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. 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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. All services are covered before you meet a 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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
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	$15 copay/visit (office visit)/No Charge (all other services)	Not Covered	Copay applies to the physician office visit only, 1 copay for each visit. See below for more info regarding your cost for other services for participating providers. You will pay a $5 copay (deductible does not apply) if you receive consultation services through Teladoc.
	Specialist visit	$15 copay/visit (office visit)/No Charge (all other services)	Not Covered	
	Preventive care/screening/ immunization	$15 copay/visit (office visits)/No Charge (all other services)	Not Covered	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. For a colonoscopy, you pay $60 copay. Copay applies to each office visit. For blood work, copay will apply when services are rendered at a free-standing facility or sent out by your provider.
If you have a test	Diagnostic test (x-ray, blood work)	$35 copay/visit	Not Covered	For blood work, 1 copay per day per provider applies. For x-ray and diagnostic testing, copay applies per type of procedure.
	Imaging (CT/PET scans, MRIs)	$35 copay/visit/No Charge (US Imaging Program facilities)	Not Covered	Preauthorization required. If you don't get preauthorization, benefits could be denied. Copay applies per type of x-ray procedure.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rxbenefits.com	Generic drugs	$15 copay (retail)/$14 copay (mail order)	Not Covered	Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription). The copay applies per prescription. Specialty drugs must be obtained from the specialty pharmacy network. After the 1st $5,000, you pay 50% copay for retail & mail order prescriptions. There is a $10 copay for generic drugs filled through the pharmacies at Wal-Mart, Sam's Club or CVS. A brand name drug with a generic available is not covered.
	Brand drugs	$20 copay (retail)/$18 copay (mail order)	Not Covered	
	Specialty drugs	Paid the same as generic and brand name drugs	Not Covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$60 copay/occurrence	Not Covered	Preauthorization required unless performed in an office setting. If you don't get preauthorization, benefits could be denied. One copay per day per provider applies.
	Physician/surgeon fees	$60 copay/visit	Not Covered	
If you need immediate medical attention	Emergency room care	$65 copay/visit (emergency services) /$65 copay/visit, then 50% coinsurance (non-emergency services)	Not Covered	Copay applies per visit. Special provisions may apply for emergency room services rendered by a non-participating provider. Review your current plan document for further information.
	Emergency medical transportation	No Charge (emergency services)/Not Covered (non-emergency services)	20% coinsurance (emergency services)/Not Covered (non-emergency services)	Air ambulance services by a Non-Participating Provider for an Emergency Medical Condition will be paid at the Participating Provider level of benefits.
	Urgent care	$15 copay/visit	Not Covered	Copay applies per visit regardless of what services are rendered. If you have no choice of providers and/or there is no participating provider available within 50 miles, you pay 20% coinsurance for a non-participating provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	$60 copay/per day, max $500/admission	Not Covered	Preauthorization required. If you don't get preauthorization, benefits could be denied.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	For mental health, services for attention deficit disorder & attention deficit hyperactivity disorder are covered for children under 19. This includes office visits, testing & medical management.
	Inpatient services	Not Covered	Not Covered	Not Covered
If you are pregnant	Office visits	$15 copay/visit	Not Covered	Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be denied.
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	$60 copay/per day, max $500/admission	Not Covered	

 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 need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Preauthorization required. If you don't get preauthorization, benefits could be denied.
	Rehabilitation services	$30 copay/visit	Not Covered	Copay applies per visit. Physical, occupational, speech/hearing & cardiac therapy limited to 30 visits per each type of therapy per year.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	$60 copay/per day, max $500/admission (inpatient)/$30 copay/visit (outpatient)	Not Covered	Preauthorization required. If you don't get preauthorization, benefits could be denied. Copay applies per visit for outpatient services.
	Durable medical equipment	20% coinsurance	Not Covered	Preauthorization required for any item in excess of $1,500. If you don't get preauthorization, benefits could be denied.
	Hospice services	$60 copay/per day, max $500/admission	Not Covered	Bereavement counseling is not covered. Preauthorization required for inpatient services. If you don't get preauthorization, benefits could be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Dental coverage is not provided under the medical plan.

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** • **Ambulance transportation for non-emergency services** • **Bariatric surgery** • **Bereavement counseling** • **Chiropractic care** • **Cosmetic surgery** • **Dental care (Adult & Child)**	• **Emergency room services for non-emergency services** • **Glasses (Adult & Child)** • **Habilitation services** • **Hearing aids** • **Infertility treatment** • **Long-term care** • **Mental health disorders**	• **Most coverage provided outside the United States. See www.meritain.com** • **Routine eye care (Adult & Child)** • **Routine eye care (covered under stand alone vision plan)** • **Routine foot care** • **Substance use disorders** • **Weight loss programs**
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• **Private-duty nursing**		

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 Poly-America, L.P. at (972) 337-7429. 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 Poly-America, L.P. at (972) 337-7175.

Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance Consumer Protection at (800) 252-3439.

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，☒☒打☒个号☒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**
Primary care physician copayment	**$15**
Hospital (facility) copayment/day	**$60**
Other coinsurance	**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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$760

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	**$15**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$720

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

The plan's overall deductible	**$0**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**$65**
Other coinsurance	**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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$350

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