay/visit	Not Covered	
	Other practitioner office visit	Chiropractic Treatment \$25 copay/visit	Not Covered	
	Preventive care/screening/immunization	No Charge	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	Charges under \$500		The deductible does not apply (this benefit is for charges under \$500). Any single diagnostic procedure that has an allowable amount of \$500 or more. Pre-certification required for procedures in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.
		PCP: \$25 copay/visit Specialist: \$35 copay/visit All Other Locations: \$25 copay/visit	Not Covered	
	Single test over \$500 allowable		20% coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	Pre-certification required for procedures in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.

Common Medical Event	Services You May Need	Your Cost If You Use an			Limitations & Exceptions
		Preferred Pharmacy	Non-Preferred Pharmacy	Out-of-Network Pharmacy	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.navitus.com.</p>	Generic drugs	\$10 copay/30-day supply \$20 copay/90-day supply	\$15 copay/30-day supply \$25 copay/90-day supply	Not Covered	<p>Prescription drug charges for individual coverage apply to the Prescription Drug Out-of-Pocket limit.</p> <p>Prescription drug charges for family coverage apply to the Medical Family Out-of-Pocket limit.</p> <p>The deductible does not apply. Copay applies per prescription. 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.</p> <p>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 co-payment 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.</p> <p>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.</p> <p>*Specialty drugs must be obtained through the Navitus Specialty Pharmacy Program.</p>
	Preferred brand drugs	\$30 copay/30-day supply \$60 copay/90-day supply	\$35 copay/30-day supply \$65 copay/90-day supply	Not Covered	
	Non-preferred brand drugs	\$60 copay/30-day supply \$120 copay/90-day supply	\$65 copay/30-day supply \$125 copay/90-day supply	Not Covered	
	Specialty drugs	\$100 copay/30-day supply*	Not Covered	Not Covered	
Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions	
		In-Network Provider	Out-of-Network Provider		
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	<p>Pre-certification required for procedures in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.</p>	
	Physician/surgeon fees	<p>Office Surgery Charges under \$500</p> <p>PCP: \$25 copay/visit Specialist: \$35 copay/visit All Other Locations: 20% coinsurance after deductible</p> <p>Surgery Charges over \$500</p> <p>20% coinsurance after deductible</p>	Not Covered		

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency room services	\$100 copay/occurrence + 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.
	Urgent care	\$50 copay/occurrence	Not Covered	The deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not Covered	Pre-certification required. Failure to pre-certify will result in a \$300 penalty.
	Physician/surgeon fee	20% coinsurance after deductible	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	PCP: \$25 copay/visit Specialist: \$35 copay/visit	Not Covered	The deductible does not apply. 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 EAP Preferred which provides up to three (3) free counseling sessions each plan year (July 01 through June 30) for each type of problem you may encounter along with work-life assistance for financial and/or legal problems.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	Not Covered	Plan year maximum: Thirty (30) days per plan participant [sixty (60) days lifetime maximum]. Pre-certification required. Failure to pre-certify will result in a \$300 penalty.
	Substance use disorder outpatient services	PCP: \$25 copay/visit Specialist: \$35 copay/visit	Not Covered	The deductible does not apply. CCT also offers an Employee Assistance Program through EAP Preferred which provides up to three (3) free counseling sessions each plan year (July 01 through June 30) for each type of problem you may encounter along with work-life assistance for financial and/or legal problems.
	Substance use disorder inpatient services	20% coinsurance after deductible	Not Covered	Plan year maximum: Thirty (30) days per plan participant [sixty (60) days lifetime maximum]. Pre-certification required. Failure to pre-certify will result in a \$300 penalty.
If you are pregnant	Prenatal and postnatal care	No charge (\$25 copay for initial visit only)	Not Covered	The deductible does not apply. Includes preventive prenatal care and certain breastfeeding support and supplies.
	Delivery and all inpatient services	20% coinsurance after deductible	Not Covered	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.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
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 required for injectable medications in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.
	Rehabilitation services	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 (penalty applied per condition). Failure to pre-certify will result in a \$300 penalty.
	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 required. Failure to pre-certify will result in a \$300 penalty.
	Durable medical equipment	20% coinsurance after deductible	Not Covered	Pre-certification required for any item in excess of \$1,000. Failure to pre-certify will result in a \$300 penalty.
	Hospice service	20% coinsurance after deductible	Not Covered	Benefit maximum: 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.
If your child needs dental or eye care	Eye exam	PCP: \$25 copay/visit Specialist: \$35 copay/visit	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.
	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.)

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|--|---|--|
| <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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. | <ul style="list-style-type: none"> • 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 |
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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.)

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|--|---|--|
| <ul style="list-style-type: none"> • Bariatric surgery (for the treatment of morbid obesity only) | <ul style="list-style-type: none"> • Chiropractic care | <ul style="list-style-type: none"> • Hearing aids |
|--|---|--|

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, 1-855-258-6455. 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 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 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 1-855-258-6455.

[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, kwiiijigo holne' 1-855-258-6455.

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 \$5,200
- Patient pays \$2,340

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	\$700
Copays	\$40
Coinsurance	\$1,300
Limits or exclusions	\$300
Total	\$2,340

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,100
- Patient pays \$1,300

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	\$0
Copays	\$1,000
Coinsurance	\$0
Limits or exclusions	\$300
Total	\$1,300

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.