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.meritain.com or call (480) 731-8415. 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 Meritain Health, Inc. at (866) 300-8449 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers: $750 person / $1,500 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.
Are there services covered before you meet your deductible?	Yes. For participating providers: Preventive care, emergency room care (all providers), prenatal & postnatal care, hospice services, urgent care, outpatient mental health/substance abuse services, primary care provider and specialist services (except office surgery) 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers: $5,000 person / $10,000 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?	Premiums, preauthorization penalty amounts, 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. Arizona employees visit: www.azblue.com/ CHSnetwork or call (602) 864-4400; All other employees visit: www.myfirsthealth.com or call (800) 226-5116 for a list of participating 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
		Participating Provider (You will pay the least)	Non-Participating 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/visit (office visit & all other services)/ 20% coinsurance (office surgery)	Not Covered	Copay applies per visit regardless of what services are rendered, excluding office surgery. There is no charge and the deductible does not apply if you receive consultation services through Teladoc.
	Specialist visit	$40 copay/visit (office visit & all other services)/ 20% coinsurance (office surgery)	Not Covered	
	Preventive care/screening/ Immunization	No Charge	Not Covered	Includes all preventive care as well as routine care (physical exam, routine testing, vaccinations/inoculations, well child care, pap smears, mammograms, colon exams, PSA testing, etc.). 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)	20% coinsurance	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com	Generic drugs	$10 copay (30-day retail)/ $30 copay (90-day retail)/ $20 copay (mail order)	Not Covered	The deductible does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription). Copay applies per prescription. There is no charge for preventive drugs. Specialty drugs must be obtained directly from the specialty pharmacy program after 2 refills at a retail pharmacy.
	Formulary drugs	$30 copay (30-day retail)/ $90 copay (90-day retail)/ $60 copay (mail order)	Not Covered	
	Non-formulary drugs	$75 copay (30-day retail)/ $225 copay (90-day retail)/ $150 copay (mail order)	Not Covered	
	Specialty drugs	Paid the same as generic, formulary and non-formulary drugs	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	Preauthorization required unless performed in an office setting. If you don't get preauthorization, benefits could be reduced by $300 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	$200 copay/visit (facility charge)/20% coinsurance (physician fees)	$200 copay/visit (facility charge)/20% coinsurance (physician fees)	Non-participating providers paid at the participating provider level of benefits. Copay is waived if admitted to the hospital.
	Emergency medical transportation	20% coinsurance	Not Covered	----------none----------
	Urgent care	$45 copay/visit	Not Covered	Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/admission, then 20% coinsurance	Not Covered	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $300 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	Not Covered	----------none----------
	Inpatient services	$300 copay/admission, then 20% coinsurance (facility charge)/20% coinsurance (physician fees)	Not Covered	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $300 of the total cost of the service.
If you are pregnant	Office visits	$25 copay/visit	Not Covered	Preauthorization required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by $300 of the total cost of the service. Cost sharing does not apply to preventive services from a participating provider. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described
	Childbirth/delivery professional services	20% coinsurance	Not Covered	
	Childbirth/delivery facility services	$300 copay/admission, then 20% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Limited to 6 hours per day. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $300 of the total cost of the service.
	Rehabilitation services	20% coinsurance	Not Covered	Physical, speech & occupational therapy limited to a combined maximum of 40 visits per year. Inpatient rehabilitation services limited to 180 days per year. Preauthorization required for inpatient services and outpatient visits exceeding the limits described above. If you don't get preauthorization, benefits could be reduced by $300 of the total cost of the service.
	Habilitation services	20% coinsurance	Not Covered	Physical, speech & occupational therapy are covered for developmental delay. These services are included in the visit limits per year for rehabilitation services.
	Skilled nursing care	20% coinsurance (1st 90 days per year)/50% coinsurance (2nd 90 days per year)	Not Covered	Limited to 180 days per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced $300 of the total cost of the service.
	Durable medical equipment	20% coinsurance	Not Covered	If you participate in the Kannact diabetes management program, your cost-sharing may be reduced for specific diabetic equipment and/or supplies, refer to your plan for further details.
	Hospice services	No Charge	Not Covered	Bereavement counseling is not covered.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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.)

- **Bereavement counseling**
- **Cosmetic surgery**
- **Dental care (Adult & Child)**
- **Glasses (Adult & Child)**
- **Long-term care**
- **Mental health and behavioral health**
- **Private-duty nursing (except for home health care & hospice)**
- **Routine eye care**
- **Routine foot care (except for diabetic or neurological involvement or peripheral vascular disease of the foot or lower leg below the knee)**
- **Substance abuse**
- **Weight loss programs**

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

- **Acupuncture**
- **Bariatric surgery (for the treatment of morbid obesity only)**
- **Chiropractic care**
- **Hearing aids**
- **Infertility treatment (except impregnation procedures)**

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 x 61565 or www.cciio.cms.gov, or Maricopa County Community College District at (480) 731-8415. 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 Maricopa County Community College District at (480) 731-8415 or Meritain Health, Inc. at (866) 300-8449.

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 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

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**
Primary care physician copayment	**$25**
Hospital (facility) copayment	**$300**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$390
Coinsurance	$688
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,888

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 coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$980
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,158

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

The plan's overall deductible	**$750**
Specialist copayment	**$40**
Hospital (facility) copayment	**$200**
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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$320
Coinsurance	$272
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,342

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