This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.meritain.com** or by calling Meritain Health, Inc. at **866-209-2929**.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	Tier 1 & Tier 2 **providers** **$500** person/ **$1,000** family. Tier 3 **providers** **$1,500** person / **$3,000** family. Tier 4 **providers** **$1,500** person / **$3,000** family.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	Yes. Tier 1 & Tier 2 **providers** **$5,750** person / **$11,500** family. Tier 3 **providers** **Unlimited** person / **Unlimited** family. Tier 4 **providers** **Unlimited** person / **Unlimited** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, balance-billed 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.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. Aetna Choice POS II. See **www.aetna.com/docfind/custom/mymeritain** or call **800-343-3140** for a list of participating **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating **provider** hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Tier 1 Your Cost If You Use an IASIS Facility	Tier 2 Your Cost If You Use a Participating Provider When Service is NOT Available at IASIS	Tier 3 Your Cost If You Use a Participating Provider When Service is Available at IASIS	Tier 4 Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or an illness	$25 copay/visit (office charge) / 10% coinsurance (all other services)	$35 copay/visit (office charge) / 25% coinsurance (all other services)	$35 copay/visit (office charge) / 25% coinsurance (all other services)	60% coinsurance	Copay only applies to the office visit charge. Deductible does not apply to office visit charge for Tier 1, 2 & 3.
	Specialist visit	10% coinsurance	25% coinsurance	25% coinsurance	60% coinsurance	---------none------------
	Other practitioner office visit	10% coinsurance for chiropractor	25% coinsurance for chiropractor	25% coinsurance for chiropractic	60% coinsurance for chiropractic	Limited to 20 visits per year.
	Preventive care/ screening/ immunization	No Charge	No Charge	No Charge	Not Covered	Deductible does not apply to Tier 1, 2 & 3.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance at hospital facility/ 25% coinsurance at outpatient location	60% coinsurance at hospital facility/ 25% coinsurance at outpatient location	60% coinsurance	---------none------------
	Imaging (CT/PET scans, MRIs)	10% coinsurance at hospital facility/ 10% coinsurance at outpatient location	20% coinsurance at hospital facility/ 25% coinsurance at outpatient location	60% coinsurance at hospital facility/ 25% coinsurance at outpatient location	60% coinsurance	Failure to precertify results in a 30% penalty
If you need drugs to treat your illness or condition.	Generic drugs	Not Applicable	$15 copay (retail)/$37.50 copay (mail order)		Reimbursement for non-participating pharmacies is	The deductible does not apply. Covers up to a 30-day supply (retail prescription); 90-day
	Brand name drugs	Not Applicable	30% coinsurance up to $100 maximum (retail)/ 30% coinsurance up to $250 maximum (mail order)			

Common Medical Event	Services You May Need	Tier 1 Your Cost If You Use an IASIS Facility	Tier 2 Your Cost If You Use a Participating Provider When Service is NOT Available at IASIS	Tier 3 Your Cost If You Use a Participating Provider When Service is Available at IASIS	Tier 4 Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.optumrx.com	Specialty drugs	Not Applicable	30% coinsurance up to $200 maximum (retail)		based on the allowed amount, less the applicable copay.	supply (mail order prescription). Cost applies per prescription. When available, a generic equivalent must be used or there will be an increase in member cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	$500 copay/ occurrence + 60% coinsurance	$500 copay/ occurrence + 60% coinsurance	Surgery performed in an IASIS Physician's office will be paid under the office visit benefit. Failure to precertify (other than an office surgery) results in a 30% penalty.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	20% coinsurance	60% coinsurance	
If you need immediate medical attention	Emergency room services	$150 copay/visit (facility charge) / 10% coinsurance (professional fees)	20% coinsurance	20% coinsurance	20% coinsurance	Deductible does not apply to Tier 1 providers for facility charges. Tier 3 & 4 providers paid at the Tier 2 provider level of benefits.
	Emergency medical transportation	10% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance	---------none------------
	Urgent Care	$100 copay/visit	$100 copay/visit	$100 copay/visit	60% coinsurance	Deductible does not apply to Tier 1, 2 & 3.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	$2,500 copay/ admission + 60% coinsurance	$2,500 copay/ admission + 60% coinsurance	Failure to precertify results in a 30% penalty.
	Physician/surgeon fee	10% coinsurance	20% coinsurance	20% coinsurance	60% coinsurance	
If you have mental health, behavioral	Mental/Behavioral health outpatient	$25 copay/visit (office charge)/10%	$35 copay/visit (office charge)/20%	$35 copay/visit (office charge)/20%	60% coinsurance	Deductible does not apply to office visit charge for

Common Medical Event	Services You May Need	Tier 1 Your Cost If You Use an IASIS Facility	Tier 2 Your Cost If You Use a Participating Provider When Service is NOT Available at IASIS	Tier 3 Your Cost If You Use a Participating Provider When Service is Available at IASIS	Tier 4 Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
health, or substance abuse needs	services	coinsurance (all other services)	coinsurance (all other services)	coinsurance (all other services)		Tier 1, 2 & 3.
	Mental/Behavioral health inpatient services	10% coinsurance	20% coinsurance	$2,500 copay/ admission + 60% coinsurance	$2,500 copay/ admission + 60% coinsurance	Failure to precertify will result in a 30% penalty.
	Substance use disorder outpatient services	$25 copay/visit (office charge)/10% coinsurance (all other services)	$35 copay/visit (office charge)/20% coinsurance (all other services)	$35 copay/visit (office charge)/20% coinsurance (all other services)	60% coinsurance	Deductible does not apply to office visit charge for Tier 1, 2 & 3.
	Substance use disorder inpatient services	10% coinsurance	20% coinsurance	$2,500 copay/ admission + 60% coinsurance	$2,500 copay/ admission + 60% coinsurance	Failure to precertify will result in a 30% penalty.
If you are pregnant	Prenatal and postnatal care	$25 copay/initial visit; No charge thereafter	$35 copay/initial visit; No charge thereafter	$35 copay/initial visit; No charge thereafter	60% coinsurance	Deductible does not apply to Tier 1, 2 & 3. There is no charge and the deductible does not apply to preventive prenatal care and certain breastfeeding support and supplies from a participating provider.
	Delivery and all inpatient services	10% coinsurance	20% coinsurance	$2,500 copay/ admission + 60% coinsurance (facility)/20% coinsurance (professional)	$2,500 copay/ admission + 60% coinsurance	Facility charges paid under the hospital benefit. Failure to precertify inpatient Hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (C-section) results in a 30% penalty.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	25% coinsurance	25% coinsurance	60% coinsurance	Limited to 60 visits / year. Failure to precertify results in a 30% penalty.
	Rehabilitation services	10% coinsurance	25% coinsurance	25% coinsurance	60% coinsurance	Limited to 30 visits each per year.

Common Medical Event	Services You May Need	Tier 1 Your Cost If You Use an IASIS Facility	Tier 2 Your Cost If You Use a Participating Provider When Service is NOT Available at IASIS	Tier 3 Your Cost If You Use a Participating Provider When Service is Available at IASIS	Tier 4 Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Habilitation services	Not Covered	Not Covered	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
	Skilled nursing care	10% coinsurance	25% coinsurance	25% coinsurance	60% coinsurance	Limited to 60 days per year. Failure to precertify results in a 30% penalty.
	Durable medical equipment	10% coinsurance	25% coinsurance	25% coinsurance	60% coinsurance	Failure to precertify Durable Medical Equipment over $1,500 results in a 30% penalty.
	Hospice service	10% coinsurance	25% coinsurance	25% coinsurance	60% coinsurance	Bereavement counseling covered within 6 months of death. Failure to precertify results in a 30% penalty.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	Not Covered	Covered under stand alone vision plan.
	Glasses	Not Covered	Not Covered	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	Covered under stand alone dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- **Acupuncture**
- **Cosmetic surgery**
- **Dental care (covered under stand alone dental plan)**
- **Glasses (covered under stand alone vision plan)**
- **Habilitation services**
- **Hearing aids**
- **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 (except medically necessary for diabetics)**
- **Weight loss programs**

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- **Bariatric surgery (for the treatment of morbid obesity at an IASIS facility only)**
- **Chiropractic care**

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact Meritain Health, Inc. at 866-209-2929. You may also contact your state insurance department, 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 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file **a grievance**. For questions about your rights, this notice, or assistance, you can contact Meritain Health, Inc. at 866-209-2929 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance at (800) 342-4029.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6,190**
- **Patient pays $1,350**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient pays:	
Deductibles	$500
Copays	$20
Coinsurance	$680
Limits or exclusions	$150
Total	**$1,350**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $3,880**
- **Patient pays $1,520**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**
Patient pays:	
Deductibles	$500
Copays	$820
Coinsurance	$120
Limits or exclusions	$80
Total	**$1,520**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Coverage examples are based on single coverage only.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from participating **providers**. If the patient had received care from non-participating **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

DISCRIMINATION IS AGAINST THE LAW

IASIS Healthcare, LLC (“IASIS”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IASIS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

IASIS:

(1) Provides free aids and services to people with disabilities to communicate effectively with us, such as:

(a) Qualified sign language interpreters

(b) Written information in other formats (large print, audio, accessible electronic formats, other formats)

(2) Provides free language services to people whose primary language is not English, such as:

(a) Qualified interpreters

(b) Information written in other languages

If you need these services, contact IASIS’ Civil Rights Coordinator, Ginger Walker, AVP of Benefits, whose contact information appears below.

If you believe that IASIS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Ginger Walker, AVP of Benefits
IASIS Healthcare LLC
117 Seaboard Lane, Bldg E
Franklin, TN 37067
Telephone: (615) 844-2747
Fax: (615) 467-1285
Email: GWalker@iasishealthcare.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ginger Walker, AVP of Benefits, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-209-2929.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-209-2929.
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-209-2929.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-209-2929。

ATTENTION : Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-866-209-2929

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-209-2929 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-209-2929.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-209-2929.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-209-2929.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-209-2929.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-209-2929.

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-866-209-2929

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-209-2929.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-209-2929.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-209-2929 تماس بگیرید.