This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.myMeritain.com** or by calling your employer at **(208) 331-1968** or Meritain Health, Inc. at **(800) 925-2272**.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	For participating **providers** **$3,000** person / **$6,000** family For non-participating **providers** **$3,000** person / **$6,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No. There are no other specific **deductibles**.	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.
Is there an **out-of-pocket limit** on my expenses?	Yes. For participating **providers** **$6,000** single / **$12,000** family For non-participating **providers** **$8,000** single / **$16,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Prescription drug copays, premiums, precertification penalty amounts, balance-billed 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.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See **www.aetna.com/docfind/custom/mymeritain** or call **(800) 343-3140** for a list of participating **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating **provider** hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or an illness	$30 copay/visit (office visit) / 30% coinsurance (all other services)	50% coinsurance	Deductible does not apply for participating provider office visits.
	Specialist visit	$30 copay/visit (office visit) / 30% coinsurance (all other services)		
	Other practitioner office visit	$30 copay/visit for chiropractor	$30 copay/visit for chiropractor	Deductible does not apply for chiropractic care. Maximum calendar year benefit of 15 visits for chiropractic care.
	Preventive care/ screening/immunization	No Charge	50% coinsurance	Deductible does not apply for participating providers. See your plan document for specifics regarding preventive services & routine care.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a $500 penalty
If you need drugs to treat your illness	Generic drugs	$10 copay (retail) / $20 copay (mail order)	$10 copay (retail)	The deductible does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
or condition. More information about **prescription drug coverage** is available at www.caremark.com	Preferred brand drugs	$25 copay (retail) / $50 copay (mail order)	$25 copay (retail)	prescription). The Plan requires Retail Pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay. Copay applies per prescription.
	Non-preferred brand drugs	$40 copay (retail) / $80 copay (mail order)	$40 copay (retail)	
	Specialty drugs	Same cost as generic / preferred / non-preferred	Same cost as generic / preferred / non-preferred	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Precertification required for surgeries over $1,000 (except surgery performed in a doctor's office). Failure to precertify will result in a $500 penalty.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	30% coinsurance (emergency) / $100 copay/visit + 30% coinsurance (non-emergency)	30% coinsurance (emergency) / $100 copay/visit + 30% coinsurance (non-emergency)	Non-participating providers paid at the participating provider level of benefits. Copay waived if admitted to the hospital.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Non-participating providers paid at the participating provider level of benefits.
	Urgent Care	30% coinsurance	50% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a $500 penalty.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit (office visits) 30% coinsurance (all other services)	50% coinsurance	Deductible does not apply for participating provider office visits.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Mental/Behavioral health inpatient services	30% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a $500 penalty.
	Substance use disorder outpatient services	$30 copay/visit (office visits) 30% coinsurance (all other services)	50% coinsurance	Deductible does not apply for participating provider office visits.
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a $500 penalty.
If you are pregnant	Prenatal and postnatal care	30% coinsurance	50% coinsurance	There is no charge and the deductible does not apply to preventive prenatal care and certain breastfeeding support and supplies from a participating provider**.**
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	Precertification required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). Failure to precertify will result in a $500 penalty.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 100 visits per year. Precertification required. Failure to precertify will result in a $500 penalty.
	Rehabilitation services	$30 copay/visit (physician's office) / 30% coinsurance (outpatient)	50% coinsurance	Deductible does not apply for participating provider office visits. Includes physical, speech & occupational therapy. Maximum combined calendar year benefit of 20 visits. Precertification required. Failure to precertify will result in a $500 penalty.
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 90 days per year. Precertification required. Failure to precertify will result in a $500 penalty.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Durable medical equipment	30% coinsurance	50% coinsurance	Precertification required for any item in excess of $1,000. Failure to precertify will result in a $500 penalty. Maximum wheelchair benefit of $10,000.
	Hospice service	30% coinsurance	50% coinsurance	Precertification of hospice services required. Failure to precertify will result in a $500 penalty.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- **Acupuncture**
- **Bariatric surgery**
- **Cosmetic surgery**
- **Dental care (Adult & child)**
- **Glasses (Adult & child)**
- **Habilitation services**
- **Hearing aids**
- **Infertility treatment (except diagnosis)**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing (except for home health care & hospice)**
- **Routine eye care (Adult & child)**
- **Routine foot care**
- **Weight loss programs**

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- **Chiropractic care**

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (208) 331-1968 or Meritain Health, Inc. at (800) 925-2272. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Idaho Independent Intergovernmental Authority Trust at (208) 331-1968 or Meritain Health, Inc. at (800) 925-2272.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

(Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

(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.

(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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $3,090**
- **Patient pays $4,450**

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient pays:	
Deductibles	$3,000
Copays	$20
Coinsurance	$1,280
Limits or exclusions	$150
Total	**$4,450**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $1,820**
- **Patient pays $3,580**

Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**
Patient pays:	
Deductibles	$3,000
Copays	$320
Coinsurance	$180
Limits or exclusions	$80
Total	**$3,580**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Coverage examples are based on single coverage only.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from participating **providers**. If the patient had received care from non-participating **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.