



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.meritain.com or by calling your employer at (479) 784-2221 or Meritain Health, Inc. at (800) 925-2272.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	For participating providers : \$2,000 single / \$4,000 family. For non-participating providers : \$4,000 single/ \$8,000 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.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers : \$5,000 single/ \$10,000 family (deductible, coinsurance & medical copays) For non-participating providers : Unlimited For prescription drug copays: \$1,850 single/ \$3,700 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 ?	Premiums, precertification penalty amounts, balance-billed charges for non-participating providers, coinsurance for dental benefits not covered under major medical, coinsurance in excess of the established plan maximums or limitations 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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See www.aetna.com/docfind/custom/mymerita 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 .

Questions: Call your employer at (479) 784-2221 or Meritain Health, Inc. at (800) 925-2272 or visit us at www.meritain.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call your employer at (479) 784-2221 to request a copy.



- **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	\$35 copay/visit	50% coinsurance	The deductible does not apply to participating providers. Copay applies per visit regardless of what services are rendered.
	Specialist visit	\$35 copay/visit	50% coinsurance	
	Other practitioner office visit	\$35 copay/visit	50% coinsurance	The deductible does not apply to participating providers. Chiropractic care is limited to 20 visits per year. Acupuncture is not covered, except in lieu of anesthesia.
	Preventive care/ screening/ immunization	Preventive Services: No Charge Routine Colonoscopy: No Charge	Preventive Services: No Charge Routine Colonoscopy: 50% coinsurance	The deductible does not apply to preventive services and to routine colonoscopy for participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Precertification is required for CT/MRA/MRI/PET scans, scintimammography, capsule endoscopy and U.S. bone density (heel). Failure to precertify will result in a \$500 (per occurrence) 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
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.restat.com	Generic drugs	20% copay (\$15 minimum /\$150 maximum)(30 day retail) / 10% copay (\$5 minimum/\$75 maximum) (30 day Align Pharmacy) /20% copay (\$25 minimum/\$275 maximum) (90 day Align Retail Pharmacy)	Not Covered	The deductible does not apply. Covers up to a 30 or 90-day supply (retail prescription). The copay applies per prescription. The Dispense As Written provision applies. Specialty drugs must be obtained directly from the specialty pharmacy program. There is no charge for preventive drugs.
	Preferred brand drugs	30% copay (\$30 minimum/ \$150 maximum) (30day retail) / 30% copay (\$75 minimum/\$275 maximum) (90 day Align Retail Pharmacy)	Not Covered	
	Non-preferred brand drugs	40% copay (\$50 minimum/ \$150 maximum)(30 day retail)/40% copay (\$150 minimum/\$275 maximum) (90 day Align Retail Pharmacy)	Not Covered	
	Specialty drugs	Paid the same as generic, preferred and non-preferred drugs	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Precertification required unless performed in an office setting. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance (medical emergency and (non-medical emergency)	20% coinsurance (medical emergency)/ 50% coinsurance (non-medical emergency)	Non-participating providers paid at the participating provider level of benefits for medical emergency only.
	Emergency medical transportation	20% coinsurance	50% coinsurance	-----none-----
	Urgent Care	\$35 copay/visit	50% coinsurance	The deductible does not apply to participating providers. Copay applies per visit regardless of what services are rendered.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$35 copay/visit (office visit) /No charge (all other outpatient)	50% coinsurance (office visit)/ No charge (all other outpatient)	The deductible does not apply to the office visit for participating provider or for all other outpatient for all providers.
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Substance use disorder outpatient services	\$35 copay/visit (office visit) /No charge (all other outpatient)	50% coinsurance (office visit)/ No charge (all other outpatient)	The deductible does not apply to the office visit for participating provider or for all other outpatient for all providers.
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) penalty.
If you are pregnant	Prenatal and postnatal care	20% 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	20% 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 (per occurrence) penalty. Baby does not count toward the mother's expense; therefore the family deductible amount may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Precertification is required for home health care services and home IV infusion therapy. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Rehabilitation services	20% coinsurance	50% coinsurance	Includes physical, speech & occupational therapy. Limited to 60 visits combined per year.
	Habilitation services	20% coinsurance	50% coinsurance	-----none-----
	Skilled nursing care	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) 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	20% coinsurance	50% coinsurance	Precertification required for any item in excess of \$1,500 (other than breast pumps covered as a preventive service) or any rental over \$500 per month. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Hospice service	No Charge	50% coinsurance	The deductible does not apply to participating providers. Bereavement counseling is only covered if received within 6 months of death. Respite care is limited to a lifetime maximum of 5 days. Precertification required. Failure to precertify will result in a \$500 (per occurrence) 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	Covered under stand alone dental plan.

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 (except in lieu of anesthesia)
- Cosmetic surgery
- Dental care (covered under stand alone dental plan)
- Glasses (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S. (If you become sick or injured while traveling, the plan may cover expenses incurred up to 120 consecutive days. This 120-day time limit does not apply if you are traveling for business or are a student.)
- Routine eye care (Adult & Child)
- Routine foot care

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.)

- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Hearing aids
- Infertility treatment (Please see your Plan Document for additional information and/or limitations)
- Private-duty nursing (outpatient only)
- Weight loss programs (for the treatment of morbid obesity only)

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 (479) 784-2221 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 City of Fort Smith at (479) 784-2221 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, kwijjigo 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 \$4,330
- Patient pays \$3,210

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	\$2,000
Copays	\$0
Coinsurance	\$1,060
Limits or exclusions	\$150
Total	\$3,210

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

- Amount owed to providers: \$5,400
- Plan pays \$2,570
- Patient pays \$2,830

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	\$2,000
Copays	\$170
Coinsurance	\$580
Limits or exclusions	\$80
Total	\$2,830

Note: These numbers assume that the patient is participating in the wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the wellness program, please contact your employer at (479) 784-2221 or Meritain Health, Inc. at (800) 925-2272.

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.



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Important Questions	Answers	Why this Matters:
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Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers : \$5,000 single/ \$10,000 family (deductible, coinsurance & medical copays). For non-participating providers : Unlimited For prescription drug copays: \$1,850 single/ \$3,700 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 ?	Premiums, precertification penalty amounts, balance-billed charges for non-participating providers, coinsurance for dental benefits not covered under major medical, coinsurance in excess of the established plan maximums or limitations 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 <i>specific</i> 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.
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- **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	\$35 copay/visit	50% coinsurance	The deductible does not apply to participating providers. Copay applies per visit regardless of what services are rendered.
	Specialist visit	\$35 copay/visit	50% coinsurance	
	Other practitioner office visit	\$35 copay/visit	50% coinsurance	The deductible does not apply to participating providers. Chiropractic care is limited to 20 visits per year. Acupuncture is not covered, except in lieu of anesthesia.
	Preventive care/ screening/ immunization	Preventive Services: No Charge Routine Colonoscopy: No Charge	Preventive Services: No Charge Routine Colonoscopy: 50% coinsurance	The deductible does not apply to preventive services or routine colonoscopy services for participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Precertification is required for CT/MRA/MRI/PET scans, scintimammography, capsule endoscopy and U.S. bone density (heel). Failure to precertify will result in a \$500 (per occurrence) 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
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.restat.com	Generic drugs	20% copay (\$15 minimum /\$150 maximum)(30 day retail) / 10% copay (\$5 minimum/\$75 maximum) (30 day Align Pharmacy) /20% copay (\$25 minimum/\$275 maximum) (90 day Align Retail Pharmacy)	Not Covered	The deductible does not apply. Covers up to a 30 or 90-day supply (retail prescription. The copay applies per prescription. The Dispense As Written provision applies. Specialty drugs must be obtained directly from the specialty pharmacy program. There is no charge for preventive drugs.
	Preferred brand drugs	30% copay (\$30 minimum/\$150 maximum) (30day retail) / 30% copay (\$75 minimum/\$275 maximum) (90 day Align Retail Pharmacy)	Not Covered	
	Non-preferred brand drugs	40% copay (\$50 minimum/\$150 maximum)(30 day retail)/40% copay (\$150 minimum/\$275 maximum) (90 day Align Retail Pharmacy)	Not Covered	
	Specialty drugs	Paid the same as generic, preferred and non-preferred drugs	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Precertification required unless performed in an office setting. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance (medical and non-medical emergency)	20% coinsurance (medical emergency)/ 50% coinsurance (non-medical emergency)	Non-participating providers paid at the participating provider level of benefits for medical emergency only.
	Emergency medical transportation	20% coinsurance	50% coinsurance	

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
	Urgent Care	\$35 copay/visit	50% coinsurance	The deductible does not apply to participating providers. Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$35 copay/visit (office visit) / No Charge(all other outpatient)	50% coinsurance (office visit) / No Charge(all other outpatient)	The deductible does not apply to the office visit for participating provider or for all other outpatient for all providers.
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Substance use disorder outpatient services	\$35 copay/visit (office visit) / No charge(all other outpatient)	50% coinsurance (office visit)/No Charge (all other outpatient)	The deductible does not apply to the office visit for participating provider or for all other outpatient for all providers.
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) penalty.
If you are pregnant	Prenatal and postnatal care	20% 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	20% 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 (per occurrence) penalty. Baby does not count toward the mother's expense; therefore the family deductible amount may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Precertification is required for home health care services and home IV infusion therapy. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Rehabilitation services	20% coinsurance	50% coinsurance	Includes physical, speech & occupational therapy. Limited to 60 visits combined per year.
	Habilitation services	20% coinsurance	50% coinsurance	-----none-----
	Skilled nursing care	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) 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	20% coinsurance	50% coinsurance	Precertification required for any item in excess of \$1,500 (other than breast pumps covered as a preventive service) or any rental over \$500 per month. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Hospice service	No Charge	50% coinsurance	The deductible does not apply to participating providers. Bereavement counseling is only covered if received within 6 months of death. Respite care is limited to a lifetime maximum of 5 days. Precertification required. Failure to precertify will result in a \$500 (per occurrence) 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	Covered under stand alone dental plan.

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 (except in lieu of anesthesia)
- Cosmetic surgery
- Dental care (covered under stand alone dental plan)
- Glasses (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S. (If you become sick or injured while traveling, the plan may cover expenses incurred up to 120 consecutive days. This 120-day time limit does not apply if you are traveling for business or are a student.)
- Routine eye care (Adult & Child)
- Routine foot care

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.)

- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Hearing aids
- Infertility treatment (Please see your Plan Document for additional information and/or limitations)
- Private-duty nursing (outpatient only)
- Weight loss programs (for the treatment of morbid obesity only)

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.

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————— *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 \$4,930
- Patient pays \$2,610

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	\$1,250
Copays	\$0
Coinsurance	\$1,210
Limits or exclusions	\$150
Total	\$2,610

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

- Amount owed to providers: \$5,400
- Plan pays \$3,180
- Patient pays \$2,220

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	\$1,250
Copays	\$180
Coinsurance	\$710
Limits or exclusions	\$80
Total	\$2,220

Note: These numbers assume that the patient is participating in the wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the wellness program, please contact your employer at (479) 784-2221 or Meritain Health, Inc. at (800) 925-2272.

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.

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call your employer at (479) 784-2221 to request a copy.



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.meritain.com or by calling your employer at (479) 784-2221 or Meritain Health, Inc. at (800) 925-2272.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	For participating providers : \$500 single / \$1,000 family. For non-participating providers : \$4,000 single/ \$8,000 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.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers : \$5,000 single/ \$10,000 family (deductible, coinsurance & medical copays). For non-participating providers : Unlimited For prescription drug copays: \$1,850 single/ \$3,700 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 ?	Premiums, precertification penalty amounts, balance-billed charges for non-participating providers, coinsurance for dental benefits not covered under major medical, coinsurance in excess of the established plan maximums or limitations 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 <i>specific</i> 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 .

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- **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	\$35 copay/visit	50% coinsurance	The deductible does not apply to participating providers. Copay applies per visit regardless of what services are rendered.
	Specialist visit	\$35 copay/visit	50% coinsurance	
	Other practitioner office visit	\$35 copay/visit	50% coinsurance	The deductible does not apply to participating providers. Chiropractic care is limited to 20 visits per year. Acupuncture is not covered, except in lieu of anesthesia.
	Preventive care/ screening/ immunization	Preventive Services: No Charge Routine Colonoscopy: No Charge	Preventive Services: No Charge Routine Colonoscopy: 50% coinsurance	The deductible does not apply to preventive services and to routine colonoscopy for participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Precertification is required for CT/MRA/MRI/PET scans, scintimammography, capsule endoscopy and U.S. bone density (heel). Failure to precertify will result in a \$500 (per occurrence) 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
<p>If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.restat.com</p>	Generic drugs	20% copay (\$15 minimum /\$150 maximum)(30 day retail) / 10% copay (\$5 minimum/\$75 maximum) (30 day Align Pharmacy) /20% copay (\$25minimum/\$275 maximum) (90 day Align Retail Pharmacy)	Not Covered	The deductible does not apply. Covers up to a 30 or 90-day supply (retail prescription. The copay applies per prescription. The Dispense As Written provision applies. Specialty drugs must be obtained directly from the specialty pharmacy program. There is no charge for preventive drugs.
	Preferred brand drugs	30% copay (\$30 minimum/ \$150 maximum) (30day retail) / 30% copay (\$75minimum/\$275 maximum) (90 day Align Retail Pharmacy)	Not Covered	
	Non-preferred brand drugs	40% copay (\$50 minimum/ \$150 maximum)(30 day retail)/40% copay (\$150 minimum/\$275 maximum) (90 day Align Retail Pharmacy)	Not Covered	
	Specialty drugs	Paid the same as generic, preferred and non-preferred drugs	Not Covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Precertification required unless performed in an office setting. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
<p>If you need immediate medical attention</p>	Emergency room services	20% coinsurance (medical emergency and non-medical emergency)	20% coinsurance (medical emergency)/ 50% coinsurance (non-medical emergency)	Non-participating providers paid at the participating provider level of benefits for medical emergency only.

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
	Emergency medical transportation	20% coinsurance	50% coinsurance	-----none-----
	Urgent Care	\$35 copay/visit	50% coinsurance	The deductible does not apply to participating providers. Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$35 copay/visit (office visit) /No charge (all other outpatient)	50% coinsurance (office visit)/ No charge (all other outpatient)	The deductible does not apply to the office visit for participating provider or for all other outpatient for all providers.
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Substance use disorder outpatient services	\$35 copay/visit (office visit) /No charge (all other outpatient)	50% coinsurance (office visit)/ No charge (all other outpatient)	The deductible does not apply to the office visit for participating provider. or for all other outpatient for all providers.
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) penalty.
If you are pregnant	Prenatal and postnatal care	20% 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	20% 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 (per occurrence) penalty. Baby does not count toward the mother's expense; therefore the family deductible amount may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Precertification is required for home health care services and home IV infusion therapy. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Rehabilitation services	20% coinsurance	50% coinsurance	Includes physical, speech & occupational therapy. Limited to 60 visits combined per year.

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
	Habilitation services	20% coinsurance	50% coinsurance	-----none-----
	Skilled nursing care	20% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Durable medical equipment	20% coinsurance	50% coinsurance	Precertification required for any item in excess of \$1,500 (other than breast pumps covered as a preventive service) or any rental over \$500 per month. Failure to precertify will result in a \$500 (per occurrence) penalty.
	Hospice service	No Charge	50% coinsurance	The deductible does not apply to participating providers. Bereavement counseling is only covered if received within 6 months of death. Respite care is limited to a lifetime maximum of 5 days. Precertification required. Failure to precertify will result in a \$500 (per occurrence) 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	Covered under stand alone dental plan.

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 (except in lieu of anesthesia)
- Cosmetic surgery
- Dental care (covered under stand alone dental plan)
- Glasses (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S. (If you become sick or injured while traveling, the plan may cover expenses incurred up to 120 consecutive days. This 120-day time limit does not apply if you are traveling for business or are a student.)
- Routine eye care (Adult & Child)
- Routine foot care

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.)

- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Hearing aids
- Infertility treatment (Please see your Plan Document for additional information and/or limitations)
- Private-duty nursing (outpatient only)
- Weight loss programs (for the treatment of morbid obesity only)

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.

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Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
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Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

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Copays	\$0
Coinsurance	\$1,360
Limits or exclusions	\$150
Total	\$2,010

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

- Amount owed to providers: \$5,400
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- Patient pays \$1,680

Sample care costs:

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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	\$500
Copays	\$350
Coinsurance	\$750
Limits or exclusions	\$80
Total	\$1,680

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