



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 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-888-690-2020 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible ?	PPO \$750/self only \$1,500/family	Non-PPO \$1,875/self only \$3,750/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 .
	PPO and Non-PPO deductibles are combined.		
Are there services covered before you meet your deductible ?	Yes, PPO preventive services , services paid with a copayment , services paid at no charge, and preadmission testing.		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?	Yes. \$250 for failure to precertify inpatient admissions, MRIs, durable medical equipment over \$1,000, and outpatient surgery (except when performed in the physician's office). 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 ?	PPO \$2,750/self only \$5,500/family	Non-PPO \$26,875/self only \$53,750/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 out-of-pocket limits until the overall family out-of-pocket limit has been met.
	PPO and Non-PPO out-of-pocket limits are combined.		
What is not included in the out-of-pocket limit ?	Premiums , balance billing charges (unless balance billing is prohibited), 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.azblue.com/chsnetworkmayo for a list of PPO 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
		PPO Provider (You will pay the least)	Non-PPO 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 copay /visit, deductible does not apply; 20% coinsurance for other outpatient services	50% coinsurance	Network provider copay is per day and applies only to office visit charge, x-ray/lab services, injections, allergy injections & treatment (copay waived if there is no office visit charge), and minor office surgery.
	Specialist visit			
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Inpatient: 20% coinsurance Office, Outpatient Hospital, & Standalone Facility: \$40 copay /visit, deductible does not apply	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Precertification is required for MRI or an additional deductible of \$250 may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO 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.primetherapeutics.com	Generic drugs	Retail \$5 copay /prescription Mail order \$10 copay /prescription	Not covered	Covers up to a 30-day supply (retail pharmacy) and up to a 90-day supply (mail order). Over-the-counter drugs (physician’s prescription required) are covered at no charge (retail pharmacy only). No coverage for purchases at a non-participating pharmacy, except non-insulin injectables, which require you to pay in full then submit a claim form for reimbursement. Deductible does not apply to prescription drugs.
	Preferred brand drugs	Retail \$40 copay /prescription Mail order \$80 copay /prescription		
	Non-preferred brand drugs	Retail \$55 copay /prescription Mail order \$110 copay /prescription		
	Specialty drugs	Retail 80% up to a max of \$150/prescription Mail order 80% up to a max of \$300/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 copay /visit, deductible does not apply	50% coinsurance	Precertification is required or an additional deductible of \$250 may apply.
	Physician/surgeon fees	\$40 copay /visit, deductible does not apply	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance		None
	Emergency medical transportation	20% coinsurance		
	Urgent care	\$50 copay /visit, deductible does not apply	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification is required or an additional deductible of \$250 may apply.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay /office visit, deductible does not apply; 20% coinsurance for other outpatient services	50% coinsurance	Network provider copay is per day and applies only to office visit charge.
	Inpatient services	20% coinsurance	50% coinsurance	Precertification is required or an additional deductible of \$250 may apply.
If you are pregnant	Office visits	\$40 copay /visit, deductible does not apply; 20% coinsurance for other outpatient services	50% coinsurance	Cost sharing does not apply for PPO office visit preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Precertification is required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery) or an additional deductible of \$250 may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits/calendar year
	Rehabilitation services	20% coinsurance	50% coinsurance	Inpatient occupational, physical, and speech therapies are limited to 60 days/calendar year combined.
	Habilitation services	Not covered	Not covered	No coverage for habilitation services
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 visits/calendar year Precertification is required or an additional deductible of \$250 may apply.
	Durable medical equipment	20% coinsurance	50% coinsurance	Precertification is required for DME over \$1,000 or an additional deductible of \$250 may apply.
	Hospice services	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one exam/calendar year
	Children's glasses	No charge	No charge	None
	Children's dental check-up	No charge	Not covered	Limited to 2 exams/calendar year

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 .)		
• Acupuncture • Cosmetic surgery • Habilitation services	• Hearing aid • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (for morbid obesity only) • Chiropractic care • Dental care (Adult) / (Child) • Private-duty nursing (limited to outpatient only; further limited to \$10,000 Lifetime max)	• Routine eye care (Adults ages 19 and older – exams limited to \$125 and 1 exam/calendar year, and materials limited to \$400/calendar year) / (Child under 19 – exams limited to 1 exam/calendar year)	• Weight loss programs (for morbid obesity only)

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

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 1-888-472-4352.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-472-4352.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-472-4352.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-472-4352.

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	\$750
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other (Tests) copayment	\$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	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$500
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,810

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$750
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other (Brand drugs) copayment	\$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	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$600
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,380

Mia's Simple Fracture

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

■ The plan's overall deductible	\$750
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other (Physical Therapy) 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	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$200
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,250

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