Summary of Benefits
PPO 80-60 $1000 Deductible

	In-Network Cost to Covered Person	Out-of-Network Cost to Covered Person*
Member Coinsurance for Eligible Expenses	20%	40%
Annual deductible [1]		
Individual	$1,000	$2,000
Family	$2,000	$4,000
Annual Out-of-pocket Maximum [2] [3]		
Individual (includes deductible)	$3,600	$7,200
Family (includes deductible)	$7,200	$14,400
Lifetime Maximum Benefit	Unlimited	
Physician Care		
General Practitioner (PCP) Office Visit	$30 copay	Deductible, then 40%
Specialist Office Visit	$50 copay	Deductible, then 40%
Lab Tests & X-rays Major	Deductible, then 20%	Deductible, then 40%
Lab Tests & X-rays Minor	Covered in full	Deductible, then 40%
Office Surgery	Deductible, then 20%	Deductible, then 40%
Allergy Injections	Deductible, then 20%	Deductible, then 40%
Urgent Care	$75 copay	$75 copay
Child Hearing Exam	Covered in full	Deductible, then 40%
Childhood Immunizations	Covered in full	Deductible, then 40%
Preventive Care (All Ages)		
Physician services;	Covered in full	Deductible, then 40%
History	Covered in full	Deductible, then 40%
Physical Exam	Covered in full	Deductible, then 40%
Development Assessment for Children	Covered in full	Deductible, then 40%
Anticipatory Guidance for Children	Covered in full	Deductible, then 40%
Laboratory Test, X-rays, blood pressure and other services for the early detection of diseases when ordered by a Physician	Covered in full	Deductible, then 40%
Annual Pap Exam & Lab	Covered in full	Deductible, then 40%
Prostate Cancer Screening	Covered in full	Deductible, then 40%
Mammography	Covered in full	Deductible, then 40%
Maternity Care		
Office visits (prenatal)	Covered in full	Deductible, then 40%
Hospitalization	Deductible, then 20%	Deductible, then 40%
Vision Exam - Routine (Limited to 1 visit per year)	Covered in full	Deductible, then 40%
Adult hearing exam (Limited to 1 visit per year)	Covered in full	Deductible, then 40%

	In-Network Cost to Covered Person	Out-of-Network Cost to Covered Person*
Hospitalization Inpatient Services		
Semi-private Hospital Room & Board	Deductible, then 20%	Deductible, then 40%
Physician & Surgeon Services	Deductible, then 20%	Deductible, then 40%
Lab, X-ray and other facility charges	Deductible, then 20%	Deductible, then 40%
Inpatient Rehabilitation	Deductible, then 20%	Deductible, then 40%
Hospital Outpatient Surgery	Deductible, then 20%	Deductible, then 40%
Hosptial Outpatient services	Deductible, then 20%	Deductible, then 40%
Emergency Room	$100 copay, then 20%	$100 copay, then 20%
Ambulance		
Ground transportation	Deductible, then 20%	Deductible, then 20%
Air transportation	Deductible, then 20%	Deductible, then 20%
Mental or Emotional Illness or Disorders & Chemical Dependency		
Inpatient Mental or Emotional Illness Disorder	Deductible, then 20%	Deductible, then 40%
Inpatient Chemical Dependency	Deductible, then 20%	Deductible, then 40%
Outpatient Mental or Emotional Illness Disorder	$30 copay	Deductible, then 40%
Outpatient Chemical Dependency	$30 copay	Deductible, then 40%
Office Visits Related to Mental or Emotional Disorder	$30 copay	Deductilble, then 40%
Office Visits Related to Chemical Dependency	$30 copay	Deductible, then 40%
Serious mental illness - Inpatient	Deductible, then 20%	Deductible, then 40%
Serious mental illness - Outpatient	$30 copay	Deductible, then 40%
Rehabilitation Services		
Inpatient rehabilitation services	Deductible, then 20%	Deductible, then 40%
Outpatient rehabilitation services (35 visits per calendar year)	$30 copay	Deductible, then 40%
Durable Medical Equipment		
	Deductible, then 50%	Deductible, then 50%
Skilled Nursing Facility		
25 days maximum per calendar year	Deductible, then 20%	Deductible, then 40%
Home Health Care		
60 visits per calendar year maximum benefit.	Deductible, then 20%	Deductible, then 40%
Hospice Service		
	Covered in full	Deductible, then 40%
Organ Transplant		
	Deductible, then 20%	Deductible, then 40%
Manipulative Services		
$500 Calendar Year maximum benefit.	Deductible, then 20%	Deductible, then 40%

	In-Network Cost to Covered Person	Out-of-Network Cost to Covered Person*
Acupressure/Acupuncture		
10 visits per calendar year maximum benefit.	Deductible, then 20%	Deductible, then 40%
Temporomandibular Joint Dysfunction (TMJ)		
	Deductible, then 20%	Deductible, then 40%

(1) Co-pays do not count toward the Calendar Year deductible.
(2) Deductibles apply to OOP maximum.
(3) Co-pays apply to OOP maximum
Pre-Authorization. There is a $500 penalty for failure to obtain pre-authorization.

The following are subject to Pre-Authorization prior to obtaining services:
DME
Inpatient admissions
Inpatient rehabilitation
Organ transplants
Skilled nursing Facilities
Home health care
Providers visit http://www.aetna.com/docfind/custom/mymeritain/

*All out of network benefits are subject to usual and customary charges.