

 **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, call Summit Administration Services at 1-888-690-2020. 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.summit-inc.net or www.cciio.cms.gov or call 1-888-690-2020 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network providers</u> per plan year: \$600/individual; \$1,200/family. <u>Out-of-Network providers</u> : \$1,200/individual; \$2,400/family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , network PCP and behavioral health office visits, non-hospital based lab, and outpatient <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	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 <u>plan</u> 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Depending on the dental <u>plan</u> option that you choose, you may have a <u>deductible</u> under your dental <u>plan</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical Plan <u>Network providers</u> per plan year: \$6,600/individual; \$13,200/family. Outpatient <u>prescription drugs</u> accumulate to the medical plan out-of-pocket limit. <u>Out-of-Network providers</u> : None, except emergency room in an emergency situation.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. 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.
What is not included in the out-of-pocket limit?	For the Medical Plan: <u>Premiums</u> , <u>balance-billing charges</u> , penalties for failure to obtain precertification, health care this <u>plan</u> doesn't cover, dental <u>plan</u> and vision <u>plan</u> expenses.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes, see www.azblue.com/chsnetwork or call 1-888-690-2020 for a list of <u>Network providers</u> .	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 network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Network Provider (You will pay the least)	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	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Requires precertification on procedures and treatments over \$1,000 to avoid a \$150 penalty or non-payment. Teladoc virtual visit: no charge. <u>Deductible</u> does not apply.
	Specialist visit	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Preventive care/screening/immunization	No charge. <u>Deductible</u> does not apply.	Children: 50% <u>coinsurance</u> . Adults: No charge, <u>deductible</u> does not apply.	<ul style="list-style-type: none"> □ <u>Plan</u> covers required <u>preventive services</u> and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. ▫ Age and frequency guidelines apply to covered preventive care. □ You may have to pay for services that aren't <u>preventive care</u>. Ask your provider if the services needed are <u>preventive</u>. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Hospital based test: 40% <u>coinsurance</u> . Non-hospital based lab: No charge, <u>deductible</u> does not apply. Non-hospital based X-ray: 40% <u>coinsurance</u> .	50% <u>coinsurance</u>	Requires precertification on procedures and treatments over \$1,000 to avoid a \$150 penalty or non-payment. Physician/provider's professional fees may be billed separately. No <u>deductible</u> for ACA required <u>preventive care</u> .
	Imaging (CT/PET scans, MRIs)	40% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com or call 800-562-6223.	Generic drugs	Retail Pharmacy for 30-day supply: \$10 <u>copayment</u> . Mail Order for 90-day supply: \$15 <u>copayment</u> .	If you fill a prescription at an Out-of-Network pharmacy, you pay 100% for the drug at the time of purchase and file a claim with Optum for reimbursement and <u>Plan</u> reimburses the receipt cost minus the appropriate retail <u>network copayment</u> or <u>coinsurance</u> amount.	<ul style="list-style-type: none"> □ <u>Deductible</u> does not apply. □ Outpatient <u>prescription drugs</u> accumulate to the medical plan <u>out-of-pocket limit</u>. □ You pay the lesser of the <u>copayment</u> or the drug cost. □ Certain over-the-counter (OTC) and <u>prescription drugs</u> are payable at no charge with a prescription. □ Some prescription drugs are subject to <u>preauthorization</u> (to avoid non-payment), quantity limits, or step therapy requirements. □ <u>Specialty drugs</u> require preapproval (to avoid non-payment) by calling the OptumRx Specialty Pharmacy (BriovaRx) at 1-866-218-5445.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: 20% <u>coinsurance</u> to a maximum of \$100/fill, Mail Order for 90-day supply: \$40 <u>copayment</u> .		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: 50% <u>coinsurance</u> with a \$20 minimum payment and \$150 maximum payment/fill; Mail Order for 90-day supply: \$100 <u>copayment</u> .		
	<u>Specialty drugs</u>	For up to a 30-day supply, you pay the same as above.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Requires precertification on outpatient procedures and treatments over \$1,000 to avoid a \$150 penalty or non-payment.
	Physician/surgeon fees	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copayment/visit</u> , plus 40% <u>coinsurance</u>	\$150 <u>copayment/visit</u> , plus 40% <u>coinsurance</u>	Professional/physician charges may be billed separately. You pay 100% for non-emergency use of an emergency room. <u>Copayment</u> waived if hospitalized within 24 hrs.
	<u>Emergency medical transportation</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	You pay 100% for non-emergency transportation.
	<u>Urgent care</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Admission requires precertification to avoid a \$150 penalty or non-payment.
	Physician/surgeon fees	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Private room payable only if <u>medically necessary</u> or the hospital only has private rooms.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and other outpatient services: 40% <u>coinsurance</u>	50% <u>coinsurance</u>	Plan covers up to 6 free EAP visits through Jorgensen Brooks Group (JGB) at 1-888-520-5400.
	Inpatient services	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Hospital and residential treatment program admission requires precertification to avoid a \$150 penalty or non-payment.
If you are pregnant	Office visits	Female employee, spouse, or daughter: No charge for office visits and ACA-required <u>preventive services</u> . <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	<ul style="list-style-type: none"> □ Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply. □ <u>Cost sharing</u> does not apply for <u>network preventive services</u>. □ Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). □ Prenatal care (other than office visits and ACA-required <u>preventive screenings</u>) is not covered for dependent children.
	Childbirth/delivery professional services	\$150 <u>copayment</u> , then 40% <u>coinsurance</u>	\$150 <u>copayment</u> , then 50% <u>coinsurance</u>	<ul style="list-style-type: none"> □ Precertification is required (to avoid a \$150 penalty or non-payment) only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section. □ You must pay 100%, even <u>in-network</u>, for ultrasounds and delivery expenses for a dependent child.
	Childbirth/delivery facility services	40% <u>coinsurance</u>		
If you need help recovering or have other special health needs	<u>Home health care</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Plan covers part-time or intermittent skilled nursing care</u> . Maximum benefit is 60 visits/ <u>plan year</u> .
	<u>Rehabilitation services</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<ul style="list-style-type: none"> □ Maximum benefit for outpatient physical and occupational therapy is 50 visits/<u>injury or illness</u>. □ Maximum benefit for speech therapy is 8 visits/<u>plan year</u>. □ Maximum benefit for inpatient rehab is 60 days/<u>injury or illness</u>.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	<u>Skilled nursing care</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Requires precertification to avoid a \$150 penalty or non-payment. Maximum benefit is 60 days/ <u>injury or illness</u> .
	<u>Durable medical</u>	40% <u>coinsurance</u> up to	50% <u>coinsurance</u> up to	Equipment over \$1,000 per item requires

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>equipment</u>	\$5,000/ <u>plan year</u> then you pay 90% <u>coinsurance</u> . Oxygen: 40% <u>coinsurance</u> up to \$3,000/ <u>plan year</u> then you pay 90% <u>coinsurance</u> .	\$5,000/ <u>plan year</u> then you pay 90% <u>coinsurance</u> . Oxygen: 50% <u>coinsurance</u> up to \$3,000/ <u>plan year</u> then you pay 90% <u>coinsurance</u> .	precertification to avoid a \$150 penalty or non-payment. No charge from <u>network providers</u> for breastfeeding pump and supplies needed to operate pump.
	<u>Hospice services</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Covered if terminally ill.
If your child needs dental or eye care	Children's eye exam	No charge for first \$300/ <u>plan year</u> . You pay 100% for vision expenses over \$300/ <u>plan year</u> . <u>Medical plan deductible</u> does not apply.		If you elect vision coverage, it will be available under a separate vision <u>plan</u> . Your <u>cost sharing</u> for vision services does not count toward the medical <u>plan's out-of-pocket limit</u> .
	Children's glasses			
	Children's dental check-up	No charge. <u>Medical plan deductible</u> does not apply.		If you elect dental coverage, it will be available under a separate dental <u>plan</u> . Your <u>cost sharing</u> for dental services does not count toward the medical <u>plan's out-of-pocket limit</u> .

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.)		
<input type="checkbox"/> Cosmetic surgery	<input type="checkbox"/> Infertility treatment	<input type="checkbox"/> Non-emergency use of an emergency room
<input type="checkbox"/> Habilitation services	<input type="checkbox"/> Long term care	<input type="checkbox"/> Private duty nursing
	<input type="checkbox"/> Non-emergency care when traveling outside the U.S.	<input type="checkbox"/> Weight loss programs, except as required by health reform law.
	<input type="checkbox"/> Non-emergency transportation	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<input type="checkbox"/> Acupuncture (8 visits/plan year combined with chiropractic care)	<input type="checkbox"/> Chiropractic care (8 visits/plan year combined with acupuncture)	<input type="checkbox"/> Hearing Aids (\$1,500/person every 3 years)
<input type="checkbox"/> Bariatric surgery (maximum \$20,000 per lifetime)	<input type="checkbox"/> Dental care (Adult), if you elect one of the Dental <u>plan</u> options.	<input type="checkbox"/> Routine eye care (Adult), if you elect Vision coverage it's payable up to \$300/ <u>plan</u> year.
		<input type="checkbox"/> Routine foot care when medically necessary.

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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Summit Administration Services, Inc. at 1-888-690-2020.

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 1-888-690-2020.

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 section.—————

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 \$600
- Specialist coinsurance 40%
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$380
Coinsurance	\$3,940
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$4,930

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

- The plan's overall deductible \$600
- Specialist coinsurance 40%
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$610
Coinsurance	\$820
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,090

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

- The plan's overall deductible \$600
- Specialist coinsurance 40%
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$150
Coinsurance	\$490
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,240

