

 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 (316) 973-4581. 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 <https://www.healthcare.gov/sbc-glossary> or call Meritain Health, Inc. at (866) 760-9568 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For participating <u>providers</u> : \$2,000 person / \$4,000 family For non-participating <u>providers</u> : \$4,000 person / \$8,000 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>diagnostic tests</u> , prenatal/postnatal care & delivery professional fees, outpatient mental health/substance abuse services, office visits, routine eye exams (all <u>providers</u> ) and <u>urgent care</u> (all <u>providers</u> ), 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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://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>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> .
<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	\$30 <u>copay</u> /visit	50% <u>coinsurance</u>	<p><u>Copay</u> applies per visit regardless of what services are rendered. You will pay a \$15 <u>copay</u> (<u>deductible</u> does not apply) if you receive telephone consultation services through the telemedicine program.</p> <p>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.</p>
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	Not Covered	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$30 <u>copay</u> /visit	50% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /visit then 30% <u>coinsurance</u>	50% <u>coinsurance</u>	Your costs will be lower if you use the One Call Care Management radiology network.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.meritain.com">www.meritain.com</a>	Generic drugs	Not Covered	Not Covered	Not Covered
	Brand name drugs	Not Covered	Not Covered	
	<u>Specialty drugs</u>	Not Covered	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<p><u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u>, benefits could be reduced by 50% of the total cost of the service. See your <u>plan</u> document for a detailed listing.</p>
	Physician/surgeon fees	30% <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 immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit then 30% <u>coinsurance</u> ( <u>emergency services</u> )/Not Covered ( <u>non-emergency services</u> )	\$100 <u>copay</u> /visit then 30% <u>coinsurance</u> ( <u>emergency services</u> )/Not Covered ( <u>non-emergency services</u> )	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> . <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <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 per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <u>copay</u> /visit	50% <u>coinsurance</u>	-----none-----
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	No Charge	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 50% of the total cost of the service. <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Global maternity care may include tests and services described elsewhere in the SBC. Baby counts towards the mother's expense.
	Childbirth/delivery professional services	\$50 <u>copay</u> /pregnancy/\$50 <u>copay</u> /visit (ultrasound)	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <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 50% of the total cost of the service.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Physical, speech & occupational therapy limited to a combined maximum of 120 visits per year. Combined maximum includes treatment for autism, age 12 and over. Cardiac rehab is limited to a maximum of 36 sessions in a 12 week period. Pulmonary therapy is limited to a maximum of 36 hours or a 6 week period.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Therapy limits are combined with the autism, occupational, physical and speech therapy combined limits listed above.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	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 50% of the total cost of the service.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for any leased or purchased item in excess of \$1,500, including all electric motorized wheelchairs and scooters. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Bereavement counseling is not covered.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	50% <u>coinsurance</u>	Limited to 1 exam per year.
	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- |                                                                                 |                                                                                                                 |                                                                                     |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| • Acupuncture (except as a form of anesthesia for a covered surgical procedure) | • Hearing aids                                                                                                  | • Prescription drugs                                                                |
| • Bariatric surgery                                                             | • Infertility treatment (except for the diagnosis and treatment of the underlying medical cause of infertility) | • Private-duty nursing (inpatient)                                                  |
| • Bereavement counseling                                                        | • Long-term care                                                                                                | • Routine foot care                                                                 |
| • Cosmetic surgery                                                              | • Non-emergency care when traveling outside the U.S.                                                            | • Routine foot care (except for diabetes, metabolic or peripheral vascular disease) |
| • Dental care (Adult & Child)                                                   |                                                                                                                 | • Weight loss programs                                                              |
| • Glasses (Adult & Child)                                                       |                                                                                                                 |                                                                                     |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|---------------------|-------------------------------------|------------------------------------|
| • Chiropractic care | • Private-duty nursing (outpatient) | • Routine eye care (Adult & Child) |
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**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 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), or Unified School District 259 DBA The Wichita Public Schools at (316) 973-4581. 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 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, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, Unified School District 259 DBA The Wichita Public Schools at (316) 973-4581 or Meritain Health, Inc. at (866) 760-9568. Additionally, a consumer assistance program can help you file your appeal. Contact the Kansas Insurance Department, Consumer Assistance Division at (800) 432-2484 (in state)/ (785) 296-7829.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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, kwiiijigo 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 **\$2,000**
- Primary care physician coinsurance **0%**
- Hospital (facility) coinsurance **30%**
- Other coinsurance **30%**

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>\$12,840</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles*	\$2,000
Copayments	\$594
Coinsurance	\$3,406
<i>What isn't covered</i>	
Limits or exclusions	\$96**
<b>The total Peg would pay is</b>	<b>\$6,096</b>

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

- The plan's overall deductible **\$2,000**
- Specialist copayment **\$50**
- Hospital (facility) coinsurance **30%**
- Other coinsurance **30%**

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>\$7,460</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,210
Copayments	\$820
Coinsurance	\$518
<i>What isn't covered</i>	
Limits or exclusions	\$4,313**
<b>The total Joe would pay is</b>	<b>\$6,861</b>

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

- The plan's overall deductible **\$2,000**
- Specialist copayment **\$50**
- Hospital (facility) copayment **\$100**
- Other coinsurance **30%**

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>\$2,010</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,102
Copayments	\$280
Coinsurance	\$399
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,781</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: (316) 973-4581.

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services."

\*\*Note: See the documentation provided by your prescription drug vendor for specific costs associated with prescription drugs.