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 (215) 723-5518. 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 or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers: $2,500 person / $5,000 family For non-participating providers: $10,000 person / $20,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. For participating providers: Preventive care, diagnostic tests & imaging, initial prenatal visit, outpatient mental health/substance abuse services, urgent care, routine eye exams, and office visit charges are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers: $5,000 person / $10,000 family For non-participating providers: $20,000 person / $40,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	$20 copay/visit (office visit)/ $150 copay/test (diagnostic tests & x-ray)/ 20% coinsurance (all other services)	50% coinsurance	Copay applies to the physician office visit and diagnostic tests & x-rays. Includes telemedicine other than Teladoc. There is no charge, and the deductible does not apply if you receive consultation services through Teladoc. There is no charge and the deductible does not apply for services received at a MinuteClinic.
	Specialist visit	$40 copay/visit (office visit)/ $150 copay/test (diagnostic tests & x-ray)/20% coinsurance (all other services)	50% coinsurance	
	Preventive care/screening/ immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge (lab)/ $150 copay/test (all other diagnostic tests & x-ray)	50% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	$300 copay/scan	50% coinsurance	Preauthorization recommended for PET scans and non-orthopedic CT/MRI's.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mysmithrx.com	Generic drugs	$10 copay (retail)/ $20 copay (mail order)	Not Covered	Deductible does not apply. Covers up to a 90-day supply (retail or mail order prescription); 30-day supply (specialty drugs). The copay applies per prescription. There is no charge for preventive drugs or preventive maintenance drugs. Dispense as Written (DAW) provision applies. Specialty drugs must be obtained directly from the specialty pharmacy network. *Certain specialty drugs may be subject to the SmithRx Specialty Assistance Program. Prior authorization is required on all specialty drugs. Step therapy provision applies.
	Preferred brand drugs	$50 copay (retail)/ $100 copay (mail order)	Not Covered	
	Non-preferred brand drugs	$150 copay (retail)/ $300 copay (mail order)	Not Covered	
	Specialty drugs	$0 copay *	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)	
				Preauthorization recommended for injectables costing over $2,000 per drug per month.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization recommended for certain surgeries, including infusion therapy costing over $2,000 per drug per month. See your plan document for a detailed listing.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Non-participating providers paid at the participating provider level of benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-participating providers paid at the participating provider level of benefits.
	Urgent care	$80 copay/visit	50% coinsurance	Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization recommended.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	50% coinsurance	Includes telemedicine other than Teladoc.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization recommended.
If you are pregnant	Office visits	20% coinsurance ($20 copay on initial visit)	50% coinsurance	For labs and ultrasounds, refer to the diagnostic tests (x-ray, bloodwork) benefit. Preauthorization recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). Cost sharing does not apply to preventive services 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 deductible amount may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

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	Home health care	20% coinsurance	50% coinsurance	Limited to 90 days per year. Preauthorization recommended.
	Rehabilitation services	$40 copay/visit	50% coinsurance	Physical, speech/hearing & occupational therapy limited to 60 visits per each type of therapy per year.
	Habilitation services	$40 copay/visit	50% coinsurance	----------none----------
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 90 days per year. Preauthorization recommended.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices.
	Hospice services	20% coinsurance	50% coinsurance	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	50% coinsurance	Limited to 1 exam per year.
	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**
- **Cosmetic surgery**
- **Dental care (Adult & Child)**
- **Glasses (Adult & Child)**
- **Hearing aids**
- **Infertility treatment (except diagnosis or treatment of underlying medical condition)**
- **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)**

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

- **Bariatric surgery (for morbid obesity only – 1 surgical procedure per lifetime)**
- **Chiropractic care**
- **Routine eye care (Adult & Child – 1 exam per year)**
- **Weight loss programs (for morbid obesity only)**

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 (866) 444-3272 or www.dol.gov/ebsa/healthreform or Bergey's Electric Inc. at (215) 723-5518. 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 (866) 444-3272 or www.dol.gov/ebsa/healthreform or Bergey's Electric Inc. at (215) 723-5518.

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, kwiijigo 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	**$2,500**
Primary care physician coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$300
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,560

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

The plan's overall deductible	**$2,500**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,820

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

The plan's overall deductible	**$2,500**
Specialist copayment	**$40**
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:

Cost Sharing	
Deductibles	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,400

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