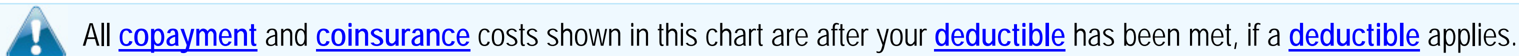
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://content.meritain.com/DownloadFile.aspx?docid=3D97358E-2ADA-425C-A10F-DC5FAA8BE14F (Certificate) and https://content.meritain.com/DownloadFile.aspx?docid=C8A9E1D1-CABE-4C4E-AF18-F93B0288B5C3 (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 deductible?	For network **providers $0** person/ **$0** family. For out-of-network **providers $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 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. Preventive care and prescription drugs 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 https://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 network providers $4,000 individual / $8,000 family; for out-of-network providers $8,000 individual / $16,000 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 1-800-847-8361 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.



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 provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay deductible waived	50% coinsurance	None
	Specialist visit	$40 copay deductible waived	50% coinsurance	None
	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)	Lab - $20 copay deductible waived X-ray - $40 copay deductible waived	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$150 copay deductible waived	50% coinsurance	Pre-authorization required or a $500 penalty may apply.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://content.meritain.com/DownloadFile.aspx?docid=ADA7D78C-8D6D-420F-AF82-EC13AF6B5D43	Generic drugs (Tier 1)	Retail – $5 copay Mail Order - $10 copay	Retail – $5 copay* Mail Order - $10 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 – $15 copay Mail Order - $30 copay	Retail – $15 copay* Mail Order - $30 copay*	
	Non-preferred brand drugs (Tier 3)	Retail $25 copay Mail Order - $50 copay	Retail $25 copay* Mail Order - $50 copay*	
	Specialty drugs (Tier 4)	10% coinsurance up to $250 per script	10% coinsurance up to $250 per script	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay deductible waived	50% coinsurance	Pre-authorization required or a $500 penalty may apply.
	Physician/surgeon fees	$40 copay deductible waived	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay deductible waived	$150 copay deductible waived	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)	
	Emergency medical transportation	$150 copay deductible waived	$150 copay deductible waived	
	Urgent care	$15 copay deductible waived	$15 copay deductible waived	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay per day. Limited to 5 copays per stay. deductible waived	50% coinsurance	Pre-authorization required or a $500 penalty may apply.
	Physician/surgeon fees	$40 copay deductible waived	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay deductible waived	50% coinsurance	None
	Inpatient services	$250 copay per day. Limited to 5 copays per stay. deductible waived	50% coinsurance	
If you are pregnant	Office visits	Preventive prenatal office visits: No charge nonpreventive prenatal care office visits: $15 copay deductible waived	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance 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	$40 copay deductible waived	50% coinsurance	
	Childbirth/delivery facility services	$250 copay Limited to 5 copays per stay. deductible waived	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	$20 copay deductible waived	50% coinsurance	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.
	Rehabilitation services	Inpatient: $250 copay per day limited to 5 copays per stay deductible waived Outpatient: $15 copay	50% coinsurance	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)	
		deductible waived		
	Habilitation services	Inpatient: $250 copay per day limited to 5 copays per stay deductible waived Outpatient: $15 copay deductible waived	50% coinsurance	
	Skilled nursing care	$150 copay per day limited to 5 copays per stay. deductible waived	50% coinsurance	Pre-authorization required or a $500 penalty may apply. Limited to 100 days per benefit period.
	Durable medical equipment	10% coinsurance deductible waived	50% coinsurance	Pre-authorization required or a $500 penalty may apply. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	50% coinsurance	Pre-authorization required or a $500 penalty may apply.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	Coverage limited to one exam/year.
	Children's glasses	No charge	50% coinsurance	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No charge	50% coinsurance	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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- Hearing Aids

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

- Acupuncture
- Bariatric Surgery
- Routine eye care (Adult)
- Weight Loss Programs
- Infertility Treatment

(limited to a max benefit of $2,000 per year.)

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, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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. 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 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 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. 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, 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 $0
- Specialist copayment $40
- Hospital (facility) coinsurance 0%
- Other coinsurance 10%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,320**

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

- The plan's overall deductible $0
- Specialist copayment $40
- Hospital (facility) coinsurance 0%
- Other coinsurance 10%

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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$130
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$585**

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

- The plan's overall deductible $0
- Specialist copayment $40
- Hospital (facility) coinsurance 0%
- Other coinsurance 10%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$370
Coinsurance	$130
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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