



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 (863) 674-4550. 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 (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For participating <u>providers</u> : \$5,000 person / \$10,000 family For non-participating <u>providers</u> : \$15,000 person / \$30,000 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. For participating <u>providers</u> : <u>Preventive care</u> and routine eye exams are covered before you meet your <u>deductible</u> . For non-participating <u>providers</u> : <u>Preventive</u> and routine mammograms 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For participating <u>providers</u> : \$6,250 person / \$12,500 family For non-participating <u>providers</u> : \$20,000 person / \$40,000 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.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>preauthorization</u> penalty amounts, <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> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind/custom/my_meritain 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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
Is a Health Reimbursement Arrangement (HRA) available under this <u>plan</u> option?	Yes. \$1,500 individual	An HRA is an account that is set up and contributed to by your employer. You may not make any contributions to the HRA. The HRA may only be used to pay a portion of your <u>out-of-pocket</u> expenses incurred under the <u>plan</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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Includes telemedicine other than Teladoc. There is no charge and the <u>deductible</u> does not apply if you receive general medicine consultation services through Teladoc. After the <u>deductible</u> you pay 50% of the consult fee if you receive dermatology consultation services through Teladoc. There is no charge and the <u>deductible</u> does not apply for services received at a MinuteClinic.
	<u>Specialist</u> visit	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge	No Charge (<u>preventive</u> / routine mammograms)/ 50% <u>coinsurance</u> (all other <u>preventive</u> / routine services)	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for PET scans and non-orthopedic CT/MRI's. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating providers.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	\$10 <u>copay</u> (30-day retail)/ \$30 <u>copay</u> (90-day retail & mail order)	Not Covered	Major medical <u>deductible</u> applies. Covers up to a 90-day supply (retail or mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge or <u>deductible</u> for preventive drugs or preventive maintenance drugs. Dispense as Written (DAW) provision applies. Step therapy provision applies. See Employer for more information
	Preferred brand drugs	\$30 <u>copay</u> (30-day retail)/ \$90 <u>copay</u> (90-day retail & mail order)	Not Covered	
	Non-preferred brand drugs	\$50 <u>copay</u> (30-day retail)/ \$150 <u>copay</u> (90-day retail & mail order)	Not Covered	
	<u>Specialty drugs</u>	\$10 <u>copay</u> (generic)/ \$30 <u>copay</u> (preferred)/	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)	
		\$50 <u>copay</u> (non-preferred)		regarding coverage for <u>prescription drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u> (ambulatory surgery center)/ \$250 <u>copay</u> /occurrence, then 50% <u>coinsurance</u> (all other outpatient locations)	50% <u>coinsurance</u> (ambulatory surgery center)/ \$250 <u>copay</u> /occurrence, then 50% <u>coinsurance</u> (all other outpatient locations)	<u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating <u>providers</u> . See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	50% <u>coinsurance</u> (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	50% <u>coinsurance</u> (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> .
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /admission (\$1,500 maximum/year), then 50% <u>coinsurance</u>	\$500 <u>copay</u> /admission (\$1,500 maximum/year), then 50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating <u>providers</u> . If in the same type of facility more than once, and the stays are separated by less than 10 days (regardless of cause), only 1 per admission <u>deductible</u> will apply.
	Physician/surgeon fees	50% <u>coinsurance</u>	50% <u>coinsurance</u>	

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 need mental health, behavioral health, or substance abuse services	Outpatient services	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Includes telemedicine other than Teladoc. There is no charge and the <u>deductible</u> does not apply if you receive consultation services through Teladoc.
	Inpatient services	\$500 <u>copay</u> /admission (\$1,500 maximum/year), then 50% <u>coinsurance</u> (facility charge)/ 50% <u>coinsurance</u> (professional fees)	\$500 <u>copay</u> /admission (\$1,500 maximum/year), then 50% <u>coinsurance</u> (facility charge)/ 50% <u>coinsurance</u> (professional fees)	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating <u>providers</u> . If in the same type of facility more than once, and the stays are separated by less than 10 days (regardless of cause), only 1 per admission <u>deductible</u> will apply.
If you are pregnant	Office visits	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section). If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating <u>providers</u> . <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 does not count toward the mother's expense; therefore the family <u>deductible</u> amount may apply.
	Childbirth/delivery professional services	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 <u>copay</u> /admission (\$1,500 maximum/year), then 50% <u>coinsurance</u>	\$500 <u>copay</u> /admission (\$1,500 maximum/year), then 50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating <u>providers</u> .
	<u>Rehabilitation services</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Physical, occupational, & speech/hearing therapy limited to 20 visits per each type of therapy per year.
	<u>Habilitation services</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----

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)	
	<u>Skilled nursing care</u>	\$500 <u>copay</u> /admission (\$1,500 maximum/year), then 50% <u>coinsurance</u>	\$500 <u>copay</u> /admission (\$1,500 maximum/year), then 50% <u>coinsurance</u>	Limited to 60 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating <u>providers</u> . If in the same type of facility more than once, and the stays are separated by less than 10 days (regardless of cause), only 1 per admission <u>deductible</u> will apply.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for electric/motorized scooters or wheelchairs and pneumatic compression devices. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating <u>providers</u> .
	<u>Hospice services</u>	\$500 <u>copay</u> /admission (\$1,500 maximum/year), then 50% <u>coinsurance</u> (inpatient)/ 50% <u>coinsurance</u> (outpatient)	\$500 <u>copay</u> /admission (\$1,500 maximum/year), then 50% <u>coinsurance</u> (inpatient)/ 50% <u>coinsurance</u> (outpatient)	If in the same type of facility more than once, and the stays are separated by less than 10 days (regardless of cause), only 1 per admission <u>deductible</u> will apply. Bereavement counseling is covered.
If your child needs dental or eye care	Children's eye exam	No Charge	50% <u>coinsurance</u>	Limited to 1 exam every 24 months.
	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> .)		
• Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child) • Emergency room services for non-emergency services • Glasses (Adult & Child)	• Infertility treatment (except diagnosis or treatment of underlying medical condition) • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing (except for home health care & hospice) • Routine foot care (except for metabolic or peripheral vascular disease) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Acupuncture (10 visits per year) • Chiropractic care (20 visits per year)	• Hearing aids (\$2,000 per aid per ear every year)	• Routine eye care (Adult & Child – 1 exam every 24 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 (877) 267-2323 x 61565 or www.cciio.cms.gov, or FLEHT / School Board of Hendry County Florida at (863) 674-4550. 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 FLEHT / School Board of Hendry County Florida at (863) 674-4550 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 <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Primary care physician coinsurance</u>	50%
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>coinsurance</u>	50%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$500
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,860

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist coinsurance</u>	50%
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>coinsurance</u>	50%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$70
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$5,110

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist coinsurance</u>	50%
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>coinsurance</u>	50%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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