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 visit the website: : https://secure.healthx.com/sshealthcare.asp 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uniform-Glossary-01-2020.pdf or call 1-855-479-5156 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	This plan does not have a deductible. This plan covers preventive care only at no charge. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there services covered before you meet your deductible?	Not Applicable	This plan does not have a deductible.
Are there other deductibles for specific services?	No	There are no deductibles.
What is the out-of-pocket limit for this plan?	$7,350 individual / $14,700 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 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?	Copayments for certain services, 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. Visit www.multiplan.com or call 1- 877-952-7427 for a list 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 100% of the cost for services received from an out-of-network provider 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 may see any specialist without a referral. However, this plan covers only preventive care services which typically do not include treatment from a specialist.

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 Copay	$25 Copay	All other primary care, non-emergency, urgent care services $50 Copay. Prior authorization is required for physician services performed in the office. If prior authorization is not obtained, the benefits payable by the plan will be denied.
	Specialist visit	$50 Copay	$50 Copay	None
	Preventive care/screening/ immunization	No Charge	Not covered	Hospital Based services are Not Covered, 100% paid by Member. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
If you have a test	Diagnostic test (x-ray, blood work)	$50 Copay	$50 Copay	None
	Imaging (CT/PET scans, MRIs)	$350 Copay (Subject to Reference Based Pricing)	$350 Copay (Subject to Reference Based Pricing)	Prior authorization is required. If prior authorization is not obtained, the benefits payable by the plan will be denied.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	$10 Copay (Retail) $30 Copay (Mail Order)		Preventive Prescriptions Generic - $0 Copay Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	Not Covered 100% paid by Member		
	Non-preferred brand drugs (Tier 3)	Not Covered 100% paid by Member		
	Specialty drugs (Tier 4)	Not Covered 100% paid by Member		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 Copay (Subject to Reference Based Pricing)	$350 Copay (Subject to Reference Based Pricing)	Prior authorization is required. If prior authorization is not obtained, the benefits payable by the plan will be denied.
	Physician/surgeon fees	$50 Copay	$50 Copay	
If you need immediate medical attention	Emergency room care	Not Covered 100% paid by Member	Not Covered 100% paid by Member	None
	Emergency medical transportation	Not Covered 100% paid by Member	Not Covered 100% paid by Member	None
	Urgent care	$50 Copay	$50 Copay	None

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)	Not Covered 100% paid by Member	Not Covered 100% paid by Member	None
	Physician/surgeon fees	Not Covered 100% paid by Member	Not Covered 100% paid by Member	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay	$25 Copay	None
	Inpatient services	Not Covered 100% paid by Member	Not Covered 100% paid by Member	None
If you are pregnant	Office visits	$25 Copay	$25 Copay	None
	Childbirth/delivery professional services	Not Covered 100% paid by Member	Not Covered 100% paid by Member	None
	Childbirth/delivery facility services	Not Covered 100% paid by Member	Not Covered 100% paid by Member	
If you need help recovering or have other special health needs	Home health care	Not Covered 100% paid by Member	Not Covered 100% paid by Member	None
	Rehabilitation services	Not Covered 100% paid by Member	Not Covered 100% paid by Member	
	Habilitation services	Not Covered 100% paid by Member	Not Covered 100% paid by Member	
	Skilled nursing care	Not Covered 100% paid by Member	Not Covered 100% paid by Member	
	Durable medical equipment	Not Covered 100% paid by Member	Not Covered 100% paid by Member	
	Hospice services	Not Covered 100% paid by Member	Not Covered 100% paid by Member	
If your child needs dental or eye care	Children's eye exam	Not Covered 100% paid by Member	Not Covered 100% paid by Member	Not covered except services listed under the ACA guidelines (Network)
	Children's glasses	Not Covered 100% paid by Member	Not Covered 100% paid by Member	None.
	Children's dental check-up	Not Covered 100% paid by Member	Not Covered 100% paid by Member	Not covered except services listed under the ACA guidelines (Network)

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 • Bariatric surgery • Cosmetic surgery • Chiropractic care • Dental care (Adult)	• Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine eye care (Adult) • Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Preventive 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: Industrial Commission of Arizona: Labor Department, 2675 E. Broadway Blvd. Unite 125, Tucson, AZ 85716, (520) 628-5459, https://www.azica.gov/divisions/labor-department. the Department of Labor's Employee Benefits Security Administration at 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: 1-888 -505-7724 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may be available in your state to help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ or you may contact 1-888-505-7724 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? **No.**
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 1-855-479-5156
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-479-5156
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-479-5156
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-479-5156

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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**
- **copayment** **$25**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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: $12,518	
Cost Sharing	
Deductibles	$0
Copayments	$940
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,578
The total Peg would pay is	**$12,518**

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** **$50**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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: $6,775	
Cost Sharing	
Deductibles*	$0
Copayments	$1,410
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,365
The total Joe would pay is	**$6,775**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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: $1,782	
Cost Sharing	
Deductibles*	$0
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,632
The total Mia would pay is	**$1,782**