MEDICAL SCHEDULE OF BENEFITS – VALUE GOLD BANNER 2024-2025

VALUE GOLD BANNER 2024-2025	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited		
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited		
CALENDAR YEAR DEDUCTIBLE			
Single	$600	$750	$3,000
Family	$1,200	$1,500	$9,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance, Copays and Precertification Penalties – combined with Prescription Drug Card)			
Single	$4,000	$5,000	Not Applicable
Family	$8,000	$10,000	Not Applicable
MEDICAL BENEFITS			
Allergy Serum & Injections			
Injections (If no office visit charge)	100% after $5 Copay per visit; Deductible waived	100% after $5 Copay per visit; Deductible waived	50% after Deductible
Serum	100% after $36 Copay per visit; Deductible waived	100% after $45 Copay per visit; Deductible waived	50% after Deductible
Ambulance Services			
Ground Ambulance Services	75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Air Ambulance Services	$200 Copay per trip, then 75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Ambulatory Surgical Center	75% after Deductible	75% after Deductible	50% after Deductible
Anesthesiologist	75% after Deductible	75% after Deductible	50% after Deductible
Anti-Embolism Garments	$40 Copay per pair, then 75%; Deductible waived	$50 Copay per pair, then 75%; Deductible waived	$50 Copay per pair, then 50% after Deductible
Calendar Year Maximum Benefit	3 pairs		

VALUE GOLD BANNER 2024-2025	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Cardiac Rehab (Outpatient)	100% after $28 Copay per visit; Deductible waived	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Chemotherapy (Outpatient – includes all related charges)	75% after Deductible	75% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	100% after $28 Copay per visit; Deductible waived	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	20 visits		
Diabetic Supplies	100% after $30 Copay per item; Deductible waived	100% after $30 Copay per item; Deductible waived	50% after Deductible
Diagnostic Testing, X-Ray and Lab Services (Outpatient)			
Any Single Service Costing Less Than $500	75% after Deductible	75% after Deductible	50% after Deductible
Any Single Service Costing $500 or More	75% after Deductible	75% after Deductible	50% after Deductible
Freestanding Laboratory	75%; Deductible waived	75%; Deductible waived	50% after Deductible
Oncotype Diagnostic Testing	75% after Deductible	75% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	75% after Deductible	75% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	75% after Deductible	75% after Deductible	50% after Deductible
Emergency Services			
Emergency Medical Condition			
Facility Charges	75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Professional Fees and Ancillary Charges	75% after Deductible	Paid at Tier 1 level of benefits	Paid at Tier 1 level of benefits
Non-Emergency Medical Condition			
Facility Charges	75% after Deductible	75% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	75% after Deductible	75% after Deductible	50% after Deductible

VALUE GOLD BANNER 2024-2025	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Empower Health (TIN: 36-4836722)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: Empower Health wellness program is a voluntary wellness program available to the Employee only, Dependent Spouses and Children are not eligible. If you elect to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related choices. You will also be asked to complete a biometric screening, which will include a blood pressure reading and blood test. For more information regarding this program you may call Empower Health at (866) 367-6974.			
Foot Orthotics	$40 Copay per orthotic, then 75%; Deductible waived	$50 Copay per orthotic, then 75%; Deductible waived	$50 Copay per orthotic, then 50% after Deductible
Maximum Benefit	Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months		
Hearing Aids (including any office visit and any related services, includes cochlear Implants)	75% after Deductible	75% after Deductible	50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period		
Hemodialysis (Outpatient)	75% after Deductible	75% after Deductible	50% after Deductible
Hinge Health Program (TIN 81-1884841)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: Please refer to the Hinge Health Program section of this Plan for a more detailed description of this benefit. If treatment is received from providers outside of the Hinge Health Network, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits.			
Home Health Care	75% after Deductible	75% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits*		
*Home health care supplies are not subject to the Calendar Year Maximum.			
Hospice Care			
Inpatient	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Outpatient	75% after Deductible	75% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)			
Inpatient	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	75% after Deductible	75% after Deductible	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.			

VALUE GOLD BANNER 2024-2025	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Infusion Therapy in Facility or Physician's Office	75% after Deductible	75% after Deductible	50% after Deductible
Maternity (Non-Facility Charges)*			
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	75% after Deductible	75% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.			
Medical and Surgical Supplies	75% after Deductible	75% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders			
Inpatient			
Facility Charge	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Professional Fees	75% after Deductible	75% after Deductible	50% after Deductible
Outpatient Facility	75% after Deductible	75% after Deductible	50% after Deductible
Office Visits	100% after $28 Copay; Deductible waived	100% after $35 Copay; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.			
Morbid Obesity (Surgical Treatment Only)			
Facility (Inpatient and outpatient)	$200 Copay, then 75%; Deductible waived	$250 Copay, then 75%; Deductible waived	50% after Deductible
Professional Services	75% after Deductible	75% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure		
Nutritional Food Supplements	50% after Deductible	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	100% after $28 Copay per visit; Deductible waived	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		

VALUE GOLD BANNER 2024-2025	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Pain Management	Paid based on place of service	Paid based on place of service	Paid based on place of service
Calendar Year Maximum Benefit	Not Applicable	Not Applicable	4 visits
Physical Therapy (Outpatient)	100% after $28 Copay per visit; Deductible waived	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Physician's Services			
Inpatient/Outpatient Services			
Primary Care Physician	75% after Deductible	75% after Deductible	50% after Deductible
Specialist	75% after Deductible	75% after Deductible	50% after Deductible
Office Visits			
Primary Care Physician	100% after $28 Copay*; Deductible waived	100% after $35 Copay*; Deductible waived	50% after Deductible
Specialist	100% after $36 Copay*; Deductible waived	100% after $45 Copay*; Deductible waived	50% after Deductible
Physician Office Surgery			
Primary Care Physician	Under $1,000 - 100% after $28 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	Under $1,000 - 100% after $35 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	50% after Deductible
Specialist	Under $1,000 - 100% after $36 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	Under $1,000 - 100% after $45 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			

VALUE GOLD BANNER 2024-2025	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care			
Preventive Services (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%; Deductible waived	100%; Deductible waived	Not Covered
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% of the first $300 per Calendar Year, then 10%; Deductible waived	100% of the first $300 per Calendar Year, then 10%; Deductible waived	Not Covered
Flu, Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	100% after $28 Copay per exam; Deductible waived	100% after $35 Copay per exam; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam		
NOTE: Preventive prenatal and breastfeeding support are paid under the Maternity Benefit. Please see Maternity listed above for additional details.			
Prosthetics (other than bras)	75% after Deductible	75% after Deductible	50% after Deductible
Prosthetic Bras	75% after Deductible	75% after Deductible	75% after Deductible
Calendar Year Maximum Benefit	2 bras		
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient - includes all related charges)	75% after Deductible	75% after Deductible	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Calendar Year Maximum Benefit	60 days		
Skilled Nursing Facility	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days		
SkinIO Provider (Skin Cancer Screenings)	Not Applicable	100%; Deductible waived	Not Applicable
NOTE: SkinIO is technology-based skin cancer screenings – providing access for early detection of skin cancer via photo-taking; remote dermatologist review; mole mapping; and change tracking and outlier detection for earlier detection for persons age 18 and over. TIN: 82-2035738			

VALUE GOLD BANNER 2024-2025	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Speech Therapy (Outpatient)	100% after $28 Copay per visit; Deductible waived	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	60 visits		
Surgery (Inpatient)			
Facility	$200 Copay per admission, then 75%; Deductible waived	$250 Copay per admission, then 75%; Deductible waived	50% after Deductible
Professional Services	75% after Deductible	75% after Deductible	50% after Deductible
Surgery (Outpatient) (does not include Surgery in the Physician's office)			
Facility	75% after Deductible	75% after Deductible	50% after Deductible
Professional Services	75% after Deductible	75% after Deductible	50% after Deductible
Teladoc Network Providers	Not Applicable	100%; Deductible waived	Not Applicable
Telemedicine			
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Temporomandibular Joint Dysfunction (TMJ)	$40 Copay per occurrence, then 75%; Deductible waived	$50 Copay per occurrence, then 75%; Deductible waived	$50 Copay per occurrence, then 50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	1 Surgical Procedure 1 appliance $1,000		

VALUE GOLD BANNER 2024-2025	TIER 1: BANNER HEALTH NETWORK	TIER 2: PARTICIPATING PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Transplants			
Facility Charges	$200 Copay per admission, then 75%; Deductible waived (Aetna IOE Program)*	$250 Copay per admission, then 75%; Deductible waived (Aetna IOE Program)*	Not Covered
Professional Fees	75% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	75% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.			
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.			
Urgent Care Facility	$46 Copay* per visit, then 100%; Deductible waived	$55 Copay* per visit, then 100%; Deductible waived	50% after Deductible
*Copay applies per visit regardless of what services are rendered.			
Virta Health Providers (TIN 36-4841662)	100%; Deductibles and Copays waived	Paid at Tier 1 level of benefits	Not Applicable
NOTE: Virta Health is an online specialty medical clinic that reverses Type 2 diabetes safely and sustainably, without the risks, costs, or side effects of medications or Surgery**.** For more information you may complete an application at www.virtahealth.com.			
Wig (see Eligible Medical Expenses)	$40 Copay per wig, then 75%; Deductible waived	$50 Copay per wig, then 75%; Deductible waived	$50 Copay per wig, then 75%; Deductible waived
Maximum Benefit per 24 Month Period	1 wig		
All Other Eligible Medical Expenses	$40 Copay*, then 75%; Deductible waived	$50 Copay*, then 75%; Deductible waived	$50 Copay*, then 50% after Deductible
*Copay applies per eligible item, service or occurrence.			

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – VALUE GOLD BANNER 2024-2025

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating pharmacy.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Copays – combined with major medical Out-of-Pocket) Single Family	 $5,000 $10,000
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	20% Copay ($25 minimum, $80 maximum)
Non-Preferred Drug	40% Copay ($40 minimum, $110 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications Generic Brand Diabetic Supplies Generic Brand	 $5 Copay $15 Copay $5 Copay $15 Copay
Specialty Pharmacy Network: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through PrudentRx Solution	$200 Copay
Enrolled and Available with PrudentRx Solution	$0 Copay
Not Enrolled and Available with PrudentRx Solution	30% Copay
NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details.	
NOTE: PrudentRx Solution assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a $0 Out-of-Pocket responsibility for their prescriptions covered under the PrudentRx Solution program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Solution program.	
CVS Maintenance Choice – Allow Opt-Out: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	40% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)

Diabetic Insulin Medications	
Generic	$10 Copay
Brand	$30 Copay
Diabetic Supplies	
Generic	$10 Copay
Brand	$30 Copay
Mail Order: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	40% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Insulin Medications	
Generic	$10 Copay
Brand	$30 Copay
Diabetic Supplies	
Generic	$10 Copay
Brand	$30 Copay

CVS True Accumulation Program
Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

CVS Maintenance Choice Mandatory – Allow Opt Out
The Plan allows for 2 30-day fills of maintenance drugs at any Participating retail pharmacy. After 2 fills, a 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy or through the mail order program unless you call the Prescription Drug Program Administrator and opt out. If you opt out, you may continue to purchase a 30-day supply of maintenance drugs, however, you will not benefit from the savings of a 90-day supply. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Pharmacy Network
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Advanced Control Specialty Formulary
Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

PrudentRx Copay Program for Specialty Medications
In order to provide a comprehensive and cost-effective Prescription Drug program for you and your family, your Employer has contracted to offer the PrudentRx Solution for certain Specialty Drugs. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% Copay. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their Specialty Drugs, the member will have a $0 Out-of-Pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing Out-of-Pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more Specialty Drugs included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at (800) 578-4403 to register for any manufacturer copay assistance program available for your Specialty Drug as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will make outreach to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call (800) 578-4403. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your Plan Deductible or Out-of-Pocket Maximum (if applicable), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your Deductible or Out-of-Pocket Maximum (if any), unless otherwise required by law. A list of Specialty Drugs that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Solution.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

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, go to 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 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 Tier 1 providers: $600 individual / $1,200 family For Tier 2 providers: $750 individual / $1,500 family For Tier 3 providers: $3,000 individual / $9,000 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 as specified. For Tier 1 and Tier 2 providers services for: office visits, durable medical equipment (diabetic supplies only), 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 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 Tier 1 providers: $4,000 individual / $8,000 family For Tier 2 providers: $5,000 individual / $10,000 family For Tier 3 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. For Banner JV see www.aetna.com/docfind/custom/meritain 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(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	$28 copay/visit	$35 copay/visit	50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers. Copay applies per visit regardless of what services are rendered. Includes telemedicine other than Teladoc. There is no charge, and the deductible does not apply if you receive consultation services through Teladoc.
	Specialist visit	$36 copay/visit	$45 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: $28 copay	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: $35 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 Tier 1 and Tier 2 providers. Deductible does not apply for flu, pneumonia and shingles immunizations for Tier 3 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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	25% coinsurance	50% coinsurance	Deductible does not apply for tests performed at a Tier 1 and Tier 2 providers freestanding laboratory.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	25% coinsurance	50% coinsurance	Preauthorization required for PET scans and non-orthopedic CT/MRI's. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$15 copay (30-day retail)/ $30 copay (90-day retail & mail order)		Not Covered	Deductible does not apply. Covers up to a 30-day supply (retail prescription or specialty drugs); 90-day supply (retail prescription or mail order). Copay applies per prescription. Mandatory generic provision applies. There is no charge for preventive drugs. Diabetic insulin medications will have $5 copay (30-day retail) /$10 copay (90-day retail and mail order) for generic and $15 copay (30-day retail)/$30 copay (90-day retail and mail order) for brand name. Diabetic supplies will be paid the same as all other drugs (retail) and will have a $10 copay (mail order) for generic and $30 copay (mail order) for brand. Maintenance medications are subject to the retail or mail order supply limit and copays. Specialty drugs must be obtained directly from the specialty pharmacy network. *Certain specialty drugs may be eligible for a $0 copay 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% copay. Preauthorization required for injectables costing over $2,000 per drug per month.
	Preferred brand drugs	20% copay, ($25 minimum, $80 maximum) (30-day retail)/ 20% copay, ($50 minimum, $175 maximum) (90-day retail & mail order)		Not Covered	
	Non-preferred brand drugs	40% copay, ($40 minimum, $110 maximum) (30-day retail)/ 40% copay, ($80 minimum, $225 maximum) (90-day retail & mail order)		Not Covered	
	Specialty drugs	$200 copay *		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 Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	25% coinsurance	50% coinsurance	Preauthorization required for certain surgeries, including infusion therapy costing over $2,000 per drug per month. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. See your plan document for a detailed listing. For Tier 1 office surgery under $1,000 cost is $32 copay/occurrence (PCP) or $40 copay/occurrence (specialist) with no deductible. For Tier 2 office surgery under $1,000 cost is $40 copay /occurrence (PCP) or $50 copay/ occurrence (specialist) with no deductible. Surgery over $1,000 cost is 25% coinsurance after deductible (PCP & specialist / Tier 1 & Tier 2).
	Physician/surgeon fees	25% coinsurance	25% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	25% coinsurance (emergency services)/ 50% coinsurance (non-emergency services)	Tier 2 & 3 providers are paid at the Tier 1 provider level of benefits for emergency services.
	Emergency medical transportation	25% coinsurance/trip (ground)/ $200 copay/trip + 25% coinsurance (air)	25% coinsurance/ trip (ground)/ $200 copay/trip + 25% coinsurance (air)	25% coinsurance /trip (ground)/ $200 copay/trip + 25% coinsurance (air)	Tier 2 & 3 providers are paid at the Tier 1 provider level of benefits.
	Urgent care	$46 copay/visit	$55 copay/visit	50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/ admission + 25% coinsurance	$250 copay/ admission + 25% coinsurance	$300 copay/ admission + 50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 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	25% coinsurance	25% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$28 copay/visit (office visit)/ 25% coinsurance (all other outpatient)	$35 copay/visit (office visit)/ 25% coinsurance (all other outpatient)	50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 providers office visit. Includes telemedicine other than Teladoc.
	Inpatient services	$200 copay/ admission + 25% coinsurance (facility charge)/ 25% coinsurance (professional fees)	$250 copay/ admission + 25% coinsurance (facility charge)/ 25% coinsurance (professional fees)	$300 copay/ admission + 50% coinsurance (facility charges)/ 50% coinsurance (professional fees)	Deductible does not apply for Tier 1 and Tier 2 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	25% coinsurance	25% 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 from a Tier 1/Tier 2 provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense. Deductible does not apply for Tier 1 and Tier 2 provider facility fees.
	Childbirth/delivery professional services	25% coinsurance	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$200 copay/ admission + 25% coinsurance	$250 copay/ admission + 25% coinsurance	$300 copay/ admission + 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	25% coinsurance	50% coinsurance	Limited to 60 visits per year. Home health care supplies not subject to the calendar year maximum. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers	
		(You will pay the least)	(You will pay the most)		
	Rehabilitation services	$28 copay/visit (outpatient)/ $200 copay/admission + 25% coinsurance (inpatient)	$35 copay/visit (outpatient)/ $250 copay/admission + 25% coinsurance (inpatient)	50% coinsurance (outpatient)/ $300 copay/admission + 50% coinsurance (inpatient)	Deductible does not apply for Tier 1 and Tier 2 providers. Physical, speech & occupational therapy limited to 60 visits per each type of therapy per year. Inpatient services limited to 60 days per year.
	Habilitation services	Not Covered	Not Covered	Not Covered	This exclusion will not apply to expenses that are considered mental health or substance abuse services.
	Skilled nursing care	$200 copay/ admission + 25% coinsurance	$250 copay/ admission + 25% coinsurance	$300 copay/ admission + 50% coinsurance	Deductible does not apply for Tier 1 and Tier 2 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	$30 copay/item (diabetic supplies)/ 25% coinsurance (all other durable medical equipment)	$30 copay/item (diabetic supplies)/ 25% coinsurance (all other durable medical equipment)	50% coinsurance	Preauthorization required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. Deductible does not apply to diabetic supplies for Tier 1 and Tier 2 providers.
	Hospice services	$200 copay/ admission + 25% coinsurance (inpatient)/ 25% coinsurance (outpatient)	$250 copay/ admission + 25% coinsurance (inpatient)/ 25% coinsurance (outpatient)	$300 copay/ admission + 50% coinsurance (inpatient)/ 50% coinsurance (outpatient)	Deductible does not apply to services received on an inpatient basis from a Tier 1 and Tier 2 provider. Bereavement counseling is not covered.
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 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 – 1 procedure per lifetime)**
- **Chiropractic care (20 visits per year)**
- **Hearing aids (1 aid per ear every 36 months)**

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

The plan's overall deductible	$600
Primary care physician coinsurance	25%
Hospital (facility) copayment	$200
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician 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	$600
Copayments	$210
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,770

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

The plan's overall deductible	**$600**
Specialist copayment	**$36**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

This EXAMPLE event includes services like:
Specialist 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	$600
Copayments	$600
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,300

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

The plan's overall deductible	**$600**
Specialist copayment	**$36**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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	$600
Copayments	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,200

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