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, at www.summit-inc.net or 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 www.summit-inc.net or call 1-888-690-2020 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Yes**	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In Network** $3,000 Individual / $6,000 Family **Out of Network** $6,000 Individual / $12,000 Family	If you have other family members in this plan, they have to meet their own out-of-pocket limit 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 **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).
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 copay / visit	50% coinsurance	Copay waived if only service during visit is allergy injection.
	Specialist visit	$35 copay / visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	Out-of-network services for mammograms and foreign travel immunizations are covered at 50%
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay / visit	50% coinsurance	Copay is waived if only services received during visit are lab.
	Imaging (CT/PET scans, MRIs)	$20 copay / visit	50% coinsurance	Copay is waived if only services received during visit are lab.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://magellanrx.com/member/documents	Generic drugs	Retail - $15 copay Mail Order - $30 copay	Copay plus difference in cost between Preferred & Non-preferred	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	Retail - $35 copay Mail Order - $70 copay		
	Non-preferred brand drugs	Retail - $60 copay Mail Order - $120 copay		
	Specialty drugs	Generic - $30 copay Preferred - $60 copay Non- preferred - $90 copay	Not covered	Limited to: 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay / visit	50% coinsurance	Precertification required. 50% reduction in covered expenses to a maximum penalty of $1,000 for noncompliance.
	Physician/surgeon fees	$35 copay / visit	50% coinsurance	Surgery in network provider's office is included office visit copay
If you need immediate medical attention	Emergency room care	$150 copay / visit	$150 copay / visit	Copay is waived if admitted
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	$35 copay / visit	50% coinsurance	None

[* For more information about limitations and exceptions, see the plan or policy document at www.summit-inc.net.]

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 a hospital stay	Facility fee (e.g., hospital room)	$500 copay / visit	50% coinsurance	Precertification required. 50% reduction in covered expenses to a maximum penalty of $1,000 for noncompliance.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / visit	50% coinsurance	None
	Inpatient services	$200 copay / visit	50% coinsurance	Precertification required. 50% reduction in covered expenses to a maximum penalty of $1,000 for noncompliance..
If you are pregnant	Office visits	$20 copay for first visit and global fee; thereafter 30% coinsurance for other than physician's global fee	50% coinsurance	None
	Childbirth/delivery professional services	30% coinsurance for other than physician's global fee	50% coinsurance	None
	Childbirth/delivery facility services	$500 copay / visit	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Precertification required. 50% reduction in covered expenses to a maximum penalty of $1,000 for noncompliance.
	Rehabilitation services	30% coinsurance for up to 120 days per calendar year; then 50% coinsurance	50% coinsurance	Precertification required. 50% reduction in covered expenses to a maximum penalty of $1,000 for noncompliance. Does not apply towards out of pocket maximum expense limit.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	30% coinsurance	50% coinsurance	None
	Hospice services	30% coinsurance	50% coinsurance	Precertification required. 50% reduction in covered expenses to a maximum penalty of $1,000 for noncompliance.
If your child needs dental or eye care	Children's eye exam	0% coinsurance	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

[* For more information about limitations and exceptions, see the plan or policy document at www.summit-inc.net.]

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
- Cochlear Implants
- Cosmetic Surgery
- Infertility
- Long Term Care
- Refractive Eye Surgery
- TMJ
- Weight Loss Programs

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

- Bariatric Surgery
- Chiropractic Care
- Dependent Child Pregnancy
- Hearing Aids
- Some 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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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: the plan at 928-779-4107. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-690-2020.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 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.

[* For more information about limitations and exceptions, see the plan or policy document at www.summit-inc.net.]

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	$0
Specialist copayment	$35
Hospital (facility) copayment	$500
Other coinsurance	30%

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	$0
Copayments	$575
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,275**

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	$35
Hospital (facility) copayment	$500
Other coinsurance	30%

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	$95
Coinsurance	$460
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$555**

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

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$500
Other coinsurance	30%

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	$0
Copayments	$170
Coinsurance	$268
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$438**

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