



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, go to www.summit-inc.net or call 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 <https://www.healthcare.gov/sbc-glossary> or call 888-690-2020 to request a copy

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: Individual: \$1,000/ Family: \$3,000 Out-of-Network: Individual: \$1,100/ Family: \$3,300	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, the following services are covered before you meet your deductible – Preventive Care, Primary Care .	This plan covers some items and services even if you haven't 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?	Yes. \$50/ Individual, \$100/ Family for dental benefits. There are no other specific deductibles .	You must pay all 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 ?	In-Network: Individual: \$5,000/Family: \$15,000 Out-of-Network: There is no out-of-pocket limit .	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, Health care the plan doesn't cover, Penalties for failing to follow precertification	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 http://www.azblue.com/chsnetwork or call 1888-690-2020 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 the provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that 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	\$25 copayment /visit	50% coinsurance	PPO copay applies to office visit charge, office visit surgery and office x-ray and lab.
	Specialist visit	\$25 copayment /visit \$25 copay /visit – Chiropractor/ Other practitioner office visit	50% coinsurance	PPO copay applies to office visit charge, office visit surgery and office x-ray and lab.
	Preventive care/screening/immunization	No charge.	50% coinsurance	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)	\$25 copay /Physician's office with no office visit or independent lab 20% coinsurance / Free Standing Facility office (x-ray, blood work)	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Services rendered at a Relevant facility located outside Arizona, no charge.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.smithrx.com	Generic drugs	Retail - \$10 copay Mail - \$30 copay	Copay or coinsurance plus difference in cost between PPO and Non PPO	Covers up to 30 day supply for retail, and up to a 90 day supply mail order.
	Preferred brand drugs	Retail - \$45 copay Mail - \$135 copay		
	Non-preferred brand drugs	Retail– 50% of negotiated rate Mail – 50% of negotiated rate		
	Specialty drugs	See above as applicable Specified OTC Allergy and Ulcer Drugs Retail - \$0 copay Mail – Not Covered	Specified OTC Allergy and Ulcer Drugs Not Covered	For Specified OTC Allergy and Ulcer Drugs Limited to 30 day supply.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance 20% coinsurance Outpatient Hospital	50% coinsurance	Preauthorization required. Coinsurance reduced to 50% for noncompliance. If a PPO provider from the Select listing is used, the plan will pay you \$500/outpatient procedure.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Surgery in PPO provider office is covered under office visit copay .
If you need immediate medical attention	Emergency room care	\$500 copayment , 20% coinsurance	20% coinsurance	None
	Emergency medical transportation	Ground – 20% coinsurance Air - \$200 copayment then 20% coinsurance	Ground – 20% coinsurance Air - \$200 copay then 20% coinsurance	None
	Urgent care	\$40 copayment /visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization required. Coinsurance reduced to 50% for noncompliance. If a PPO provider from the Select listing is used, the plan will pay you \$1,000 per confinement. The NonPPO copay is waived for emergency admission.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Preauthorization required. Coinsurance reduced to 50% for noncompliance.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay /office visit and 20% coinsurance after deductible for other outpatient services	50% coinsurance	None
	Inpatient services	20% coinsurance	\$250 copay then 50% coinsurance	Preauthorization required. Coinsurance reduced to 50% for noncompliance.
If you are pregnant	Office visits	\$25 copayment	50% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Preauthorization required for inpatient services. Coinsurance reduced to 50% for noncompliance.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help	Home health care	20% coinsurance	50% coinsurance	Covers up to 60 visits per benefit year.

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)	
recovering or have other special health needs	Rehabilitation services	\$25 copayment /visit	50% coinsurance	Excludes: cardiac rehabilitation, occupational, physical, pulmonary/respiratory, speech.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	20% coinsurance	50% coinsurance	None
	Hospice services	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Also covered under vision up to \$300 per benefit year.
	Children's glasses	No Charge	No Charge	Covered under vision benefit up to \$300 maximum benefit per benefit year.
	Children's dental check-up	No Charge	Not Covered	\$1,500 maximum per benefit year for all dental services combined.

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 .)		
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery Chiropractic Care Cosmetic Surgery Dependent Child Pregnancy Habilitation services 	<ul style="list-style-type: none"> Dental care (Adult) Hearing Aids Infertility Treatment Long Term Care Non-emergency care when traveling outside the U.S. and Mexico 	<ul style="list-style-type: none"> Private-duty nursing Routine eye care (Adult) Routine foot care Weight loss programs (Except as required by ACA) Skilled nursing care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Bariatric Surgery Chiropractic Care 	<ul style="list-style-type: none"> Dental Care (Adult) Routine Eye Care (Adult) 	<ul style="list-style-type: none"> Routine Foot Care

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 Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272) or 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 on how 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: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may be available to help you file your [appeal](#). Contact www.dol.gov/ebsa/healthreform for more information.

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 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	\$400
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other copayment	\$25

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$400
Copayments	\$300
Coinsurance	\$2,300
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,000

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$400
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other copayment	\$10

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$400
Copayments	\$1,100
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$400
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other <i>not covered</i>	100%

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$400
Copayments	\$80
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$400
The total Mia would pay is	\$1,180

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.