**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 PHR Shared Services at (877) 608-0044. 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 (888) 711-7876 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For participating and non-participating providers: $300 person / $600 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, glasses, hospice services, second surgical opinions, and pre-admission testing 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. |
| **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 and non-participating providers: $5,000 person / $10,000 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, prescription drug copays and coinsurance (except medications obtained through the specialty pharmacy), benefits paid at 50%, custodial care, 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% coinsurance | 20% coinsurance | No charge for second surgical opinions. |
| | Specialist visit | 20% coinsurance | 20% coinsurance | |
| | Preventive care/screening/ immunization | No Charge | 20% coinsurance | Limited to one exam each per year. 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) | 20% coinsurance | 20% coinsurance | No charge for pre-admission testing. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.express-scripts.com | Generic drugs | $5 copay (retail)/ $0 copay (mail order) | $10 copay then 20% coinsurance (retail) | Deductible does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). The copay applies per prescription. There is no charge for preventive drugs from a participating pharmacy. Accredo is the specialty pharmacy. |
| | Brand name drugs | $10 copay (retail)/ $3 copay (mail order) | $10 copay then 20% coinsurance (retail) | |
| | Specialty drugs | 20% copay | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | ----------none---------- |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | ----------none---------- |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent care | 20% coinsurance | 20% coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance | ----------none---------- |
| | Physician/surgeon fees | 20% coinsurance | 20% 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 mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 20% coinsurance | ----------none---------- |
| | Inpatient services | 20% coinsurance | 20% coinsurance | ----------none---------- |
| **If you are pregnant** | Office visits | 20% coinsurance | 20% coinsurance | ----------none---------- |
| | Childbirth/delivery professional services | 20% coinsurance | 20% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 20% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance/ 50% coinsurance (custodial) | 20% coinsurance/ 50% coinsurance (custodial) | Limited to 100 visits per year for skilled home health care only. Custodial home health care has no limit. |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | Includes physical, speech, occupational, shock, pulmonary, respiratory, chelation and cardiac rehab therapies. |
| | Habilitation services | 20% coinsurance | 20% coinsurance | ----------none---------- |
| | Skilled nursing care | 20% coinsurance/ 50% coinsurance (custodial) | 20% coinsurance/ 50% coinsurance (custodial) | ----------none---------- |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | ----------none---------- |
| | Hospice services | No Charge | No Charge | Outpatient limited to 100 visits. Emotional support limited to $50 per day. Services of a social worker limited to 1 visit per 7 day period, $50 per day. Bereavement counseling limited to $50 per day, limited to 6 visits within 12 months following death. Transportation limited to $25 per day, $100 per lifetime. |
| **If your child needs dental or eye care** | Children's eye exam | 20% coinsurance | 20% coinsurance | Limited to 1 exam per 12 month period. |
| | Children's glasses | No Charge | No Charge | 1 pair of lenses per 12 months. Frames limited to $65 every 12 months. Contact lenses limited to $100 every 12 months in lieu of glasses. |
| | 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**<br>• **Cosmetic surgery**<br>• **Dental care (Adult & Child)** | • **Hearing aids**<br>• **Long-term care**<br>• **Non-emergency care when traveling outside the U.S. (except for business)** | • **Routine foot care (except for metabolic or peripheral vascular disease)**<br>• **Weight loss programs** |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • **Acupuncture**<br>• **Chiropractic care ($1,000 per year)** | • **Glasses (Adult & Child)**<br>• **Infertility treatment ($30,000 per lifetime)** | • **Private-duty nursing**<br>• **Routine eye care (Adult & Child)**<br>• **TMJ treatment ($2,000 per lifetime)** |

**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 www.dol.gov/ebsa/healthreform or PHR Shared Services at (877) 608-0044. 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 or PHR Shared Services at (877) 608-0044. Additionally, a consumer assistance program can help you file your appeal. Contact the California Consumer Assistance Program, operated by the California Department of Insurance at (800) 927-4357.

**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** | **$300** |
| **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 | $300 |
| Copayments | $20 |
| Coinsurance | $2,520 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $2,900 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$300** |
| **Specialist coinsurance** | **20%** |
| **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 | $300 |
| Copayments | $285 |
| Coinsurance | $585 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | $1,225 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$300** |
| **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $0 |
| Coinsurance | $385 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $685 |



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