



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, go to www.meritain.com or call 1-800-555-2022. 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 1-800-555-2022 to request a copy.

Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In- <u>Network</u> : Individual \$5,000 / Family \$10,000. Out-of- <u>Network</u> : Individual \$10,000 / Family \$20,000.	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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. For Participating <u>providers</u> : <u>Preventive care</u> is covered before you meet your <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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In- <u>Network</u> : Individual \$6,550 / Family \$13,100. Out-of- <u>Network</u> : Individual \$13,500 / Family \$27,000.	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.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of <u>network 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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
Is a Health Savings Account (HSA) available under this <u>plan</u> option?	Yes.	An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS.



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)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Includes telemedicine other than Teladoc. Your cost share may be different, depending on the <u>provider</u> rendering these services. Refer to your <u>plan</u> for more information. You pay a \$5 <u>copay</u> (<u>deductible</u> does not apply) if you receive consultation services through Teladoc. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	50% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None Penalty of \$250 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> for PET scans and non-orthopedic CT/MRI's.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	<u>Copay/prescription</u> : \$20 (retail), \$50 (MCN or mail order)	<u>Copay/prescription</u> : 50% (retail)	Major medical <u>deductible</u> applies. Covers 30-day supply (retail), 90-day supply (Maintenance Choice <u>Network</u> (MCN) or mail order), 30-day supply (<u>specialty drugs</u>). There is no charge or <u>deductible</u> for preventive drugs. After 2 fills, maintenance drugs must be purchased as a 90-day supply and must be purchased at either a Maintenance Choice <u>Network</u> pharmacy or through the mail order program, unless you opt out. Dispense as Written (DAW) provision applies. All <u>specialty drugs</u> must be filled through the Specialty Pharmacy <u>Network</u> . Certain <u>specialty drugs</u> are eligible for <u>copay</u> assistance programs through CVS True Accumulation Program. Step therapy provision applies.
	Preferred brand drugs	<u>Copay/prescription</u> : \$40 (retail), \$100 (MCN or mail order)	<u>Copay/prescription</u> : 50% (retail)	
	Non-preferred brand drugs	<u>Copay/prescription</u> : \$70 (retail), \$175 (MCN or mail order)	<u>Copay/prescription</u> : 50% (retail)	
	<u>Specialty drugs</u>	<u>Copay/prescription</u> : 20% <u>copay</u> up to \$250 maximum	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$250 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	Emergency services: 20% <u>coinsurance</u> / Non-emergency services: Not Covered	Emergency services: 20% <u>coinsurance</u> / Non-emergency services: Not Covered	Non-participating <u>providers</u> paid at the participating <u>provider</u> level. No coverage for non-emergency use.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	Urgent care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$250 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: 0% <u>coinsurance</u> ; other outpatient services: 20% <u>coinsurance</u>	50% <u>coinsurance</u>	Includes telemedicine other than Teladoc. Your cost share may be different, depending on the <u>provider</u> rendering these services. Refer to your <u>plan</u> for more information. You pay a \$5 <u>copay</u> (<u>deductible</u> does not apply) if you receive consultation services through Teladoc.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$250 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Cost sharing doesn't apply to certain <u>preventive services</u> . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Penalty of \$250 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> after hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

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)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	50 visits/year. Penalty of \$250 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	90 days/calendar year. Penalty of \$250 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$250 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No Charge	50% <u>coinsurance</u>	1 routine eye exam/12 months.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Glasses (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - Except for home health care & hospice.
- Routine foot care - Except for metabolic or peripheral vascular disease, including diabetes.
- Weight loss programs

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

- Acupuncture - 10 visits/year.
- Chiropractic care
- Hearing aids – one aid per hearing impaired ear/2 years.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - 1 routine eye exam/12 months.

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:

- For more information on your rights to continue coverage, contact the [plan](#) at 1-800-555-2022.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church [plan](#), church [plans](#) are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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 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 on how 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 the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet 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](#).

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 \$5,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,370

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

- The plan's overall deductible \$5,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Primary care provider office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$5,120

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

- The plan's overall deductible \$5,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-555-2022 'ਤੇ ਫੋਨ ਕਰੋ।
- Romanian - Pentru a accesa gratuit serviciile de limbă, apălați 1-800-555-2022.
- Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-555-2022.
- Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se tologi, vala'au le 1-800-555-2022.
- Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-800-555-2022.
- Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-800-555-2022.
- Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-555-2022.
- Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-800-555-2022.
- Syriac - ܟܝ ܫܒܩܐ, ܟܝ ܟܠ ܝܠܟܝܢܐ ܟܝ ܝܠܟܝܢܐ ܟܝܠܩܝܢܐ ܟܝܠܩܝܢܐ, ܟܝܠܩܝܢܐ ܟܝܠܩܝܢܐ: 1-800-555-2022
- Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-555-2022.
- Telugu - మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-800-555-2022 కు కాల్ చేయండి.
- Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-555-2022.
- Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-555-2022.
- Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-555-2022.
- Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-555-2022 numarayı arayın.
- Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-555-2022.
- Urdu - بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-555-2022 پر بات کریں۔
- Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-555-2022.
- Yiddish - צו צוטריט שפראך באדינונגען אין קיין פרייז צו איר, רופן 1-800-555-2022
- Yoruba - Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-800-555-2022.