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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers: $1,000 person / $2,000 family For non-participating providers: $2,000 person / $4,000 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, primary care services, specialist visits, urgent care and prescription drugs 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $5,000 individual / $10,000 family; for out- of-network providers $10,000 individual / $20,000 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, 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?	Copayments for 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.meritain.com	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.	This plan will pay some or all of the costs to see a specialist for covered services 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	$20 copay/visit; deductible does not apply	30% coinsurance	None
	Specialist visit	$40 copay/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	30% coinsurance	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)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	$15 copay/prescription (retail) $30 copay/prescription (mail)	30% coinsurance	Deductible does not apply: Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$35 copay/prescription (retail) $70 copay/prescription (mail)	30% coinsurance	
	Non-preferred brand drugs (Tier 3)	$60 copay/prescription (retail) $120 copay/prescription (mail)	30% coinsurance	
	Specialty drugs (Tier 4)	20% coinsurance up to $500 max	30% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	Preauthorization is required.
	Physician/surgeon fees	No charge	30% coinsurance	Preauthorization is required.

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 need immediate medical attention	Emergency room care	$150 copay/visit	30% coinsurance	Preauthorization is required.
	Emergency medical transportation	No charge	30% coinsurance	
	Urgent care	$50 copay/visit; deductible does not apply	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Preauthorization is required.
	Physician/surgeon fees	No charge	30% coinsurance	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit; deductible does not apply	30% coinsurance	Preauthorization is required.
	Inpatient services	No charge	30% coinsurance	
If you are pregnant	Office visits	$20 copay/office visit; deductible does not apply	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Preauthorization is required.
	Rehabilitation services	No charge	30% coinsurance	Preauthorization is required.
	Habilitation services	No charge	30% coinsurance	
	Skilled nursing care	No charge	30% coinsurance	Preauthorization is required.
	Durable medical equipment	No charge	30% coinsurance	Preauthorization is required.
	Hospice services	No charge	30% coinsurance	Preauthorization is required.