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 by calling the plan at 888-690-2020. (Note: the Uniform Glossary can be accessed at: www.dol.gov/ebsa/healthreform).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Per calendar year - **PPO -** $350 Individual/$1,050 Family **Non-PPO -** $700 Individual/$2,100 Family; **Deductible** doesn't apply to preventive care	You must pay all costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See 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?	Yes per calendar year – Dental Benefits - $50 Individual/$150 Family	You must pay all of the costs for these services up to the specific **deductible** amount before the **plan** begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes per calendar year - **PPO** - $3,000 Individual	The **out-of-pocket limit** is the most you could pay for covered services 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?	**Premiums, balanced billed charges, copays, deductibles,** 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?	Yes – Medical/Prescription Drugs - $2,000,000 Dental - $1,500	This **plan** will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of participating providers?	Yes. See www.azblue.com/chsnetwork for a list of **PPO providers**	If you use a **PPO provider** doctor or other health care provider, this **plan** will pay some or all of the costs of covered services. Be aware, your **PPO provider** doctor or hospital may use a **Non-PPO provider** for some services. Plans use the term **in-network, preferred or participating providers** in their network. See the chart starting on page 2 for how this **plan** pays different providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from the **plan.**
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or **plan** document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	**Primary care** visit to treat an injury or illness	20% **coinsurance** after $25 **copay**	50% **coinsurance**	
	Specialist visit	20% **coinsurance** after $35 **copay**	50% **coinsurance**	
	Other practitioner office visit Chiropractor Rehabilitative Therapy	 $25 **copay** 20% **coinsurance** after $50 **copay**	 50% **coinsurance** 50% **coinsurance**	 Chiropractor limited to $1,200 per benefit year
	Preventive care/screening/immunization	0% **coinsurance**	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work) Lab tests under $500 X-rays Complex tests over $500	20% **coinsurance** after $25 **copay** 20% **coinsurance** 20% **coinsurance**	50% **coinsurance** 50% **coinsurance** 50% **coinsurance**	Precertification required for tests over $1,000. 20% reduction in benefits for noncompliance.
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	50% **coinsurance**	Precertification required for tests over $1,000. 20% reduction in benefits for noncompliance.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mycatamaranRx.com	Generic drugs	Retail - $15 **copay** Mail - $30 **copay**	**Copay** plus difference in cost between **PPO** & **Non-PPO**	Limited to: 30 day supply – Retail 90 day supply – Mail
	Preferred Brand Name drugs	Retail – 20% of prescription cost with a $20 minimum **copay** and $75 maximum **copay** Mail – 20% of prescription cost with a $40 minimum **copay** and $150 maximum **copay**	**Copay** plus difference in cost between **PPO** & **Non-PPO**	Limited to: 30 day supply – Retail 90 day supply – Mail If you purchase a name brand drug when a generic can be dispensed, you will pay the **copay** plus the cost difference between generic and name brand.
	Non-Preferred Brand Name drugs	Retail – 30% of prescription cost with a $35 minimum **copay** and $100 maximum **copay** Mail – 30% of prescription cost with a $70 minimum **copay** and $200 maximum **copay**	**Copay** plus difference in cost between **PPO** & **Non-PPO**	Limited to: 30 day supply – Retail 90 day supply – Mail If you purchase a name brand drug when a generic can be dispensed, you will pay the **copay** plus the cost difference between generic and name brand.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	50% **coinsurance**	Precertification required. 20% benefit reduction for noncompliance.
	Physician/surgeon fees	20% **coinsurance**	50% **coinsurance**	Surgery under $1,000 in **PPO provider** office is covered under office visit **copay.**
If you need immediate medical attention	Emergency room services	20% **coinsurance** after $100 **copay**	20% **coinsurance** after $100 **copay**	**Copay** waived if admitted.
	Emergency medical transportation Ground Air	20% **coinsurance** 20% **coinsurance** after $200 **copay**	20% **coinsurance** 20% **coinsurance** after $200 **copay**	
	Urgent care	20% **coinsurance**	50% **coinsurance** after $50 **copay**	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance** after $200 **copay**	50% **coinsurance** after $300 **copay**	Precertification required. 20% benefit reduction for noncompliance.
	Physician/surgeon fee	20% **coinsurance**	50% **coinsurance**	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% **coinsurance**	50% **coinsurance**	
	Mental/Behavioral health inpatient services	20% **coinsurance** after $200 **copay**	50% **coinsurance** after $300 **copay**	Precertification required. 20% benefit reduction for noncompliance.
	Substance abuse disorder outpatient services	20% **coinsurance**	50% **coinsurance**	
	Substance abuse disorder inpatient services	20% **coinsurance** after $200 **copay**	50% **coinsurance** after $300 **copay**	Precertification required. 20% benefit reduction for noncompliance.
If you are pregnant	Prenatal and postnatal care **Physician**	20% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Delivery and all inpatient services Facility **Physician**	20% **coinsurance** after $200 **copay** 20% **coinsurance**	50% **coinsurance** after $300 **copay** 50% **coinsurance**	
If you need help recovering or have other special health needs	**Home health care**	20% **coinsurance**	50% **coinsurance**	Covers up to 60 visits per benefit year
	Rehabilitation services Inpatient Outpatient	20% **coinsurance** after $25 per day **copay** 20% **coinsurance** after $50 **copay**	50% **coinsurance** 50% **coinsurance**	Precertification required for services over $1,500. 20% benefit reduction for noncompliance.
	Habilitation services	20% **coinsurance**	50% **coinsurance**	Covers up to 60 days per benefit year
	Skilled nursing care	20% **coinsurance**	50% **coinsurance**	
	Durable medical equipment	20% **coinsurance**	50% **coinsurance**	
	Hospice service	20% **coinsurance**	50% **coinsurance**	
If your child needs dental or eye care	Eye exam	0% **coinsurance**	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	0% **coinsurance**	0% **coinsurance**	$1,500 maximum per benefit year for all dental services combined

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.)

- Acupuncture
- Cosmetic Surgery
- Dependent Child Pregnancy
- Infertility Treatment
- Long Term Care
- Refractive Eye Surgery
- Weight Loss Programs

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.)

- Bariatric Surgery
- Chiropractic Care ($1,200 annually)
- Cochlear Implants ($1,500 every 3 years)
- Hearing Aids ($1,500 every 3 years)
- Infertility Testing
- Some Routine Foot Care
- Treatment of TMJ ($1,000 maximum benefit)

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 928-633-6592. 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 X 61565 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: Navajo County Schools: (928) 633-6592 or the Department of Labor, Employee Benefit Security Administration at 1-866-444-EBSA or www.dol.ebsa/healthreform

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** $6,845
- **Patient pays** $2,595

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	$350
Copays	$275
Coinsurance	$1,170
Limits or exclusions	$900
Total	**$2,595**

Note: Assumes **PPO Providers**
Assumes all charges are for the mother except routine nursery, vaccines and other preventive
Assumes 5 generic prescriptions

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,104
- **Patient pays** $1,296

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	$350
Copays	$325
Coinsurance	$321
Limits or exclusions	$300
Total	**$1,296**

Note: Assumes **PPO Providers**
Assumes 12 generic prescriptions
Assumes 4 physician office visits

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.