MEDICAL SCHEDULE OF BENEFITS – CNI Plan A

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN/Calendar YEAR DEDUCTIBLE **Single** **Spouse/Children/Family**	 $2,500 $2600 per individual- $5,000 family maximum	 $5,000 $10,000
PLAN/Calendar YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card) **Single** **Family**	 $6,350 $12,700	 $12,700 $25,400
MEDICAL BENEFITS		
Allergy Services (all)	80%, after Deductible	60%, after Deductible
Ambulance Services	80%, after Deductible	60%, after Deductible
Chiropractic Care/Spinal Manipulation	80%, after Deductible	60%, after Deductible
Plan/Calendar Year Maximum Benefit	20 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	80%, after Deductible	60%, after Deductible
Durable Medical Equipment (DME)	80%, after Deductible	60%, after Deductible
Emergency Services – Emergency Medical Condition	80%, after Deductible	Paid at the Participating Provider level of benefits.
Emergency Room – Non-Emergency Medical Condition	Not Covered	Not Covered
Home Health Care	80%, after Deductible	60%, after Deductible
Plan/Calendar Year Maximum Benefit	120 visits	
Hospice Care	80%, after Deductible	60%, after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80%, after Deductible	60%, after Deductible
Room and Board Allowance*	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	80%, after Deductible	60%, after Deductible
Miscellaneous Services & Supplies	80%, after Deductible	60%, after Deductible
Outpatient	80%, after Deductible	60%, after Deductible
• A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%, Deductible waived	60%, after Deductible
Lactation Consultations	100%, Deductible waived	100%, Deductible waived
All Other Prenatal and Postnatal Care	80%; after Deductible	60%, after Deductible
Delivery	80%, after Deductible	60%, after Deductible

Mental Disorders and Substance Use Disorders		
Inpatient	80%, after Deductible	60%, after Deductible
Outpatient	80%, after Deductible	60%, after Deductible
NOTE: Emergency care (ambulance and Emergency Services) will be paid the same as the benefit for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Outpatient Therapies (e.g. physical, speech, occupational)	80%, after Deductible	60%, after Deductible
Combined Plan/Calendar Year Maximum Benefit	PT/OT Visits – combined up to 20 Speech Visits up to 20	
Physician's Services		
Inpatient/Outpatient Services	80%, after Deductible	60%, after Deductible
Office Visits: Primary Care Physician Specialist	 80%, after Deductible 80%, after Deductible	 60%, after Deductible 60%, after Deductible
Physician Office Surgery: Primary Care Physician Specialist	80%, after Deductible	60%, after Deductible 60%, after Deductible
Copay applies per visit regardless of what services are rendered.		
Preventive Services and Routine Care (includes the office visit and any other eligible item or service rendered at the same time as the preventive service or routine care, whether billed at the same time or separately)	100%; Deductible waived	60%, after Deductible
Routine Eye Examination	100%; Deductible waived	60%, after Deductible
Maximum Benefit Per 24-Month Period	1 exam	
Routine Hearing Examination	100%; Deductible waived	60%, after Deductible
Maximum Benefit Per 24-Month Period	1 exam	
Skilled Nursing Facility and Rehabilitation Facility	80%, after Deductible	60%, after Deductible
Combined Plan/Calendar Year Maximum Benefit	150 days	
Transplants	80%, after Deductible (Aetna IOE Program)*	60%, after Deductible
Urgent Care Facility	80%, after Deductible	60%, after Deductible
All Other Eligible Medical Expenses	80%, after Deductible	60%, after Deductible

This is a brief outline of your benefits. It is not a Summary Plan Description or intended to replace the Schedule of Benefits contained within the Plan Document. If any provision is inconsistent with the language of the Plan Document, the Plan Document will govern.

Meritain Health Benefit/Claim Customer Service #: 1-800-925-2272. A Meritain Health Customer Service Representative will be able to assist you with benefit/claims questions.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Calendar Year Out-of-Pocket Maximum (includes Copays – combined with major medical Out-of-Pocket Maximum)		
Single Family	$6,350 $12,700	$12,700 $25,400
Retail Pharmacy: 30-day		
Generic Drug	80%; after Deductible	60%; after Deductible
Formulary Drug	80%; after Deductible	60%; after Deductible
Non-Formulary Drug	80%; after Deductible	60%; after Deductible
Preventive	100%	100%
Mail Order Pharmacy: 90-day supply		
Generic Drug	80%; after Deductible	Not Covered
Formulary Drug	80%; after Deductible	Not Covered
Non-Formulary Drug	80%; after Deductible	Not Covered
Preventive	100%	Not Covered

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