



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, <https://content.meritain.com/DownloadFile.aspx?docid=C87A48C1-03DE-47BF-BEC0-> (Certificate) and <https://content.meritain.com/DownloadFile.aspx?docid=39A02A59-4C55-47B3-81A7-CD3040B02099> (Schedule). 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 1-800-847-8361 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For network <a href="#">providers</a> \$2,000 person/ \$4,000 family. For out-of-network <a href="#">providers</a> \$4,000 person/\$8,000 family. Does not apply to preventive care.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes, Prescription Drug: \$125 person/\$250 family	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$7,000 individual / \$14,000 family; for <a href="#">out-of-network providers</a> \$14,000 individual / \$28,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.aetna.com/docfind/custom/mymeritain">www.aetna.com/docfind/custom/mymeritain</a> or call 1-800-847-8361 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the specialist you choose without a <a href="#">referral</a> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$45 copay deductible waived	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$75 copay deductible waived	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab - \$40 copay deductible waived X-ray - \$70 copay deductible waived	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	\$300 copay deductible waived	50% <a href="#">coinsurance</a>	Pre-authorization required or a \$500 penalty may apply.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://content.meritain.com/DownloadFile.aspx?docid=EBEE6BF2-0224-45C2-A1EC-685EA635B581">https://content.meritain.com/DownloadFile.aspx?docid=EBEE6BF2-0224-45C2-A1EC-685EA635B581</a>	Generic drugs (Tier 1)	Retail – \$15 copay Mail Order - \$30 copay;	Retail – \$15 copay* Mail Order - \$30 copay*	Generic mandatory when available unless a non-generic drug is medically necessary. Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription) *(plus the additional amount over what We would have paid at a participating dispensing pharmacy)
	Preferred brand drugs (Tier 2)	Retail – \$55 copay Mail Order - \$110 copay	Retail – \$55 copay* Mail Order - \$110 copay*	
	Non-preferred brand drugs (Tier 3)	Retail \$85 copay Mail Order - \$170 copay	Retail \$85 copay* Mail Order - \$170 copay*	
	<a href="#">Specialty drugs</a> (Tier 4)	20% coinsurance up to \$250 per script	20% coinsurance up to \$250 per script	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance deductible waived	50% <a href="#">coinsurance</a>	Pre-authorization required or a \$500 penalty may apply.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> deductible waived	50% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$350 copay; deductible waived	\$350 copay	Emergency room copay waived if admitted

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Emergency medical transportation</a>	\$250 copay	\$250 copay	
	<a href="#">Urgent care</a>	\$45 copay deductible waived	\$45 copay deductible waived	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required or a \$500 penalty may apply.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% <a href="#">coinsurance</a>	None
	Inpatient services	0% <a href="#">coinsurance</a> deductible waived	50% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	Preventive prenatal office visits: No charge nonpreventive prenatal care office visits: \$45 copay deductible waived	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). Pre-authorization is required in excess of 48 hrs (vaginal) and 96 hrs (c-section) after the baby is born.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$45 copay deductible waived	50% <a href="#">coinsurance</a>	Pre-authorization required or a \$500 penalty may apply. Limited to 100 visits per year. Rehabilitative and Habilitative services – 100 visits per year per service.
	<a href="#">Rehabilitation services</a>	Inpatient: 20% <a href="#">coinsurance</a> Outpatient: \$45 copay deductible waived	50% <a href="#">coinsurance</a>	Pre-authorization required or a \$500 penalty may apply.
	<a href="#">Habilitation services</a>	Inpatient: 20% <a href="#">coinsurance</a> Outpatient: \$45 copay deductible waived	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required or a \$500 penalty may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Limited to 100 days per benefit period.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> deductible waived	50% <a href="#">coinsurance</a>	Pre-authorization required or a \$500 penalty may apply. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	No charge	50% <a href="#">coinsurance</a>	Pre-authorization required or a \$500 penalty may apply.
If your child needs dental or eye care	Children's eye exam	No charge	50% <a href="#">coinsurance</a>	Coverage limited to one exam/year.
	Children's glasses	No charge	No charge	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No charge	50% <a href="#">coinsurance</a>	None

### 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](#).)

<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Foot Care</li> <li>• Hearing Aids</li> </ul>
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Weight Loss Programs</li> <li>• Infertility Treatment (limited to a max benefit of \$2,000 per year.)</li> </ul>
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**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: California Department of Insurance, Consumer Communication Bureau Health Unit, 300 South Spring St., South Tower, Los Angeles, CA 90013, 1-800-927-HELP(4357), 1-800-482-4833 TDD, [www.insurance.ca.gov](http://www.insurance.ca.gov), the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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: 1-800-847-8361, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or your California Department of Insurance, Consumer Communication Bureau Health Unit, 300 South Spring St., South Tower, Los Angeles, CA 90013, 1-800-927-HELP(4357), 1-800-482-4833 TDD, [www.insurance.ca.gov](http://www.insurance.ca.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Department of Insurance at the contact information provided above.

**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 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](#) \$2,000
- [Specialist copayment](#) \$75
- 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$75
Coinsurance	\$2,160
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,295</b>

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$2,000
Copayments	\$0
Coinsurance	\$1080
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3140</b>

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$75
- 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,900
Copayments	\$0
Coinsurance	
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.