



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, [www.meritain.com](http://www.meritain.com) or call (866) 300-8449. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call Meritain Health, Inc. at (866) 300-8449 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For Tier 1 providers: \$1,600 individual / \$3,200 family. For Tier 2 providers: \$2,150 individual / \$4,300 family. For Tier 3 providers: \$2,500 individual / \$5,000 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 policy, the overall family deductible must be met before the plan begins to pay.
<b>Are there services covered before you meet your deductible?</b>	Yes. Preventive care, flu shots, pneumonia and shingles immunizations 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For Tier 1 providers: \$4,500 individual / \$9,000 family. For Tier 2 providers: \$5,500 individual / \$11,000 family. For Tier 3 providers: Unlimited individual or 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.
<b>What is not included in the out-of-pocket limit?</b>	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.
<b>Will you pay less if you use a network provider?</b>	Yes. For Banner JV see <a href="http://www.aetna.com/docfind/custom/my_meritain">www.aetna.com/docfind/custom/my_meritain</a> or call (800) 343-3140 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.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the specialist you choose without a referral.
<b>Is a Health Savings Account (HSA) available under this plan option?</b>	Yes.	An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS.



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 Banner Providers	Tier 2 Participating Provider	Tier 3 Non-Participating Provider	
		(You will pay the least)	(You will pay the most)		
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered. Includes telemedicine other than Teladoc. There is no charge after the <u>deductible</u> if you receive consultation services through Teladoc.
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit	\$35 <u>copay</u> /visit	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / immunization	<u>Preventive care</u> : No Charge Routine care: No charge for the first \$300 per year, then 90% <u>coinsurance</u> Flu, pneumonia & shingles immunization: No Charge Hearing exam: 20% <u>coinsurance</u>	<u>Preventive care</u> : No Charge Routine care: No charge for the first \$300 per year, then 90% <u>coinsurance</u> Flu, pneumonia & shingles immunization: No Charge Hearing exam: 20% <u>coinsurance</u>	<u>Preventive care</u> : Not Covered Routine care: No charge for flu, pneumonia & shingles immunizations Hearing exam: 50% <u>coinsurance</u> All other routine care: Not Covered	<u>Deductible</u> does not apply for participating <u>providers</u> . <u>Deductible</u> does not apply for flu, pneumonia and shingles immunizations for non-participating <u>providers</u> . Hearing exams limited to 1 per year. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for PET scans and non-orthopedic CT/MRI's. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	\$15 <u>copay</u> (30-day supply)/ \$30 <u>copay</u> (90-day supply)		Not Covered	Major medical <u>deductible</u> applies. Covers up to a 30-day supply (retail prescription or <u>specialty drugs</u> ); 90-day supply (retail prescription or mail order). <u>Plan</u> requires pharmacies to dispense generic drugs when available. Mandatory generic provision applies. There is no charge or <u>deductible</u> for preventive drugs.
	Preferred drugs	20% <u>coinsurance</u> (\$25 min/\$80 max) (30-day supply)/ 20% <u>coinsurance</u> (\$50 min/\$175 max) (90-day supply)		Not Covered	
	Non-preferred drugs	40% <u>coinsurance</u> (\$40 min/\$110 max) (30-day supply)/ 40% <u>coinsurance</u> (\$80 min/\$225 max) (90-day supply)		Not Covered	

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		(You will pay the least)	(You will pay the most)		
	<u>Specialty drugs</u>	\$200 <u>copay</u> *		Not Covered	This <u>plan</u> will allow maintenance medications to be filled at any retail pharmacy and through mail order in 90-day quantities only. Persons benefit from paying 2 <u>copays</u> for a 90-day supply. Maintenance medications are subject to the retail or mail order supply limit and <u>copays</u> . <u>Specialty drugs</u> must be obtained directly from the specialty pharmacy <u>network</u> . *Certain <u>specialty drugs</u> may be eligible for a \$0 <u>copay</u> if you are enrolled under the PrudentRx Copay Program. If drugs are eligible under the Prudent Rx Copay Program and you do not enroll you will be subject to a 30% <u>copay</u> . <u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> (emergency services)/ 50% <u>coinsurance</u> (non-emergency services)	Tier 2 and Tier 3 <u>providers</u> paid at the Tier 1 <u>provider</u> level of benefits for <u>emergency services</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> /trip (ground)/ \$200 <u>copay</u> /trip + 20% <u>coinsurance</u> (air)	20% <u>coinsurance</u> /trip (ground)/ \$200 <u>copay</u> /trip + 20% <u>coinsurance</u> (air)	20% <u>coinsurance</u> /trip (ground)/ \$200 <u>copay</u> /trip + 20% <u>coinsurance</u> (air)	Tier 2 and Tier 3 <u>providers</u> paid at the Tier 1 <u>provider</u> level of benefits.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Banner Providers	Tier 2 Participating Provider	Tier 3 Non-Participating Provider	
		(You will pay the least)	(You will pay the most)		
	<u>Urgent care</u>	\$40 <u>copay</u> /visit	\$45 <u>copay</u> /visit	50% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$200 <u>copay</u> /admission + 20% <u>coinsurance</u>	\$250 <u>copay</u> /admission + 20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <u>copay</u> /visit (office visit)/ 20% <u>coinsurance</u> (all other outpatient)	\$25 <u>copay</u> /visit (office visit)/ 20% <u>coinsurance</u> (all other outpatient)	50% <u>coinsurance</u>	Includes telemedicine other than Teladoc.
	Inpatient services	\$200 <u>copay</u> /admission + 20% <u>coinsurance</u> (facility charge)/ 20% <u>coinsurance</u> (professional fees)	\$250 <u>copay</u> /admission + 20% <u>coinsurance</u> (facility charge)/ 20% <u>coinsurance</u> (professional fees)	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service. <u>Cost sharing</u> does not apply to <u>preventive services</u> from a Tier 1 or Tier 2 <u>provider</u> . Depending on the type of services, a <u>copay</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense.
	Childbirth/ delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/ delivery facility services	\$200 <u>copay</u> /admission + 20% <u>coinsurance</u>	\$250 <u>copay</u> /admission + 20% <u>coinsurance</u>	50% <u>coinsurance</u>	

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		(You will pay the least)	(You will pay the most)		
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 visits per year. <u>Home health care</u> supplies not subject to the calendar year maximum. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> (outpatient)/ \$200 <u>copay</u> /admission + 20% <u>coinsurance</u> (inpatient)	20% <u>coinsurance</u> (outpatient)/ \$250 <u>copay</u> /admission + 20% <u>coinsurance</u> (inpatient)	50% <u>coinsurance</u>	Physical, speech & occupational therapy limited to 60 visits per each type of therapy per year. Inpatient services limited to 60 days per year.
	<u>Habilitation services</u>	Not Covered	Not Covered	Not Covered	This exclusion will not apply to expenses that are considered mental health or substance abuse services.
	<u>Skilled nursing care</u>	\$200 <u>copay</u> / admission + 20% <u>coinsurance</u>	\$250 <u>copay</u> / admission + 20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 days per 12 month period. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Includes diabetic supplies. <u>Preauthorization</u> required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	<u>Hospice services</u>	20% <u>coinsurance</u> (outpatient)/ \$200 <u>copay</u> / admission + 20% <u>coinsurance</u> (inpatient)	20% <u>coinsurance</u> (outpatient)/ \$250 <u>copay</u> / admission + 20% <u>coinsurance</u> (inpatient)	50% <u>coinsurance</u>	Bereavement counseling is not covered.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Banner Providers	Tier 2 Participating Provider	Tier 3 Non-Participating Provider	
		(You will pay the least)	(You will pay the most)		
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's glasses	Not Covered	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Covered under stand alone dental plan.

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bereavement counseling</li> <li>• Cosmetic surgery</li> <li>• Dental care (covered under stand alone dental plan)</li> <li>• Glasses (covered under stand alone vision plan)</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitation services (except autism &amp; preventive services)</li> <li>• Infertility treatment (except diagnosis)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (except for home health care &amp; hospice)</li> <li>• Routine eye care (covered under stand alone vision plan)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these <u>services</u> . This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery (for the treatment of morbid obesity only – 1 procedure per lifetime)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (20 visits per year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (1 aid per ear every 36 months)</li> </ul>

**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: 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](http://www.cciio.cms.gov), or Meritain Health at (866) 300-8449. 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](http://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 Meritain Health, Inc. at (866) 300-8449.

**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 1-800-378-1179.

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, kwijigo 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 Tier 1 pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,600
- Primary Care Physician copayment \$20
- Hospital (facility) copayment \$200
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$200
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,660</b>

**Managing Joe's Type 2 Diabetes**  
(a year of routine Tier 1 care of a well-controlled condition)

- The plan's overall deductible \$1,600
- Specialist copayment \$30
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$200
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,420</b>

**Mia's Simple Fracture**  
(Tier 1 emergency room visit and follow up care)

- The plan's overall deductible \$1,600
- Specialist copayment \$30
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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