



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 (800) 925-2272. 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 (800) 925-2272 to request a copy.

Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For participating <u>providers</u> : \$500 individual/\$1,000 employee plus one/\$1,500 family For non-participating <u>providers</u> : \$500 individual/ \$1,500 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. For participating <u>providers</u> : <u>Preventive care</u> , <u>emergency room care-emergency services</u> only (all <u>providers</u>), outpatient mental health/substance abuse services, <u>rehabilitation services</u> (physical, speech, cognitive & occupational therapy only), <u>habilitation services</u> , <u>urgent care</u> and office visits are 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>?	For participating <u>providers</u> : \$5,350 person/\$8,025 family (<u>deductible</u> , <u>coinsurance</u> and medical <u>copays</u>) For non-participating <u>providers</u> : \$5,500 person/ \$8,250 family (<u>deductible</u> and <u>coinsurance</u>) For participating <u>provider</u> : <u>prescription drug copays</u> : \$1,000 person/\$3,000 family	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> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>preauthorization</u> penalty amounts, <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> .

Questions	Answers	Why This Matters:
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 charge</u> 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> .



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 office or clinic</u>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	40% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered. You will pay a \$25 <u>copay</u> if you receive telemedicine consultations. There is no charge and the <u>deductible</u> does not apply for services received at a MinuteClinic. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	40% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None <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 \$500 of the total cost of the service for non-participating <u>providers</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition	Generic drugs	15% <u>copay</u> (retail)/ 10% <u>copay</u> (mail order)	Not Covered	<u>Deductible</u> does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription), 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Step Therapy provision applies.
	Preferred brand drugs	20% <u>copay</u> (retail)/ 15% <u>copay</u> (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)	
More information about prescription drug coverage is available at www.mysmithrx.com	Non-preferred brand drugs	30% <u>copay</u> (retail)/ 25% <u>copay</u> (mail order)	Not Covered	<u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> after one fill at a retail pharmacy. <u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.
	<u>Specialty drugs</u>	No Charge	Not Covered	
If you have outpatient surgery	<u>Facility fee</u> (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <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 \$500 of the total cost of the service for non-participating <u>providers</u> . See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$125 <u>copay</u> /visit	\$125 <u>copay</u> /visit	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	No charge after deductible	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	<u>Facility fee</u> (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service for non-participating <u>providers</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit	40% <u>coinsurance</u>	Includes telemedicine.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service for non-participating <u>providers</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 are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get <u>preauthorization</u>, benefits could be reduced by \$500 of the total cost of the service for non-participating <u>providers</u>. <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u>. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family <u>deductible</u> amount may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 120 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u>, benefits could be reduced by \$500 of the total cost of the service for non-participating <u>providers</u>.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit (physical, speech/hearing, cognitive & occupational therapy)/ 20% <u>coinsurance</u> (cardiac rehab and pulmonary therapy)	40% <u>coinsurance</u>	Physical therapy is limited to 50 visits per year. Speech/hearing, cognitive & occupational therapy limited to a combined maximum of 45 visits per year. Cardiac rehab therapy is limited to 36 sessions in a 12 week period. Pulmonary therapy is limited to 36 hours or a 6 week period.
	<u>Habilitation services</u>	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u>, benefits could be reduced by \$500 of the total cost of the service for non-participating <u>providers</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)	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <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 \$500 of the total cost of the service for non-participating <u>providers</u> .
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Bereavement counseling is covered if received within 6 months of death.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	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.)

- Acupuncture - (except when used as a form of anesthesia for a covered surgical procedure)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids
- Infertility treatment - (except diagnosis and surgical treatment of underlying medical cause)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - (except for home health care & hospice)
- Routine eye care (Adult & Child)
- Routine foot care - (except for metabolic or peripheral vascular disease)
- Weight loss programs
- Glasses (Adult & Child)

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

- Chiropractic care

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 (800) 925-2272.
- 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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,760

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,520

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$125
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,090

TTY: 711

Language Assistance:

To access language services at no cost to you, call (800) 925-2272.

Albanian -	Për shërbime përkthimi falas për ju, telefononi (800) 925-2272.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ (800) 925-2272 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم (800) 925-2272
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք (800) 925-2272 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi (800) 925-2272 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara (800) 925-2272.
Bengali-Bangala -	আপনাকে বিনামূল্যে ভাষা পবিকষি পপকে হকয এই নম্বকি পেবযক ান েরন: (800) 925-2272 ।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa (800) 925-2272.
Burmese -	သင့်အနေဖြင့် အခမဲ့စကားပြော မေးရပဲ ဘာသာစကားဝန်ဆောင်ခန်းရရှိဖို့ (800) 925-2272 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al (800) 925-2272.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang (800) 925-2272.
Cherokee -	ᄆᄡᆫᄃ ᄆᄡᆫᄃ ᄆᄡᆫᄃ ᄆᄡᆫᄃ ᄆᄡᆫᄃ ᄆᄡᆫᄃ ᄆᄡᆫᄃ ᄆᄡᆫᄃ ᄆᄡᆫᄃ ᄆᄡᆫᄃ (800) 925-2272.
Chinese -	如欲使用免費語言服務，請致電 (800) 925-2272.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya (800) 925-2272.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili (800) 925-2272.
Dutch -	Voor gratis toegang tot taaldiensten, bell (800) 925-2272.
French -	Afin d'accéder aux services langagiers sans frais, composez le (800) 925-2272.
French Creole -	Pou jwenn sèvis lang gratis, rele (800) 925-2272.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie (800) 925-2272 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό (800) 925-2272.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવાઓની પહોંર માટે, કોલ કરો1-888-982-3862.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona (800) 925-2272. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,(800) 925-2272 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu (800) 925-2272.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ (800) 925-2272
Ilocano -	Tapno maaksesyô dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti (800) 925-2272.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi (800) 925-2272.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero (800) 925-2272.
Japanese -	言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。
Karen -	လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢၤအတၢ်ဖဲးတၢ်မၤတဖၣ်လၢတၢ်အိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး (800) 925-2272 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 (800) 925-2272 번으로 전화해 주십시오.
Kru-Bassa -	M̈ dyi wuḍu-dù kà kò ḍò b̈ě dyi m̈oú n̈ ní Pídyi ní, n̈íí, ḍá n̈òbà n̈ià k̈e: (800) 925-2272
Kurdish -	بۆ دەستگیر ئەگەشتن بە خزمەتگوزاری زمان بەجی تێچوون بۆ تۆ، پەیوەندی بەکە بە ژمارە (800) 925-2272
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ (800) 925-2272
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, (800) 925-2272 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirllok (800) 925-2272.
Micronesian- Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih (800) 925-2272.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ (800) 925-2272 ។
Navajo -	T’áá ni nizaad k’ehjí bee níká a’doowoł doo báąh ílínígóó koji’ hólne’ (800) 925-2272.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न (800) 925-2272 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të koor yin weëř de thokic ke cîn wëu ḳor keek ṭen̄on̄ yîn. Ke c̣ol ḳoc ye ḳoc kuony ne n̄omba (800) 925-2272.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring (800) 925-2272.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff (800) 925-2272.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره (800) 925-2272 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć (800) 925-2272.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para (800) 925-2272.

