



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](http://www.meritain.com) or call (215) 875-9440. 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For participating <u>providers</u> : \$0 person / \$0 family  For non-participating <u>providers</u> : \$10,000 person / \$20,000 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 deductible?</b>	Yes. For participating <u>providers</u> : all services are covered before you meet a <u>deductible</u> .  For non-participating <u>providers</u> : <u>Emergency medical transportation</u> , and <u>emergency room care</u> 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For participating <u>providers</u> : \$1,500 person / \$3,000 family  For non-participating <u>providers</u> : \$20,000 person / \$40,000 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> , 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 out-of-pocket limit?</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 network provider?</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 <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.
<b>Do you need a referral to see a specialist?</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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit (office visit) / No Charge (all other services)	40% <u>coinsurance</u>	<u>Copay</u> applies to the physician office visit only. Includes telemedicine.
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit (office visit) / No Charge (all other services)	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$50 <u>copay</u> /visit	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	\$250 <u>copay</u> /visit	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for PET scans and non-orthopedic CT/MRI's.
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.primetherapeutic.com">www.primetherapeutic.com</a>	Generic drugs	\$10 <u>copay</u> (30-day retail) / \$30 <u>copay</u> (90-day retail) / \$20 <u>copay</u> (mail order)	Not Covered	Covers up to a 90-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. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained directly from the specialty pharmacy network after one fill, at a retail pharmacy. Step Therapy provision applies. <u>Preauthorization</u> recommended for injectables costing over \$2,000 per drug per month.
	Preferred brand drugs	\$20 <u>copay</u> (30-day retail) / \$60 <u>copay</u> (90-day retail) / \$40 <u>copay</u> (mail order)	Not Covered	
	Non-preferred brand drugs	\$50 <u>copay</u> (30-day retail) / \$150 <u>copay</u> (90-day retail) / \$100 <u>copay</u> (mail order)	Not Covered	
	<u>Specialty drugs</u>	No Charge	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> /occurrence	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	No Charge	40% <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 immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> /visit ( <u>emergency services</u> )/ Not Covered (non- <u>emergency services</u> )	\$250 <u>copay</u> /visit ( <u>emergency services</u> )/ Not Covered (non- <u>emergency services</u> )	Non-participating providers paid at the participating provider level of benefits for <u>emergency services</u> .
	<u>Emergency medical transportation</u>	\$250 <u>copay</u> /trip	\$250 <u>copay</u> /trip	Non-participating providers paid at the participating provider level of benefits.
	<u>Urgent care</u>	\$100 <u>copay</u> /visit (office visit) / No Charge (all other services)	40% <u>coinsurance</u>	Copay applies to the physician office visit only.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /day (max. of 5 <u>copays</u> /admission)	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	No Charge	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay</u> /visit (office visits) / No Charge (all other outpatient)	40% <u>coinsurance</u>	Includes telemedicine.
	Inpatient services	Facility charges: \$250 <u>copay</u> /day (max. of 5 <u>copays</u> /admission) / Professional fees: No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
If you are pregnant	Office visits	No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating provider. 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	No Charge	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250 <u>copay</u> /day (max. of 5 <u>copays</u> /admission)	40% <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>	No Charge	40% <u>coinsurance</u>	Limited to 120 visits per year. <u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit	40% <u>coinsurance</u>	Physical & occupational therapy limited to a combined maximum of 60 visits per year. Speech/hearing therapy is limited to 60 visits per year. Cardiac rehab limited to 36 sessions in a 12 week period. Pulmonary therapy limited to 36 hours or a 6 week period.
	<u>Habilitation services</u>	Not Covered	Not Covered	This exclusion will not apply to expenses that are considered mental health or substance abuse services.
	<u>Skilled nursing care</u>	\$250 <u>copay</u> /day (max. of 5 <u>copays</u> /admission)	40% <u>coinsurance</u>	Limited to 120 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	\$50 <u>copay</u> /item	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices.
	<u>Hospice services</u>	No Charge	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	No Charge	40% <u>coinsurance</u>	Limited to 1 exam per 12 month period.
	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Acupuncture (except when used as anesthesia for a covered surgical procedure)</li><li>• Cosmetic surgery</li><li>• Dental care (Adult &amp; Child)</li><li>• Emergency room services for non-emergency services</li></ul>	<ul style="list-style-type: none"><li>• Glasses (Adult &amp; Child)</li><li>• Habilitation services</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (except for home health care &amp; hospice)</li><li>• Routine foot care (except for diabetes and metabolic or peripheral vascular disease)</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Bariatric surgery (for the treatment of morbid obesity only – 1 surgical procedure per 2 year period)</li><li>• Chiropractic care (20 visits per year)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (1 aid per ear up to \$1,000 per 36 month period)</li><li>• Infertility treatment (Artificial insemination and ovulation inductions limited to 6 cycles per lifetime each)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult &amp; Child - 1 exam per 12 month period)</li></ul>

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/ebsa/healthreform> or Customized Energy Solutions Ltd. at (215) 875-9440. 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 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](https://www.dol.gov/ebsa/healthreform) or Customized Energy Solutions Ltd. at (215) 875-9440.

## 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 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, kwijjigo 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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Primary care physician coinsurance</u>	0%
■ Hospital (facility) <u>copayment</u>	\$250/day
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Primary care physician 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:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,160</b>

### 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>	\$0
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Specialist office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$620</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	0%

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:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,000</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.