Mexico Network RFP

Request for Proposal

City of San Luis, AZ

December 29, 2025

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CBIZ Employee Benefits
A Division of CBIZ Benefits & Insurance Services, Inc.

1765 E Skyline Dr | Tucson | AZ| 85718

I. Introduction

Client Name

City of San Luis Employee Benefits Trust

The City of San Luis, Arizona was founded in 1930 and incorporated in 1979. San Luis is an Arizona general law city, operating under the Council-Manager form of government. The Mayor serves a 4-year term, and six Council members serve staggered 4-year terms.

Located at Arizona's southwest corner of the Colorado River, San Luis borders California and San Luis Rio Colorado, Sonora, Mexico. With a population of 37,207, daily cross-border activity shapes its culture, economy, and environment.

The City employs about 355 full-time and 9 part-time staff, offering comprehensive benefits including medical, dental, vision, life insurance, STD/LTD and supplemental coverage. San Luis operates a self-funded health insurance program managed by the City of San Luis Employee Benefits Trust, overseen by five trustees with executive advisors from HR, Finance, and the City Manager.

Client Information

Address	800 E. Cesar Chavez Blvd., San Luiz, AZ 85349
Covered Population	90 enrolled in Mexico plan
Eligibility	First of the month, following date of hire
Employer Contributions	90% EE only; 80% dependents
Funding	ASO with Personify, renting BCBSAZ Network
Stop Loss Vendor	Nationwide Life Insurance Co., Ryan Specialty
Pharmacy Benefit Manager	Liviniti and RxCompass

Current Benefit Administration

The City of San Luis Employee Benefits Trust currently offers its eligible employees and dependents a single PPO Plan along with a Mexico plan. The current TPA is Personify Health using the BCBS of AZ PPO Network. The Mexico Network plan is through Siarmed and integrated with Personify Health. PBM Services are provided through Liviniti and RxCompass. Stop loss is carved out through Nationwide (Ryan Specialty).

Requested Services and Objective

The City of San Luis Employee Benefits Trust seeks proposals for a Mexico Network to support its employee benefits program. The City will evaluate proposals based upon the following focus areas:

1. Experience working with government employer, like the City of San Luis, and the ability to administer a Mexico based provider network.
2. Exceptional customer service and account management
3. Integration with U.S. Based TPAs

4. Implementation
5. Pricing and Fee Guarantee
6. Provider Network Capabilities
7. Reporting

Contact and Timeline

Direct all communications concerning this Request for Proposal to CBIZ. Under no circumstances may a vendor contact the City of San Luis, its staff or the Trustees of the City of San Luis Employee Benefits Trust Board regarding this RFP. Submit all RFP questions by email to Jennifer Aragon and Debbie Jamison by 01/12/2026. **Questions submitted after this date or via phone message will not be addressed. CBIZ will respond directly to the vendor and only via email. Addendums or clarifications will be provided via email to all vendors that have expressed interest or have provided a proposal.**

CBIZ RFP Contacts	Jennifer Aragon – jaragon@cbiz.com Debbie Jamison – djamison@cbiz.com
CBIZ Producer(s)	Dave Madden – david.madden@cbiz.com
Plan Effective Date	7/1/2026
Proposal Due Date	1/19/2026
RFP Questions Due	1/12/2026
Vendor Decision Date	By: 3/25/2026

Interviews and Best and Final

The City of San Luis Employee Benefits Trust reserves the right, upon review of submitted proposals, to negotiate directly with vendors. This may, but not necessarily, include interviews, requests for clarification, or best and final pricing.

II. General Specifications

Plan Effective Date and Anniversary Date

The effective date is July 1, 2026; anniversary dates will be July 1st of subsequent years.

Commissions

Proposals should not include commissions to CBIZ.

Guaranteed Rates and Renewals

The city prefers a proposal with a fee guarantee or rate cap over multiple years. The City of San Luis requires that administrative fee changes may only be implemented on the anniversary date (July 1 of each year). All fees or pricing changes must be provided to the City of San Luis, in writing, at least six months prior to the anniversary date of each year.

Run Out Services

Upon termination of this contract, the selected vendor agrees to process runout claims for at least twelve months with no additional fees including assisting the City of San Luis by providing transition data and files to subsequent vendors.

Plan Designs and Reporting

The selected vendor agrees to administer the City of San Luis' current plan designs and provide the City and CBIZ access to claims and utilization reports.

Rights to Records

All claim records and eligibility data used by the carrier in its role as claim administrator shall remain the property of the City of San Luis Employee Benefits Trust as Plan Sponsor.

Confidentiality Agreement

Information relative to this RFP may not be released to parties external to this process without the written consent of the City of San Luis and CBIZ. In addition, CBIZ and the City of San Luis agree to hold the information you provide in the strictest confidence and will not share your proposal responses with others outside of our respective organizations.

Vendors Errors/Omissions

Neither the City of San Luis nor CBIZ will be responsible for errors or omissions made in your proposal. You will be permitted to submit only one proposal. You may not revise or withdraw your submitted proposal after the deadline date. After that, revisions to your original submission will not be allowed except as requested by CBIZ or the City of San Luis.

III. Instructions

Submit seven (7) printed/bound copies and one (1) electronic copy on a thumb drive to the CBIZ contacts in Section I by the due date. The proposals must be received by the CBIZ office no later than the RFP due date. Proposals received after the RFP due date will not be considered. Please provide a comprehensive proposal that includes **details** and **narrative explanations** for the following topics.

All proposals should include at least (3) references to include client name, industry, size and contact information, should the city wish to contact a reference prior to awarding.

You may use any format you prefer, but ensure your response addresses each area thoroughly. Please limit examples and supporting documentation to items that directly support the topic:

1. Experience with Government Employer

a. Please describe your experience serving Government employers and administering a Mexico based provider network.

b. What is your licensing and accreditation status for operating in Mexico?

2. Exceptional Customer Service and Account Management

a. Explain your approach to delivering exceptional customer service to members (i.e., understanding how the benefits work, limits/exclusions, resolving provider/claim issues, prior authorization requirements) and helping members access needed services.

b. Provide details about the account management team and other key personnel who will support the City's plan.

c. Describe any additional services that you provide the City or its members accessing your services.

3. Integration with U.S. Based TPAs

a. Please identify your 3 preferred Third-Party Administrators (TPAs) with whom you have established integration and strong working relationships. What makes a preferred Third-Party Administrator (e.g., integration capabilities, operational efficiency, historical performance, or strategic alignment).

b. How do you confirm services are covered by the Plan (limitations and exclusions)?

c. Do you agree to work with non-preferred TPA selected by the City? If yes, please describe the process and any additional fees to set up integration.

4. Implementation

a. Describe your implementation process, timing and how you will support the city and its employees to ensure a smooth transition (i.e., continuation of care and network disruptions).

b. What resources or services will you provide to the City and employees to support the transition to your network?

5. Pricing and Fee Guarantee

a. Provide an itemized breakdown of your pricing by year.

6. Provider Network Capabilities

a. Provide a detailed description of your provider network (i.e., PCPs, Hospitals, Convenience Care Clinics, Specialist). Please include types of providers, specialties, facilities and locations.

b. Are you providers accredited or certified to meet international standards?

c. How do you ensure quality and continuity of care for members?

d. Do you require referrals or can members pick a provider in your network?

e. How do you monitor and maintain credentialing and compliance with local and international standards?

f. What is your process for adding or removing provider from the network, and how do you communicate changes to members?

g. Do you offer telemedicine or virtual care options within your network?

h. How do you handle emergency care or urgent care needs for members outside their immediate community?

i. What measures are in place to prevent balance billing or unexpected charges for members?

j. Please describe your provider payment model. Are providers paid in advance (capitation or prepayment) or after claims have been processed (fee-for-service)?

k. Are providers employed directly by your organization, or do you contract with them independently? Describe what percentage of the providers are employees of your organization.

7. Reporting

a. Describe your reporting capabilities and what standard reports do you provide the City?

b. How frequently are reports available (monthly, quarterly)?

c. Can you provide reporting on provider performance, quality metrics, and member outcomes?

V. Attachments -

The following documents are included as attachments to this RFP:

A. Current U.S. Benefit Summary
B. Current Mexico Benefit Summary

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, call 1-800-221-8942 or visit us at www.trans-western.com. 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 1-800-221-8942 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 and services this plan covers.
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.	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable.	This plan does not have an out-of-pocket limit.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. All medical services must be rendered by Hospital Santa Margarita. Please contact Transwestern at (800) 221-8942 for more information.	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?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

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	$10 co-pay	Not covered	Maximum of 5 office visits per calendar year combined with specialist visits.
	Specialist visit	$10 co-pay	Not covered	Maximum of 5 visits per year combined with primary care visits. Must be approved prior to appointment.
	Preventive care/screening/ immunization	No charge	Not covered	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. Preventive services do not include healthcare related services that are provided as a result of illness, injury or congenital defect.
If you have a test	Diagnostic test (x-ray, blood work)	$10 co-pay	Not covered	No charge if performed during office visit or hospitalization; otherwise $10 co-payment per visit per patient. Maximum of 5 procedures/test per calendar
	Imaging (CT/PET scans, MRIs)	$50 co-pay for CT scan and $100 co-pay for MRI	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.transwestern.com	Generic drugs	$5 co-pay	Not covered	Maximum of 10 Generic and Brand Rx combined per calendar year.
	Preferred brand drugs	$20 co-pay	Not covered	Maximum of 10 Generic and Brand Rx combined per calendar year.
	Non-preferred brand drugs	Not covered	Not covered	None
	Specialty drugs	Not covered	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 co-pay	Not covered	Maximum of 2 visit per year
	Physician/surgeon fees	$10 co-pay	Not covered	Maximum of 2 visit per year
If you need immediate medical attention	Emergency room care	$100 per hospitalization per patient	Not covered	Maximum of 1 ER visit per year

* For more information about limitations and exceptions, see the plan or policy document at www.trans-western.com.

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)	
	Emergency medical transportation	Not covered	Not covered	None
	Urgent care	$50 co-pay	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 co-pay per surgical hospitalization.	Not covered	Confinement of 18 hours or more. 1 inpatient stay per calendar year.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services	Not covered	Not covered	None
If you are pregnant	Office visits	$10 co-pay	Not covered	Prenatal and Postnatal Care office visits
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	$150 co-pay per patient	Not covered	48 hours following a vaginal delivery 96 hours following a cesarean delivery
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None
	Rehabilitation services	Not covered	Not covered	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	Not covered	Not covered	None
	Hospice services	Not covered	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	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
- Bariatric Surgery
- Dental Care (Adult)
- Cosmetic Surgery
- Chiropractic Care
- Hearing Aids
- Infertility treatment
- Long Term care
- 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.)

- Coverage provided outside the United States contact Transwestern Insurance at (800) 221-8942 for Mexico coverage

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 are 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 x 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 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: www.dol.gov/ebsa/healthreform.

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 1-800-221-8942.

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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 *[cost sharing]*	**$10**
Hospital (facility) *[cost sharing]*	**$150**
Other *[cost sharing]*	**$10**

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	**$12,759**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$370
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$430**

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 *[cost sharing]*	**$10**
Hospital (facility) *[cost sharing]*	**$150**
Other *[cost sharing]*	**$10**

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	**$7,431**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$485
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,685
The total Joe would pay is	**$3,170**

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

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$10**
Hospital (facility) *[cost sharing]*	**$150**
Other *[cost sharing]*	**$10**

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	**$1,991**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$340
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,007
The total Mia would pay is	**$1,347**

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

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, call 1-888-472-4352. 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 1-888-472-4352 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, all services.		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?	Network Not Applicable	Non-Network $20,000/self only $20,000/individual $40,000/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 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 billing charges (unless balance billing is prohibited), health care this plan doesn't cover, and penalties for failure to obtain pre-certification for services.		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.hchealthbenefits.com or call 1-888-472-4352 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 a non-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 a non-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?	Yes.		This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

* For more information about limitations and exceptions, see the plan or policy document at www.hchealthbenefits.com.

⚠ 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)	Non-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	$5 copay/visit	Not covered	Members must request a Specialist referral through Siarmed.
	Specialist visit	$5 copay/visit	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	**Inpatient:** No charge **Office, Outpatient, & Standalone facility:** $5 copay	Not covered	Network provider copay applies to services performed in the office.
	Imaging (CT/PET scans, MRIs)	$25 copay/visit	Not covered	Precertification is required or the network benefit could be reduced by $250; or the non-network benefit could be reduced by 40%.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hchealthbenefits.com	Generic drugs	$2/prescription	Purchases at a non-participating pharmacy require you to pay in full then submit a claim form for reimbursement.	Covers up to a 30-day supply (retail pharmacy).
	Formulary brand drugs	$5/prescription		
	Non-formulary brand drugs	Not covered		
	Specialty drugs	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 copay/visit	Not covered	Precertification is required or the network benefit could be reduced by $250; or the non-network benefit could be reduced by 40%.
	Physician/surgeon fees	No charge	Not covered	None

* For more information about limitations and exceptions, see the plan or policy document at www.hchealthbenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	**Services performed in Mexico** (Siarmed)**:** $20 copay/visit **Services performed in the US:*** $150 copay/visit		The copay is waived if you are admitted to the hospital directly from the emergency room. *Non-network services are only covered in case of emergency. Out of pocket maximum will apply.
	Emergency medical transportation	No charge		
	Urgent care	$20 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$50 copay/visit	50% coinsurance*	Precertification is required or the network benefit could be reduced by $250; or the non-network benefit could be reduced by 40%. *Non-network services are only covered in case of emergency. Out of pocket maximum will apply.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office visits:** $5 copay/visit	Not covered	None
	Inpatient services	Fewer than 12 hours: $25 copay/visit More than 12 hours: $50 copay/visit	50% coinsurance*	Precertification is required or the network benefit could be reduced by $250; or the non-network benefit could be reduced by 40%. *Non-network services are only covered in case of emergency. Out of pocket maximum will apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Initial visit: $5 copay Subsequent visits: No charge	Not covered	Cost sharing does not apply for network preventive care 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	Not covered	None
	Childbirth/delivery facility services	$50 copay/visit	50% coinsurance*	Precertification is required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery) or the network benefit could be reduced by $250; or the non-network benefit could be reduced by 40%. *Non-network services are only covered in case of emergency. Out of pocket maximum will apply.
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No coverage for home health care.
	Rehabilitation services	$5 copay/visit	Not covered	Limited to Physical, Pulmonary, and Speech therapies.
	Habilitation services	$5 copay/visit	Not covered	
	Skilled nursing care	Not covered	Not covered	No coverage for skilled nursing care.
	Durable medical equipment	$5 copay/visit	Not covered	Jobst stockings limited to 1 pair per calendar year. Mastectomy bras limited to 7 per calendar year.
	Hospice services	Not covered	Not covered	No coverage for Hospice Services.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 exam per calendar year.
	Children's glasses	Not covered	Not covered	No coverage for children's glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

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
- Chiropractic care
- Cosmetic surgery
- Dental Care (Adult) / (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. and/or Mexico, unless otherwise indicated. Refer to your Plan Document and Summary Plan Description for additional details.
- Private-duty nursing
- 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.)

- Habilitation services (Limited to physical, pulmonary, and speech therapies)
- Hearing Aid (Limited to $1,500 per ear every 3 calendar years)
- Routine eye care (Adult) / (Child) (Limited to 1 exam/calendar year)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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? 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 1-888-472-4352.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-472-4352.

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.hchealthbenefits.com.

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** **$5**
- **Hospital (facility) copayment** **$50**
- **Other (Tests) copayment** **$5**

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	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$260**

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** **$5**
- **Hospital (facility) copayment** **$50**
- **Other (Brand drug) copayment** **$5**

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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$220**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$5**
- **Hospital (facility) copayment** **$50**
- **Other (Physical Therapy) copayment** **$5**

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	$0
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$80**

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