

Yavapai Combined Trust (YCT): Basic Plus Plan

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

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

Coverage for: Individual + 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.summit-inc.net or www.yctrust.net or by calling Summit Administration Services, Inc. at 1-888-690-2020.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network Provider: \$600 /person per year; \$1,200 /family per year. Non-network provider: No coverage except in an emergency. Does not apply to certain preventive care, in-network PCP office visits & non-hospital based lab & behavioral health counseling visits, plan-required second & third physician opinions and outpatient prescription drugs. Copayments, non-covered expenses, and a penalty for failure to obtain precertification do not count toward the <u>deductible</u> .	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, In-network Provider: \$6,000 /person per year; \$12,000 /family per year. This plan does not cover services from Non-Network providers, except in an emergency.	The <u>out-of-pocket limit</u> 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 pay for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, non-covered expenses, copayments, deductibles, charges in excess of benefit maximums, a penalty for failure to obtain precertification, wellness services in excess of \$300/year, outpatient retail/mail order prescription drug expenses and expenses related to non-network providers do not count toward the In-Network <u>out-of-pocket limit</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of <u>in-network providers</u> , see www.azblue.com or call Summit Administration Services, Inc. at 1-888-690-2020 for assistance.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

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Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> 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 6. See your policy or plan document for additional information about <u>excluded services</u> .



- 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 In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% coinsurance, after deductible met.	Not covered.	Precertification required for procedures/treatments over \$1,000 to avoid a \$150 penalty.
	Specialist visit	40% coinsurance, after deductible met.	Not covered.	Precertification required for procedures/treatments over \$1,000 to avoid a \$150 penalty.
	Other practitioner office visit	40% coinsurance, after deductible met.	Not covered.	Acupuncture services and Chiropractic services: maximum benefit is 8 visits/plan year.
	Preventive care/screening/immunization	Immunizations: No charge. Birth – 18 months: \$20 copayment per visit, no deductible. 19 months & older: No charge for 1 st \$300 per year, no deductible, then you pay 90% coinsurance after deductible.	Not covered.	Age and frequency guidelines apply to covered preventive care. Not all preventive services required by Health Reform law are covered by this Plan. Screening Colonoscopy: In-network you pay 40% coinsurance after deductible met.

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If you have a test	Diagnostic test (x-ray, blood work)	Non-hospital based lab: No charge. Hospital based: 40% coinsurance after deductible.	Not covered.	Precertification required for procedures/treatments over \$1,000 to avoid a \$150 penalty.
	Imaging (CT/PET scans, MRIs)	40% coinsurance, after deductible met.	Not covered.	Precertification required for procedures/treatments over \$1,000 to avoid a \$150 penalty.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available from OptumRx at www.optumrx.com or call 1-866-328-2005.	Generic drugs	Retail Pharmacy for 30-day supply: \$10 copayment; Mail Order for 90-day supply: \$15 copayment.	You pay 100%. Plan reimburses billed charges minus the appropriate copay/coinsurance for generic or brand drugs.	No deductible applies to any outpatient prescription drugs. The plan offers a 90-day supply at retail : <ul style="list-style-type: none"> <input type="checkbox"/> \$30 copayment for generic <input type="checkbox"/> 20% coinsurance to a maximum of \$300 for preferred brand <input type="checkbox"/> 50% coinsurance with a minimum \$60 and maximum \$450 for non-preferred brand. If you purchase a brand drug when generic drug is available you pay the brand drug cost-sharing plus the difference in cost between the brand drug and the generic drug. If the cost of the drug is less than the copayment, you pay just the drug cost. Some prescriptions are subject to preapproval, quantity limits or step therapy requirements.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: 20% coinsurance to a max of \$100. Mail Order for 90-day supply: \$40 copayment.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: \$50% coinsurance with a \$20 minimum and \$150 maximum copayment; Mail Order for 90-day supply: \$100 copayment.		
	Specialty drugs	Up to a 30-day supply you pay the cost-sharing noted above.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance, after deductible met.	Not covered.	Precertification required for procedures/treatments over \$1,000 to avoid a \$150 penalty.
	Physician/surgeon fees	40% coinsurance, after deductible met.	Not covered.	---none---

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If you need immediate medical attention	Emergency room services	\$100 copayment/ER visit plus 40% coinsurance after deductible met.	\$100 copayment/ER visit plus 40% coinsurance after deductible met.	Copayment waived if hospitalized in 24 hrs. No coverage for non-emergency use of an emergency room.
	Emergency medical transportation	40% coinsurance after deductible met.	Not covered.	No coverage for non-emergency use of an ambulance.
	Urgent care	40% coinsurance after deductible met.	Not covered.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after deductible met.	Not covered.	Elective hospital admission requires precertification to avoid a \$150 penalty.
	Physician/surgeon fee	40% coinsurance after deductible met.		
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	40% coinsurance, after deductible met.	Not covered.	---none---
	Mental/Behavioral health inpatient services	40% coinsurance, after deductible met.	Not covered.	Elective hospital admission and partial hospitalization requires precertification to avoid a \$150 penalty.
	Substance use disorder outpatient services	40% coinsurance, after deductible met.	Not covered.	---none---
	Substance use disorder inpatient services	40% coinsurance, after deductible met.	Not covered.	Elective hospital admission and partial hospitalization requires precertification to avoid a \$150 penalty.
If you are pregnant	Prenatal and postnatal care	\$100 copayment plus 40% coinsurance after deductible met.	Not covered.	You pay 100% for prenatal and delivery expenses for a pregnant dependent child.
	Delivery and all inpatient services	40% coinsurance after deductible met.	Not covered.	Precertification required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section. You pay 100% for prenatal and delivery expenses for a pregnant dependent child.

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If you need help recovering or have other special health needs	Home health care	40% coinsurance, after deductible met.	Not covered.	Plan covers part-time or intermittent skilled nursing care. Home health maximum benefit is 60 visits/year.
	Rehabilitation services	40% coinsurance, after deductible met.	Not covered.	Outpatient physical & occupational therapy max is 50 visits/person/injury or illness. Speech therapy max is 8 visits/plan year. Inpatient rehab max is 60 days/injury or illness.
	Habilitation services	Not covered.	Not covered.	You pay 100% of these expenses.
	Skilled nursing care	40% coinsurance, after deductible met.	Not covered.	Maximum benefit is 60 days per injury or illness.
	Durable medical equipment	40% coinsurance, after deductible met.	Not covered.	Equipment over \$1,000 per item requires precertification to avoid a \$150 penalty. DME is payable at the usual cost-sharing up to \$5,000 per person/plan year, thereafter you pay 90%. Oxygen is payable at the usual cost-sharing up to \$3,000/person/plan year, thereafter you pay 90%.
	Hospice service	40% coinsurance, after deductible met.	Not covered.	Covered if terminally ill.
If your child needs dental or eye care	Eye exam	Not covered.	Not covered.	You pay 100% of these expenses. Vision benefits are purchased separately from medical benefits.
	Glasses	Not covered.	Not covered.	
	Dental check-up	Not covered.	Not covered.	You pay 100% of these expenses. Dental benefits are purchased separately from medical benefits.

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.)		
<input type="checkbox"/> Ambulance, non-emergency use	<input type="checkbox"/> Eyeglasses	<input type="checkbox"/> Non-emergency care when traveling outside the U.S.
<input type="checkbox"/> Cosmetic surgery	<input type="checkbox"/> Habilitation services	<input type="checkbox"/> Private duty nursing
<input type="checkbox"/> Dental care (Adult) (Child)	<input type="checkbox"/> Infertility treatment	<input type="checkbox"/> Routine eye care (Adult) (Child)
	<input type="checkbox"/> Long-term care	<input type="checkbox"/> 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.)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Acupuncture and Chiropractic care (combined payable up to 8 visits per plan year) | <input type="checkbox"/> Bariatric surgery (max \$20,000/lifetime) | <input type="checkbox"/> Hearing aids (max benefit is \$1,500/person every 3 years.) | <input type="checkbox"/> Routine foot care payable when medically necessary) |
|--|--|--|--|

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 Summit Administration Services, Inc. at 1-888-690-2020. 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 the Medical Plan Claims Administrator, Summit Administration Services, Inc. at 1-888-690-2020.

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 1-888-690-2020.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-690-2020.

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

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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 \$4,320
- Patient pays \$3,220

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	\$600
Copays	\$20
Coinsurance	\$2,450
Limits or exclusions	\$150
Total	\$3,220

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

- Amount owed to providers: \$5,400
- Plan pays \$3,630
- Patient pays \$1,770

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	\$600
Copays	\$400
Coinsurance	\$560
Limits or exclusions	\$210
Total	\$1,770

The coverage example above assumes that the Plan's 5 visit benefit for diabetes education has not already been met.

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.

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