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, https://www.meritain.com. For general definitions of common terms, such as allowed amount, balance billing,coinsurance, copay-ment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossay at https://www.healthcare.gov/sbc-glossary or call 1-800-847-8361 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network **providers** **$1,000** individual/**$2,000** family. For out-of-network **providers** **$5,000** individual/**$10,000** family. Does not apply to preventive care.	Generally, you must pay all 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.
Are there services covered before you meet your deductible?	Yes. **Preventive care** is 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 **deductible** for specific services?	No.	You don't have to meet **deductibles** for specific services.
Is there an **out-of-pocket limit** on my expenses?	For network **providers** **$7,350** individual/**$14,700** family. For out-of-network **providers** **$15,000** individual/**$30,000** family.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan,** the overall family **out-of-pocket limits** must be met.
What is not included in the **out-of-pocket limit?**	**Copayment** on certain services, **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. See **www.aetna.com/docfind/custom/mymeritain** or call 1-800-847-8361 for a list of network **providers**.	This **plan** uses a **network provider**. 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 I 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic.	**Primary care visit to treat an injury or illness**	$35 Copay	50% Coinsurance	Deductible does not apply to in-network providers.
	Specialist visit	$80 Copay	50% Coinsurance	Deductible does not apply to in-network providers.
	Preventive care/screening/ immunization	0% coinsurance	50% Coinsurance	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)	Major:$500 Copay Minor: 0% coinsurance	50% Coinsurance	Deductible does not apply to in-network providers.
	Imaging (CT/PET scans, MRIs)	$500 Copay	50% Coinsurance	----------none----------
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.caremark.com	Generic drugs	Retail: $10 Copay Mail Order: $20 Copay	Retail: * $10 Copay Mail Order: * $20 Copay	Generic mandatory when available. Covers up to a 34-day supply (retail prescription), 90-day (mail order prescription) Deductible waived for generic drugs.
	Preferred brand drugs	Retail: $50 Copay Mail Order: $100 Copay	Retail: * $50 Copay Mail Order: * $100 Copay	
	Non-preferred brand drugs	Retail: $90 Copay Mail Order: $180 Copay	Retail: * $90 Copay Mail Order: * $180 Copay	
	Specialty drugs	25% Coinsurance	25% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	----------none----------
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$500 Copay	$500 Copay	Copay waived if admitted. Pays at In-Network level.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Pays at In-Network level.
	Urgent care	$75 Copay	$75 Copay	Deductible does not apply to in-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1000 copay per day Limited to 3 copays per stay	50% Coinsurance	Pre-authorization required or $500 penalty may apply.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 Copay	50% Coinsurance	Deductible does not apply to in-network providers.
	Inpatient services	$1000 copay per day Limited to 3 copays per stay	50% Coinsurance	Pre-authorization required or $500 penalty may apply.
If you are pregnant	Office visits	Preventive prenatal office visits: No charge Nonpreventive prenatal care office visits: 0% coinsurance	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-authorization is required in excess of 48 hrs (vaginal) and 96 hrs (c-section) births.
	Childbirth/delivery professional services	20% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	$1000 copay per day Limited to 3 copays per stay	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	Limited to 60 visits per year Pre-authorization required or $500 penalty may apply.
	Rehabilitation services	Inpatient:$1000 copay per day Limited to 3 copays per stay. Outpatient: $80 Copay	Inpatient: 50% Coinsurance Outpatient: 50% Coinsurance	Inpatient: Pre-authorization required or $500 penalty may apply. Outpatient: Limited to 35 visits per year
	Habilitation services	Inpatient: $3000 Copay Outpatient: $80 Copay	Inpatient: 50% Coinsurance Outpatient: 50% Coinsurance	
	Skilled nursing care	$1000 copay per day Limited to 3 copays per stay	50% Coinsurance	Limited to 25 days per year Pre-authorization required or $500 penalty may apply.
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Pre-authorization required or $500 penalty may apply.
	Hospice services	20% Coinsurance	50% Coinsurance	----------none----------
If your child needs dental or eye care	Children's eye exam	$80 Copay	50% Coinsurance	Limited to 1 exam per year
	Children's glasses	No coverage	No coverage	None
	Children's dental check-up	No coverage	No coverage	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover(Check your policy or plan documents for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & child)
- Hearing aids (unless rider is attached)
- Long-term care
- Non-emergency care outside of the US.
- Private-duty nursing
- Routine foot care
- Weight loss program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care Limited to 35 visits per year	• Routine eye care (Adult)

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: for group health coverage subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform; for non-federal government group health plans, the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.
Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, and a grievance for any reason to your plan. information about your rights, the notice, or assistance, contact: 1-866-209-2933, the department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Idaho Department of Insurance, Consumer Affairs, 700 W. State Street, 3rd Floor, Boise, ID 83720-0043, 1-800-721-3272, www.DOI.Idaho.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Department of Insurance at the contact information provided above. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.
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 tax credit.
Does this plan meet 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 ninyoaug 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*.----------

PRA Disclosure Statement

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About these Coverage Examples:

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

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

The plan's overall deductible	$1,000
Specialist copayment	$80 Copay
Hospital (facility) coinsurance	20% Coinsurance
Other coinsurance	20% Coinsurance

This EXAMPLE event includes services like:
Specialist visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit (*anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$910
Copayments	$5,670
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,640

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

The plan's overall deductible	$1,000
Specialist copayment	$80 Copay
Hospital (facility) coinsurance	20% Coinsurance
Other coinsurance	20% Coinsurance

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$680
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,760

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

The plan's overall deductible	$1,000
Specialist copayment	$80 Copay
Hospital (facility) coinsurance	20% Coinsurance
Other coinsurance	20% Coinsurance

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

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$210
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,110

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