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, contact Tall Tree Administrators. 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.talltreehealth.com or call 1-877-453-4201 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers $0/Individual or $0/Family Out-of-Network Providers $500/Individual or $1,000/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. Preventive care services 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.	
What is the out-of-pocket limit for this plan?	Network Providers $2,000/Individual, $13,200/Family Out-of-Network Providers Unlimited for Family and Individual	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. See www.talltreehealth.com or call 1-877-453-4201 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). 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 do not need a referral to see a specialist.	You can see the specialist you choose without permission from the plan.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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	Deductible, then 40%	Per Plan Provisions
	Specialist visit	$40 copay	Deductible, then 40%	
	Preventive care/screening/ immunization	No charge	Deductible, then 60%	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.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay	Deductible, then 40%	Per Plan Provisions
	Imaging (CT/PET scans, MRIs)	No Benefit	No Benefit	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Generic drugs (Tier 1)	$10 copay/prescription	No Benefit	Covers up to a 30-day supply.
	Preferred brand drugs (Tier 2)	No Benefit	No Benefit	
	Non-preferred brand drugs (Tier 3)	No Benefit	No Benefit	
	Specialty drugs (Tier 4)	No Benefit	No Benefit	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Benefit	No Benefit	
	Physician/surgeon fees	No Benefit	No Benefit	
If you need immediate medical attention	Emergency room care	$400 copay, (Plan payment based on 125% of Medicare Allowable Payment)		Patient may be balance billed if provider does not accept 125% of Medicare Allowable Payment
	Emergency medical transportation	No Benefit	No Benefit	Per Plan Provisions
	Urgent care	$50 copay	Deductible, then 40%	

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)	$400 copay, (Plan payment based on 125% of Medicare Allowable Payment)		Plan payment based on 125% of Medicare Allowable Payment
	Physician/surgeon fees	No Charge	40% of allowed amount	Per Plan Provisions
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Benefit	No Benefit	
	Inpatient services	No Benefit	No Benefit	
If you are pregnant	Office visits	No Charge	No Benefit	Cost sharing does not apply to certain 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	No Charge	40% of allowed amount	
	Childbirth/delivery facility services	$400 copay, (Plan payment based on 125% of Medicare Allowable Payment)		
If you need help recovering or have other special health needs	Home health care	No Benefit	No Benefit	
	Rehabilitation services	No Benefit	No Benefit	
	Habilitation services	No Benefit	No Benefit	
	Skilled nursing care	No Benefit	No Benefit	Per Plan Provisions
	Durable medical equipment	No Benefit	No Benefit	
	Hospice services	No Benefit	No Benefit	
If your child needs dental or eye care	Children's eye exam	No Charge	Deductible, then 60%	
	Children's glasses	No Benefit	No Benefit	
	Children's dental check-up	No Benefit	No Benefit	None

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 (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Long Term Care
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing

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

- Inpatient Hospitalization

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: 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, extension 61565 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: [insert applicable contact information from instructions].

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 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 1-877-453-4201.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-453-4201.]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-453-4201.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-453-4201.]

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	$500
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

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

The plan's overall deductible	$500
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$800
Copayments	$1,200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,360**

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

The plan's overall deductible	$500
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$700
Copayments	$50
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: NOT APPLICABLE
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

Summit Express, Inc.
Minimum Value Coverage Plan (MVP)
Schedule of Medical Benefits
Option ID: SUE7B

Group ID: ESUEI

This Plan provides Minimal Value Coverage for Medical Care.
If the service is not listed on this Schedule of Benefits it is not covered.

*** Pre-Certification: Arizona Foundation - FoundationUM (AZF) 833-291-2519**

Claims Address:
P.O. Box 1807
Draper, Utah 84020
Emdeon Payor ID: 88067
Customer Service: 877-453-4201

PPO Provider Network:
Physicians: PHCS- Specific Services Network
Facilities: 125% of Medicare

Coverage begins the 1st day of the month following 60 days of employment. Coverage ends the last day of the month following termination.
Minimum hours for full time: 130 per month/30 per week

Lifetime Max: None	Network Providers	Non-Network Providers	Benefit Limits Per Plan Year
Annual Deductibles **Does not include Co-pays.** **In-network and Out-of-network are separate accumulations and do not cross apply**	Individual: None Family: None	Individual $500 Family $1,000	**All benefits and accumulations are on a Plan Year.** **Beginning December 1 and ending November 30.** **All limits and accumulations are per person per plan year.**
Annual Co-pay and Co-Insurance **Out of Pocket Maximums** **(Medical and Rx co-pays apply to the annual out of pocket maximums)**	Individual $2,000 Family $13,200	Individual: Unlimited Family: Unlimited	
Office Visits - Primary Care (exam or consultation)	$20 Co-pay, Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
Office Visits - Specialist (exam or consultation)	$40 Co-pay, Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
Office Services - basic services with exam (does not include pain management, chemo, surgical services)	Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
Telemedicine	Plan pays 100%		Physicians available 24 hours a day, seven days a week if you call 800-835-2362
Wellness Care - Adult	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	
Wellness Care - Children	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	
Wellness Care includes, but not limited to: pap smear, mammogram, prostate screening, gynecological exam, routine physical exam, routine vision exam for children, routine hearing exam for children, immunizations and related laboratory blood tests, colonoscopies. Other preventive services as identified by the Patient Protection and Affordable Care Act (PPACA) will be covered.			
Ambulance	No Benefit		
Birth Control / IUD	Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
Breast Pumps	Plan pays 100%		One per delivery. Purchase Breast Pump at a local retail store and submit the receipt for reimbursement
Chemical Dependency - Inpatient	No Benefit		
Chemical Dependency - Outpatient	No Benefit		
Chemotherapy / Radiation Therapy	No Benefit		
Chiropractic Services	No Benefit		
Colonoscopy (For Medical Reasons)	No Benefit		
Diagnostic Services - Basic labs/x-rays (related to office visit, LabCorp, etc.)	$50 Co-pay, Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
Diagnostic Services - Major (MRI, CT, PET, Nuclear Medicine,etc.)	No Benefit		
Diagnostic Services - Minor (ultrasounds, bone density, echography, etc)	No Benefit		
Diabetic Education	No Benefit		
Dialysis	No Benefit		
Durable Medical Equipment (includes orthotics & prosthetics)	No Benefit		
Emergency Room Facilities	$400 Co-pay, Plan pays 100% (Plan payment based on 125% of Medicare Allowable Payment)		** Patient may be balance billed if provider does not accept 125% of Medicare Allowable Payment
Emergency Room - All covered services other than facility charges	Plan pays 100% after $400 ER Co-pay	Plan pays 100% of allowed amount	
Gastric Bypass Surgery / Lap Banding	No Benefit		

	Home Health Care	No Benefit		
	Hospice Care	No Benefit		
AZF	* Hospital Facility - Inpatient Services	$400 Co-pay, Plan pays 100% (Plan payment based on 125% of Medicare Allowable Payment)		** Patient may be balance billed if provider does not accept 125% of Medicare Allowable Payment
	Attending Physician, Surgeon and Anesthesiologist charges during an inpatient hospital confinement	Plan pays 100%	Plan pays 60% of allowed amount	
	Hospital - Outpatient Services (any charge billed from a hospital)	No Benefit		
	Infertility Services	No Benefit		
	Maternity - Prenatal Office Visits Only (billed separately from total delivery)	Plan pays 100%	Deductible, Plan pays 60% of allowed amount	Prenatal office visit is covered for all females covered under the plan
	Maternity - (Labs, x-rays, ultrasounds and related covered services)	No Benefit		Coverage is limited to Employee and Spouse only
AZF	* Maternity - Facility	$400 Co-pay, Plan pays 100% (Plan payment based on 125% of Medicare Allowable Payment)		** Patient may be balance billed if provider does not accept 125% of Medicare Allowable Payment
	Attending Physician, Surgeon and Anesthesiologist charges during an inpatient hospital confinement	Plan pays 100%	Plan pays 60% of allowed amount	
	Medical Supplies (Including but not limited to: Insulin, Diabetic test strips, Insulin pumps, etc.) These supplies may also be covered under Prescription Benefit.	No Benefit		
AZF	* Mental Health - Inpatient	No Benefit		
	Mental Health - Outpatient	No Benefit		
	Outpatient Therapy Physical, Speech and Occupational	No Benefit		
	Outpatient Surgery performed in an office or urgent care facility	Included with office visit or urgent care Co-pay	Deductible, Plan pays 60% of allowed amount	Maximum of $300 per visit
	Skilled Nursing	No Benefit		
	Sleep Studies	No Benefit		
	Sterilization for Women	Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
	Sterilization for Men	No Benefit		
	TMJ and Orthognathic	No Benefit		
AZF	* Transplant Facility	$400 Co-pay, Plan pays 100% (Plan payment based on 125% of Medicare Allowable Payment)		Transplant Services Limited to inpatient hospitalization only ** Patient may be balance billed if provider does not accept 125% of Medicare Allowable Payment
	Attending Physician, Surgeon and Anesthesiologist charges during an inpatient hospital confinement	Plan pays 100%	Plan pays 60% of allowed amount	
	Urgent Care Center & 24 Hours	$50 Co-pay, Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
	Prescription Benefits			
	Covered Prescription Drugs - MagellanRx Management, A Member of The Clean Health Project Pharmacy Member Services: 1-800-424-0472 or www.magellanrx.com Rx Bin #: 017449 Rx PCN #: 6792000 RxGRP: PRXTTA	Generic Prescriptions: $10 Co-pay Brand Prescriptions: No Benefit	No Benefit	Specialty Medications: No Benefit All prescriptions are limited to 31 day supply

Effective: 12/1/2017

*** Pre Certification Required. Failure to obtain Pre Certification may result in a reduction of $250 or denial of benefits.**

**** Payment will be capped at 125% of the Medicare Allowable Payment. If provider does not accept the Medicare Allowable Amount, patient may be balance billed.**

Note: Any non-allowed or not covered amounts or services are the responsibility of the patient and are not included in the Out-of-Pocket Maximum.

Dependents are covered to age 26 regardless of student or marital status.

Timely Filing - Claims must be filed within 12 months from the date of service.

Coordination of benefits - Non duplicating meaning this Plan will not pay in excess of the normal plan benefit in absence of other insurance.

Rural Area is defined as 30 miles. If covered services are not available in the network within 30 miles the provider will be paid in network.

No Pre-existing for employees or dependents.

Out of Country services will be paid as a in-network for covered medical emergencies only, to a maximum of $15,000 of billed charges.

We believe this coverage is a non grandfathered health plan under the Patient Protection and Affordable Care Act. (PPACA)

Visit ***www.talltreehealth.com*** to view the Plan Document, Schedule of Benefits, enrollment information, your claims history, link to the PPO network and more.

All claims are subject to Plan provisions at the time of service. Any benefits quoted telephonically or in writing is not a guarantee of payment.

Claims are determined upon receipt of the claim and any additional information required to make a benefit determination.