



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](http://www.meritain.com) or call (970) 498-5970. 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](http://www.healthcare.gov/sbc-glossary) or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For participating <u>providers</u> : \$1,000 person / \$2,000 family For non-participating <u>providers</u> : \$2,000 person / \$4,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. For participating <u>providers</u> : <u>Preventive care</u> , <u>urgent care</u> , <u>emergency room care</u> (all providers, except x-rays & imaging), lab services, routine eye exams, <u>rehabilitation services</u> , and office visit services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For participating <u>providers</u> : \$6,000 person / \$12,000 family For non-participating <u>providers</u> : \$12,000 person / \$24,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.aetna.com/docfind/custom/mymeritain">www.aetna.com/docfind/custom/mymeritain</a> or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	40% <u>coinsurance</u>	Copay applies per visit regardless of what services are rendered (includes telemedicine other than Teladoc), except imaging. There is no charge ( <u>deductible</u> does not apply) if you receive consultation services through Teladoc.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>coinsurance</u>	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No Charge (lab)/20% <u>coinsurance</u> (x-ray)	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for PET scans and non-orthopedic CT/MRIs.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	\$10 <u>copay</u> (30-day retail)/ \$20 <u>copay</u> (90-day retail & mail order)	Not Covered	<u>Deductible</u> does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply ( <u>specialty drugs</u> ). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> . <u>Preauthorization</u> recommended for injectables costing over \$2,000 per drug per month.
	Preferred brand drugs	20% <u>copay</u> (\$25 min, \$50 max) (30-day retail)/ 20% <u>copay</u> (\$50 min, \$100 max) (90-day retail & mail order)	Not Covered	
	Non-preferred brand drugs	50% <u>copay</u> (\$50 min, \$100 max) (30-day retail)/ 50% <u>copay</u> (\$100 min, \$200 max) (90-day retail & mail order)	Not Covered	
	<u>Specialty drugs</u>	\$100 <u>copay</u> (30-day supply)	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	\$250 <u>copay</u> /occurrence, then 40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit (facility and professional fees)	\$200 <u>copay</u> /visit (facility and professional fees)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	<u>Copay</u> applies to the physician office visit only. Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	\$500 <u>copay</u> /admission, then 40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit (office visit) /20% <u>coinsurance</u> (all other outpatient)	\$25 <u>copay</u> /visit (office visit) /40% <u>coinsurance</u> (all other outpatient)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for office visits. Includes telemedicine other than Teladoc. There is no charge ( <u>deductible</u> does not apply) if you receive Teladoc behavioral health consultations.
	Inpatient services	20% <u>coinsurance</u>	\$500 <u>copay</u> /admission, then 40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.

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 are pregnant	Office visits	No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense. Doula services limited to \$1,000 per pregnancy and non-participating <u>providers</u> paid at participating <u>provider</u> level of benefits.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% coinsurance (Doula services)/40% <u>coinsurance</u> (all other services)	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	\$500 <u>copay</u> /admission, then 40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 visits per year. <u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> /visit	40% <u>coinsurance</u>	Includes physical, speech/hearing and occupational therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	\$500 <u>copay</u> /admission, then 40% <u>coinsurance</u>	Limited to 100 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices.
	<u>Hospice services</u>	20% <u>coinsurance</u>	\$500 <u>copay</u> /admission, then 40% <u>coinsurance</u> (inpatient)/40% <u>coinsurance</u> (outpatient)	Bereavement counseling is not covered.
If your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. Up to age 19 - 1 exam per year. Age 19 and over – 1 exam per year up to \$130.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Bereavement counseling</li><li>• Cosmetic surgery</li><li>• Dental care (Adult &amp; Child)</li></ul>	<ul style="list-style-type: none"><li>• Glasses (Adult &amp; Child)</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (except for home health care &amp; hospice)</li><li>• Routine foot care (except for metabolic or peripheral vascular disease)</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Acupuncture (\$1,000 per year combined with sensory deprivation and massage therapy)</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Hearing aids (age 18 and over limited to \$2,500 every 3 years)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (up to age 19 - 1 exam per year; age 19 and over – 1 exam per year up to \$130)</li><li>• Weight loss programs (Lifestyle Education Program)</li></ul>

**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 (877) 267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), or Larimer County at (970) 498-5970. 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](http://www.HealthCare.gov) or call (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 Larimer County at (970) 498-5970 or Meritain Health, Inc. at (800) 925-2272.

### 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, kwijigo 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 \$1,000
- Primary care physician coinsurance 0%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$10
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,170</b>

**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 \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This **EXAMPLE** event includes services like:

Specialist office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$400
Coinsurance	\$1,600
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,820</b>

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

- The plan's overall deductible \$1,000
- Specialist copayment \$50
- Hospital (facility) copayment \$200
- Other coinsurance 20%

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$500
Coinsurance	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,570</b>