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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers: $300 individual / $900 family For non-participating providers: $1,200 individual / $3,600 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; participating provider services for: office visits, urgent care, inpatient facility fees, freestanding lab services, and rehabilitation 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers: $4,000 individual / $8,000 family For non-participating providers: Unlimited	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-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. Blue Cross® Blue Shield® of Arizona. See www.azblue.com or call (800) 232-2345 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	50% coinsurance	Deductible does not apply for participating providers. Copay applies per visit regardless of what services are rendered.
	Specialist visit	$35 copay/visit	50% coinsurance	
	Preventive care/screening/ immunization	Preventive care: No charge Routine care: No charge for the first $300 per year, then 90% coinsurance Flu, pneumonia and shingles immunization: No charge Hearing exam: $25 copay	Preventive care: Not covered Routine care: No charge for flu, pneumonia and shingles immunizations Hearing exam: 50% coinsurance All other routine care: Not covered	Deductible does not apply for participating providers. Deductible does not apply for flu, pneumonia and shingles immunizations for non-participating providers. Hearing exams limited to 1 per year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/test (freestanding lab) / 15% coinsurance (all other facilities)	50% coinsurance	Deductible does not apply for tests performed at a participating providers freestanding laboratory.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	50% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myCatamaranrx.com	Generic drugs	$15 copay (retail) / $30 copay (mail order)	Not Covered	Deductible does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (available only by mail order). Copay applies per prescription. Mandatory generic provision applies. There is no charge and the deductible does not apply to preventive drugs. Diabetic medications will have $5 copay (retail) /$10 copay (mail order) for generic and $10 copay (retail)/$30 copay (mail order) for brand name when enrolled in the Catamaran
	Preferred drugs	20% copay ($25 min, $80 max)(retail) / 20% copay ($50 min, $175 max) (mail order)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Non-preferred drugs	40% copay ($40 min, $110 max) (retail) / 40% copay ($80 min, $225 max) (mail order)	Not Covered	Diabetic Sense Program. Maintenance medications are subject to the retail or mail order supply limit and copays.
	Specialty drugs	20% copay ($100 min, $150 max)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	50% coinsurance	Preauthorization required unless performed in an office setting. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. For participating physician office surgery under $1,000 cost is $25 copay/occurrence (PCP) or $35 copay/occurrence (specialist) with no deductible. Surgery over $1,000 cost is 15% coinsurance after deductible (PCP & specialist).
	Physician/surgeon fees	15% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance (medical emergency)/50% coinsurance (non-medical emergency)	Non-participating providers paid at the participating provider level of benefits for emergency services.
	Emergency medical transportation	15% coinsurance/trip (ground) $200 copay/trip + 15% coinsurance (air)	15% coinsurance/trip (ground) $200 copay/trip + 15% coinsurance (air)	Non-participating providers paid at the participating provider level of benefits.
	Urgent care	$50 copay/visit +15% coinsurance	50% coinsurance	Deductible does not apply for participating providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission + 15% coinsurance	$300 copay/admission + 50% coinsurance	Deductible does not apply for participating provider facility fees. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	15% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay (office visit) /15% coinsurance (all other outpatient)	50% coinsurance	Deductible does not apply for participating providers office visit.
	Inpatient services	$250 copay/admission + 15% coinsurance (facility charge)/15% coinsurance (professional fees)	$300 copay/admission + 50% coinsurance	Deductible does not apply for participating provider facility fees. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
If you are pregnant	Office visits	15% coinsurance	50% coinsurance	Preauthorization required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. Cost sharing does not apply to preventive services. Depending on the type of services, a copay, coinsurance or deductible 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	15% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$250 copay/admission + 15% coinsurance Deductible does not apply.	$300 copay/admission + 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	50% coinsurance	Limited to 60 visits per year. Home health care supplies not subject to the calendar year maximum.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Rehabilitation services	$25 copay/visit	50% coinsurance	Deductible does not apply for participating providers. Includes physical, speech & occupational therapy. Limited to 60 visits per each type of therapy, per year.
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism and to expenses covered as preventive services.
If you need help recovering or have other special health needs	Skilled nursing care	$250 copay/admission + 15% coinsurance	$300 copay/admission + 50% coinsurance	Deductible does not apply for participating providers. Limited to 60 days per 12 month period. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Durable medical equipment	15% coinsurance	50% coinsurance	Preauthorization required for any item in excess of $1,500. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Hospice services	$250 copay/admission + 15% coinsurance (inpatient) /15% coinsurance (outpatient)	$300 copay/admission + 50% coinsurance	Deductible does not apply to services received on an inpatient basis from a participating provider. Bereavement counseling is not covered. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's glasses	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's dental check-up	Not Covered	Not Covered	Covered under stand alone dental plan.

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**
- **Bereavement counseling**
- **Cosmetic surgery**
- **Dental care (covered under stand alone dental plan)**
- **Glasses (covered under stand alone vision plan)**
- **Habilitation services (except autism & preventive services)**
- **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 eye care (covered under stand alone vision plan)**
- **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.)

- **Bariatric surgery (for the treatment of morbid obesity only)**
- **Chiropractic care**
- **Hearing aids**

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa or Meritain Health, Inc. 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 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 Meritain Health, Inc. at (866) 300-8449 or The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

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

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

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$300**
Primary Care Physician copayment	**$25**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$360
Coinsurance	$1,860
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,580

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

The plan's overall deductible	**$300**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$735
Coinsurance	$996
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,086

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

The plan's overall deductible	**$300**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$205
Coinsurance	$212
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$717

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