ARNOLD FABRICATING AND MACHINE, INC. PPO

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
ARNOLD FABRICATING AND MACHINE, INC. BENEFIT PLAN: PPO Plan

Coverage Period: 08/01/2024 - 7/31/2025
Coverage for: Individual, Family | **Plan Type: PPO**

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, contact CAS customer service at 855-373-8232. 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.casbenefits.com or call 855-373-8232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For AIMM Tier 1 Guided Providers and For In-Network providers: $2,000 Individual / $4,000 Family; For Out-Of-Network providers: $4,000 Individual / $8,000 Family	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.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	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	There is no additional deductible amount you must meet before this plan begins to pay for specific services.
What is the out-of-pocket limit for this plan?	For AIMM Tier 1 Guided Providers and For In-Network providers: $7,000 Individual / $14,000 Family; For Out-Of-Network providers: $14,000 Individual / $28,000 Family	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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?	Yes. See www.casbenefits.com or call 855-373-8232 for a list of network providers.	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.
Do you need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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
		Tier 1 AIMM Guided (You will pay the least)	Tier 2 Participating Provider (You pay more)	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	No charge	$50 copay then Deductible Waived	50% coinsurance after deductible	
	Specialist visit	No charge	$75 copay then Deductible Waived	50% coinsurance after deductible	
	Preventive care/screening/ immunization	No charge		50% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for CT/PET scans and MRIs
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance after deductible	50% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.usrxcare.com	Tier 1 (Generic)	$0 copay Deductible waived /prescription (retail 30 and 90 days)		Not Covered	Preventive drugs: No charge Covers up to a 90-day supply (retail & mail order prescription). Specialty drugs limited to a 30-day supply. Generics Preferred program: If you purchase a brand medication over an available generic, you will pay an increased copayment. The brand copay will apply, with an added penalty equal to the difference in cost between the
	Tier 2 (Preferred Brand)	$35 copay Deductible waived /prescription (retail 30 and 90 days)		Not Covered	
	Tier 3 (Non-Preferred Brand)	$70 copay Deductible waived /prescription (retail 30 and 90 days)		Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 AIMM Guided (You will pay the least)	Tier 2 Participating Provider (You pay more)	Out-of-Network Provider (You will pay the most)	
	Tier 4 (Specialty Drugs)	20% coinsurance , deductible waived/ prescription (limited to a 30 day supply)		Not Covered	generic and the brand name medication. The penalty for brand medication is waived if your provider indicates "dispense as written" on your prescription. Preauthorization will be required for certain medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees (e.g., ambulatory surgery center)	No charge	20% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	N/A	$300 copay then Deductible Waived		
	Emergency medical transportation	N/A	20% coinsurance after deductible		
	Urgent care	No charge	$75 copay/visit Deductible Waived		
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees	No charge	20% coinsurance after deductible	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required.
	Outpatient services	No charge	20% coinsurance after deductible	50% coinsurance after deductible	
	Office Visits	No charge	$50 copay then Deductible Waived	50% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 AIMM Guided (You will pay the least)	Tier 2 Participating Provider (You pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Global Maternity	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required.
	Childbirth/delivery facility services	No charge	20% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance after deductible	50% coinsurance after deductible	
	Rehabilitation/Habilitation services	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Outpatient Physical Therapy limited to 20 visits/plan year; Speech, Hearing & Occupational therapy limited to 20 visits/plan year. For inpatient rehabilitation services, Preauthorization is required.
	Skilled nursing care	No charge	20% coinsurance after deductible	50% coinsurance after deductible	60 days/plan year Preauthorization is required.
	Durable medical equipment	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for DME over $500.
	Hospice services	No charge	20% coinsurance after deductible	50% coinsurance after deductible	
If your child needs dental or eye care	Children's eye exam	No charge		50% coinsurance after deductible	
	Children's glasses	No charge		50% coinsurance after deductible	
	Children's dental check-up	No charge			

* For more information about limitations and exceptions, see the plan or policy document at www.casbenefits.com

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.)

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic Care (Limited to 20 visits per Plan Year)
- Hearing Aids

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/ebsa/healthreform. 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: 1-855-373-8232

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 855-373-8232

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

About these Coverage Examples: AIMM GUIDED TIER 1

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 deductible waived	**$0**
Specialist copayment	**See Above**
Hospital (facility) coinsurance	**See Above**
Other coinsurance	**See Above**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

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

The plan's overall deductible	**$0**
Specialist copayment	**See Above**
Hospital (facility) coinsurance	**See Above**
Other coinsurance	**See Above**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$20**

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

The plan's overall deductible	**$0**
Emergency Room copayment	**See Above**
Hospital (facility) coinsurance	**See Above**
Other coinsurance	**See Above**

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	**$3,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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

Your actual costs can be significantly reduced when you utilize AIMM Tier 1 services.

About these Coverage Examples: Tier 2 In Network

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	**$2,000**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	$2,000
Copayments	$75
Coinsurance	$2,125
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,260**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$2,000
Copayments	$75
Coinsurance	$1,065
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,160**

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

The plan's overall deductible	**$2,000**
Emergency Room copayment	**$300**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	**$3,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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

Your actual costs can be significantly reduced when you utilize AIMM Tier 1 services.