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?	Network providers per plan year: $350/individual, $700/family. Out-of-Network providers per plan year: $350/individual; $700/family. The deductible for in-network providers does not accumulate to meet the deductible for out-of-network providers and vice versa.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, network PCP and behavioral health office visits, non-hospital based lab, and outpatient prescription drugs 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?	Depending on the dental plan option that you choose, you may have a deductible under your dental plan. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical Plan Network providers per plan year: $3,350/individual; $6,700/family. Outpatient prescription drugs accumulate to the medical plan out-of-pocket limit. Out-of-Network providers: None, except emergency room in an emergency situation.	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?	For the Medical Plan: Premiums, balance-billing charges, penalties for failure to obtain precertification, health care this plan doesn't cover, dental plan and vision plan expenses.	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.azblue.com/chsnetwork or call 1-888-690-2020 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 can see the specialist you choose without a referral.

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	$20 copayment/visit. Deductible does not apply.	40% coinsurance	Requires precertification on procedures and treatments over $1,000 to avoid a $150 penalty or non-payment. Teladoc virtual visit: no charge. Deductible does not apply.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Immunizations: No charge, deductible does not apply. Preventive care for: □ Birth – 18 months: $20 copayment per visit, deductible does not apply. □ Age 19 months and older: No charge, deductible does not apply.	□ Plan covers required preventive services 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 preventive care. 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)	Hospital based test: 20% coinsurance. Non-hospital based lab: No charge, deductible does not apply. Non-hospital based x-rays: 20% coinsurance.	40% coinsurance	Requires precertification on procedures and treatments over $1,000 to avoid a $150 penalty or non-payment. No deductible for ACA required preventive care. Physician/provider's professional fees may be billed separately.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

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 copayment. Mail Order for 90-day supply: $15 copayment.	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 Plan reimburses the receipt cost minus the appropriate retail network copayment or coinsurance amount.	□ Deductible does not apply. □ Outpatient prescription drugs accumulate to the medical plan out-of-pocket limit. □ You pay the lesser of the copayment or the drug cost. □ Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription. □ Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits, or step therapy requirements. □ Specialty drugs 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% coinsurance to a maximum of $100/fill, Mail Order for 90-day supply: $40 copayment.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: 50% coinsurance with a $20 minimum payment and $150 maximum payment/fill; Mail Order for 90-day supply: $100 copayment.		
	Specialty drugs	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)	20% coinsurance	40% coinsurance	Requires precertification on outpatient procedures and treatments over $1,000 to avoid a $150 penalty or non-payment.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copayment/visit, plus 20% coinsurance	$150 copayment/visit, plus 20% coinsurance	Professional/physician charges may be billed separately. You pay 100% for non-emergency use of an emergency room. Copayment waived if hospitalized within 24 hrs.
	Emergency medical transportation	20% coinsurance	20% coinsurance	You pay 100% for non-emergency transportation.
	Urgent care	20% coinsurance	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance (20% coinsurance if emergency hospital admission)	Admission requires precertification to avoid a $150 penalty or non-payment. Private room payable only if medically necessary or the hospital only has private rooms.
	Physician/surgeon fees	20% coinsurance	40% coinsurance (20% coinsurance if emergency hospital admission)	

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: $20 copayment/visit, deductible does not apply. Other outpatient services: 20% coinsurance.	40% coinsurance	Plan covers up to 6 free EAP visits through Jorgensen Brooks Group (JGB) at 1-888-520-5400.
	Inpatient services	20% coinsurance.	40% coinsurance (20% coinsurance if emergency hospital admission)	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 preventive services. Deductible does not apply.	40% coinsurance.	□ Depending on the type of services, a copayment, coinsurance, or deductible may apply. □ Cost sharing does not apply for network preventive services. □ 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 preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services	$150 copayment plus 20% coinsurance	$150 copayment plus 40% coinsurance (20% coinsurance if emergency hospital admission)	□ 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 in-network, for ultrasounds and delivery expenses for a dependent child.
	Childbirth/delivery facility services	20% coinsurance		

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 help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Plan covers part-time or intermittent skilled nursing care. Maximum benefit is 60 visits/plan year.
	Rehabilitation services	20% coinsurance	40% coinsurance	□ Maximum benefit for outpatient physical and occupational therapy is 50 visits/injury or illness. □ Maximum benefit for speech therapy is 8 visits/plan year. □ Maximum benefit for inpatient rehab is 60 days/injury or illness.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Skilled nursing care	20% coinsurance	40% coinsurance	Requires precertification to avoid a $150 penalty or non-payment. Maximum benefit is 60 days/injury or illness.
	Durable medical equipment	20% coinsurance up to $5,000/plan year then you pay 90% coinsurance. Oxygen: 20% coinsurance up to $3,000/plan year then you pay 90% coinsurance.	40% coinsurance up to $5,000/plan year then you pay 90% coinsurance. Oxygen: 40% coinsurance up to $3,000/plan year then you pay 90% coinsurance.	□ Equipment over $1,000 per item requires precertification to avoid a $150 penalty or non-payment. □ No charge from network providers for breastfeeding pump and supplies needed to operate pump.
	Hospice services	20% coinsurance	40% coinsurance	Covered if terminally ill.
If your child needs dental or eye care	Children's eye exam	No charge for first $300/plan year. You pay 100% for vision expenses over $300/plan year. Medical plan deductible does not apply.		If you elect vision coverage, it will be available under a separate vision plan. Your cost sharing for vision services does not count toward the medical plan's out-of-pocket limit.
	Children's glasses			
	Children's dental check-up	No charge. Medical plan deductible does not apply.		If you elect dental coverage, it will be available under a separate dental plan. Your cost sharing for dental services does not count toward the medical plan's out-of-pocket limit.

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	☐ Long term care	☐ Non-emergency use of an emergency room
☐ Habilitation services	☐ Non-emergency care when traveling outside the U.S.	☐ Private duty nursing
☐ Infertility treatment	☐ Non-emergency transportation	☐ Weight loss programs, except as required by health reform law.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
☐ Acupuncture (8 visits/plan year combined with chiropractic care)	☐ Chiropractic care (8 visits/plan year combined with acupuncture)	☐ Hearing Aids ($1,500/person every 3 years)
☐ Bariatric surgery (maximum $20,000 per lifetime)	☐ Dental care (Adult), if you elect one of the Dental plan options.	☐ Routine eye care (Adult), if you elect Vision coverage it's payable up to $300/plan year.
		☐ 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, kwiijigo 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**	**$350**
■ **Specialist coinsurance**	**20%**
■ **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$380
Coinsurance	$2,020
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,760**

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

■ **The plan's overall deductible**	**$350**
■ **Specialist coinsurance**	**20%**
■ **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	$350
Copayments	$690
Coinsurance	$730
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,830**

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

■ **The plan's overall deductible**	**$350**
■ **Specialist coinsurance**	**20%**
■ **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$150
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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