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 www.myhnas.com or call 1-855-581-1810. 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.myhnas.com or call 1-855-581-1810 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 providers: $0. Tier 2 providers: $950/person and $1,900/family. Tier 3 providers: $1,900/person and $3,800/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. Tier 2 & Tier 3 deductible amounts are combined.
Are there services covered before you meet your deductible?	Yes, all Tier 1 services, Tier 2 preventive care, and benefits subject to a co-pay.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 providers: $0. Tier 2 providers: $6,950/person and $13,900/family. Tier 3 providers: $13,900/person and $27,800/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, balance-billed charges, penalties, and health care services 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 or call 1-800-232-2345 for a list of network providers. For outside AZ, see www.myfirsthealth.com or	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-

	call 1-800-226-5116 for a list of network providers.	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
		Tier 1 Tucson Orthopaedic Institute Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 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	N/A	$25/visit. Deductible does not apply.	50% coinsurance*	None
	Specialist visit	No charge. Deductible does not apply.	$50/visit. Deductible does not apply.	50% coinsurance*	None
	Chiropractic care	N/A	$50/visit. Deductible does not apply.	50% coinsurance*	Limited to 12 visits/year.
	Acupuncture	N/A	$50/visit. Deductible does not apply.	50% coinsurance*	Limited to 12 visits/year.
	Telemedicine – through plan vendor	N/A	$25/call. Deductible does not apply.	N/A	Applies to telemedicine visits through the plan's designated vendor for such services. Telephone consultations with other physicians will be paid under the appropriate benefit category (e.g. primary care visit) for the service.
	Preventive care/screening/ immunization	N/A	No charge. Deductible does not apply.	Not covered	Includes preventive services as mandated by ACA. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Tucson Orthopaedic Institute Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge. Deductible does not apply.	Office visits & independent labs: No charge. Deductible does not apply. All other locations: 20% coinsurance*	50% coinsurance*	None
	Imaging (CT/PET scans, MRIs)	N/A	20% coinsurance*	50% coinsurance*	Preauthorization required for select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge. Deductible does not apply.	20% coinsurance*	50% coinsurance*	Precertification required for select procedures, including infusion therapy costing over $2,000 per drug per month.**
	Physician/surgeon fees	No charge. Deductible does not apply.	20% coinsurance*	50% coinsurance*	
If you need immediate medical attention	Emergency room care - Emergency	N/A	$200/visit. Deductible does not apply.	Paid at the Tier 2 level	Co-pay waived if admitted.
	Emergency room care – Non-emergency	N/A	$200/visit. Deductible does not apply.	50% coinsurance*	
	Emergency medical transportation	N/A	20% coinsurance*	Paid at the Tier 2 level	None
	Urgent care	N/A	$60/visit. Deductible does not apply.	50% coinsurance*	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge. Deductible does not apply.	20% coinsurance*	50% coinsurance*	Precertification required.**

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Tucson Orthopaedic Institute Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge. Deductible does not apply.	20% coinsurance*	50% coinsurance*	
If you need mental health, behavioral health, or substance abuse services	Mental or behavioral health – Office visits	N/A	$25/visit. Deductible does not apply.	50% coinsurance*	Certain behavioral health services and substance abuse are not covered.
	Mental or behavioral health – All other outpatient services	N/A	20% coinsurance*	50% coinsurance*	
	Mental or behavioral health - Inpatient services	N/A	20% coinsurance*	50% coinsurance*	Precertification required.** Certain behavioral health services and substance abuse are not covered.
If you are pregnant	Office visits	N/A	$25/visit. Deductible does not apply.	50% coinsurance*	Cost-sharing does not apply to Tier 1 and Tier 2 routine prenatal services that are considered preventive care.
	Childbirth/delivery professional services	N/A	20% coinsurance*	50% coinsurance*	Precertification** is only required for stays exceeding the day limits outlined in the Newborns' and Mothers' Health Protection Act. Newborn expenses count towards the mother's expense.
	Childbirth/delivery facility services	N/A	20% coinsurance*	50% coinsurance*	
If you need help recovering or have other special health needs	Home health care	N/A	20% coinsurance*	50% coinsurance*	Precertification required.**
	Rehabilitation services – Outpatient	No charge. Deductible does not apply.	$50/visit. Deductible does not apply.	50% coinsurance*	Physical, speech, occupational & pulmonary therapies are limited to 20 visits per each therapy/year. Outpatient cardiac rehab is limited to 36 visits/year. Inpatient care is limited to 90 days/year. Precertification required for inpatient care.**
	Rehabilitation services – Inpatient	No charge. Deductible does not apply.	20% coinsurance*	50% coinsurance*	
	Habilitation services	N/A	$50/visit. Deductible does not apply.	50% coinsurance*	None
	Skilled nursing care	N/A	20% coinsurance*	50% coinsurance*	Precertification required.** Limited to 60 days/year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Tucson Orthopaedic Institute Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	No charge. Deductible does not apply.	20% coinsurance*	50% coinsurance*	Precertification required for select equipment.**
	Hospice services	N/A	20% coinsurance*	50% coinsurance*	Limited to 360 days/lifetime.
	Bereavement counseling	N/A	$25/visit. Deductible does not apply.	50% coinsurance*	Limited to counseling received within 6 months of death.
If your child needs dental or eye care	Children's eye exam	N/A	$25/visit. Deductible does not apply.	50% coinsurance*	Limited to 1 exam/year.
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

* Deductible applies.

** Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify will result in a 20% reduction in benefits, up to a maximum penalty of $1,000.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (30 day supply)	Mail Order Pharmacy or Retail Pharmacy (90 day supply)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.southernscripts.net	Individual Out-Of-Pocket Limit	$6,950		Includes co-pays and is combined with the medical out-of-pocket amounts.
	Family Out-Of-Pocket Limit	$13,900		
	Generic drugs	$10/prescription. Deductible does not apply.	No charge. Deductible does not apply.	Certain medications considered preventive care under ACA are payable at no cost-share to the member. The Prescription Drug Plan will pay up to the generic price, less the generic co-pay, whenever a generic drug is dispensed. If a brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-pay unless the physician specifies "Dispense as Written". **Note**: Non-preferred drugs are covered only if no generic or preferred drug is available. Specialty drugs must be obtained directly from the specialty pharmacy program. Pre-authorization is required for injectables costing over $2,000 per drug per month.
	Preferred brand drugs	$40/prescription. Deductible does not apply.	$80/prescription. Deductible does not apply.	
	Non-preferred brand drugs (Only covered if no generic or preferred drug is available)	$65/prescription. Deductible does not apply.	$130/prescription. Deductible does not apply.	
	Specialty drugs	$200/prescription. Deductible does not apply.	N/A	

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.)

- Cosmetic surgery
- Dental care
- Glasses
- Hearing aids
- Infertility treatment (except diagnosis)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (except for home health care & hospice)
- Routine foot care (except for metabolic or peripheral vascular disease)
- Substance abuse

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

- Acupuncture
- Bariatric surgery (limited to morbid obesity)
- Chiropractic care
- Habilitation services
- Weight loss programs (limited to morbid obesity)

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: HealthNow Administrative Services, 1-855-581-1810, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), 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 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: HealthNow Administrative Services, 1-855-581-1810, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform.

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 1-855-581-1810.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-581-1810.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-855-581-1810.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-581-1810.

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	$950
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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:

Cost Sharing	
Deductibles	$950
Copayments	$10
Coinsurance	$2020
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3040**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$950
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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:

Cost Sharing	
Deductibles	$0
Copayments	$810
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$830**

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

The plan's overall deductible	$950
Specialist copayment	$50
Hospital (facility) coinsurance	20%
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$950
Copayments	$460
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1420**

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