

 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, [www.meritain.com](http://www.meritain.com) or call (866) 300-8449. 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) 300-8449 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For participating <u>providers</u> : \$0 For non-participating <u>providers</u> : \$900 individual / \$2,700 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. All services are covered before you meet a <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> : \$6,350 individual / \$12,700 family For non-participating <u>providers</u> : Unlimited	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>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 participating <u>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>	<u>Copay</u> applies per visit regardless of what services are rendered.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	<u>Preventive care</u> : No Charge Routine care: No charge for the first \$300 per year, then 90% <u>coinsurance</u> Flu, pneumonia and shingles immunization: No Charge Hearing exam: \$30 <u>copay</u>	<u>Preventive care</u> : Not Covered Routine care: No charge for flu, pneumonia and shingles immunizations Hearing exam: 50% <u>coinsurance</u> All other routine care: Not Covered	<u>Deductible</u> does not apply for flu, pneumonia and shingles immunizations for non-participating <u>providers</u> . Hearing exams limited to 1 per year. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$30 <u>copay</u> /test (freestanding lab and any single service test under \$500) / \$50 <u>copay</u> /test (oncotype testing and single service test \$500 and over)	50% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	\$30 <u>copay</u> /test (single service test under \$500) / \$50 <u>copay</u> /test (single service test \$500 and over)	50% <u>coinsurance</u>	<u>Preauthorization</u> required for PET scans and non-orthopedic CT/MRI's. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
<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.caremark.com">www.caremark.com</a>	Generic drugs	\$15 <u>copay</u> (30-day retail)/ \$30 <u>copay</u> (90-day retail & mail order)	Not Covered	<u>Deductible</u> does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (retail prescription or mail order); 30-day supply ( <u>specialty drugs</u> ). <u>Copay</u> applies per prescription. Mandatory generic provision applies. There is no charge for preventive drugs. Diabetic insulin medications will have \$5 <u>copay</u> (30-day retail) /\$10 <u>copay</u> (90-day retail and mail order) for generic and \$15 <u>copay</u> (30-day retail)/\$30 <u>copay</u> (90-day retail and mail order) for brand name.
	Preferred drugs	20% <u>copay</u> , \$25 minimum, \$80 maximum (30-day retail) / 20% <u>copay</u> , \$50 minimum, \$175 maximum (90-day retail & mail order)	Not Covered	

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)	
	Non-preferred drugs	40% <u>copay</u> , \$40 minimum, \$110 maximum (30-day retail) / 40% <u>copay</u> , \$80 minimum, \$225 maximum (90-day retail & mail order)	Not Covered	Diabetic supplies will be paid the same as all other drugs (retail) and will have a \$10 <u>copay</u> (mail order) for generic and \$30 <u>copay</u> (mail order) for brand. Maintenance medications are subject to the retail or mail order supply limit and <u>copays</u> . <u>Specialty drugs</u> must be obtained directly from the specialty pharmacy. <u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.
	<u>Specialty drugs</u>	20% <u>copay</u> , \$100 minimum, \$150 maximum (30-day retail)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$75 <u>copay</u> /occurrence	50% <u>coinsurance</u>	<u>Preauthorization</u> required for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service. See your <u>plan</u> document for a detailed listing. For participating <u>physician</u> office surgery under \$1,000 cost is \$30 <u>copay</u> /occurrence (PCP) or \$40 <u>copay</u> /occurrence ( <u>specialist</u> ) Surgery over \$1,000 cost is \$50 <u>copay</u> (PCP & <u>specialist</u> ).
	Physician/surgeon fees	\$75 <u>copay</u> (surgeon)	50% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> /admission (facility charge)/ \$40 <u>copay</u> (professional and ancillary fees)	<u>Emergency services</u> : \$150 <u>copay</u> /admission (facility charge)/ \$40 <u>copay</u> (professional and ancillary fees) / <u>Non-emergency services</u> : 50% <u>coinsurance</u> (all charges)	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>	\$50 <u>copay</u> /trip (ground) \$200 <u>copay</u> /trip (air)	\$50 <u>copay</u> /trip (ground) \$200 <u>copay</u> /trip (air)	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>coinsurance</u>	-----none-----

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 have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /admission	\$300 <u>copay</u> /admission +50% <u>coinsurance</u>	Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	\$75 <u>copay</u> (surgeon)	50% <u>coinsurance</u>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <u>copay</u> /visit (office visit) /\$75 <u>copay</u> /occurrence (all other outpatient)	50% <u>coinsurance</u>	-----none-----
	Inpatient services	\$250 <u>copay</u> /admission (facility fees) /\$30 <u>copay</u> /visit (professional fees)	\$300 <u>copay</u> /admission +50% <u>coinsurance</u> (facility fees)/ 50% <u>coinsurance</u> (professional fees)	Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
<b>If you are pregnant</b>	Office visits	\$300 <u>copay</u> /visit (includes prenatal, postnatal and delivery)	50% <u>coinsurance</u>	Preauthorization required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. <u>Cost sharing</u> does not apply to <u>preventive services</u> . Depending on the type of services, a <u>copay</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	\$250 <u>copay</u> /admission	\$300 <u>copay</u> /admission +50% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	\$30 <u>copay</u> /visit	50% <u>coinsurance</u>	Limited to 60 visits per year. <u>Home health care</u> supplies are not subject to the calendar year maximum. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit	50% <u>coinsurance</u>	Physical, speech & occupational therapy limited to 60 visits per each type of therapy per year.

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)	
	<u>Habilitation services</u>	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism and to expenses covered as <u>preventive care</u> .
	<u>Skilled nursing care</u>	\$250 <u>copay</u> /admission	\$300 <u>copay</u> /admission + 50% <u>coinsurance</u>	Limited to 60 days per 12 month period. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	<u>Durable medical equipment</u>	\$30 <u>copay</u> /rental / \$200 <u>copay</u> /purchase	50% <u>coinsurance</u>	<u>Preauthorization</u> required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	<u>Hospice services</u>	\$30 <u>copay</u> /visit (outpatient)/ \$250 <u>copay</u> / admission (inpatient)	50% <u>coinsurance</u> (outpatient)/\$300 <u>copay</u> / admission + 50% <u>coinsurance</u> (inpatient)	Bereavement counseling is not covered.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's glasses	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's dental check-up	Not Covered	Not Covered	Covered under stand alone dental plan.

### 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
- Bereavement counseling
- Cosmetic surgery
- Dental care (covered under stand alone dental plan)
- Glasses (covered under stand alone vision plan)
- Habilitation services (except autism & preventive services)
- 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 (covered under stand alone vision plan)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Hearing aids

**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 Meritain Health at (866) 300-8449. 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, contact Meritain Health, Inc. at (866) 300-8449.

### 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, kwijigo 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 \$0
- Primary Care Physician copayment \$300
- Hospital (facility) copayment \$250
- Other copayment \$50

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

**Total Example Cost** \$12,840

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,210
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,270</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$75
- Other copayment \$50

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

**Total Example Cost** \$7,460

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,285
Coinsurance	\$716
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$3,057</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$150
- Other copayment \$50

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

**Total Example Cost** \$2,010

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$645
Coinsurance	\$212
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$645</b>