
 **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](http://www.meritain.com) or call (860) 257-0606. 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](http://www.healthcare.gov/sbc-glossary) or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For participating providers: \$2,000 person / \$4,000 family For non-participating providers: \$4,000 person / \$8,000 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 policy, the overall family deductible must be met before the plan begins to pay.
<b>Are there services covered before you meet your deductible?</b>	Yes. For participating providers: <u>Preventive care</u> and routine eye exams 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For participating providers: \$3,275 person / \$6,550 family For non-participating providers: \$8,000 person / \$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, the overall family out-of-pocket limit must be met.
<b>What is not included in the out-of-pocket limit?</b>	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.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind/custom/mymeritain">www.aetna.com/docfind/custom/mymeritain</a> 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). 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.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the specialist you choose without a referral.
<b>Is a Health Savings Account (HSA) available under this plan option?</b>	Yes.	An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS.

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Includes telemedicine other than Teladoc. There is no charge after the <u>deductible</u> if you receive consultation services through Teladoc. There is no charge after the <u>deductible</u> for services received at a MinuteClinic.
	<u>Specialist</u> visit	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	
	<u>Preventive care/screening/immunization</u>	No Charge	30% <u>coinsurance</u> after <u>deductible</u>	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> required for certain imaging, see your <u>plan</u> document for full details.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.medone-rx.com">www.medone-rx.com</a>	Generic drugs	\$10 <u>copay</u> after <u>deductible</u> (30-day retail) / \$30 <u>copay</u> after <u>deductible</u> (90-day retail or mail order)	Not Covered	Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply ( <u>specialty drugs</u> ). The <u>copay</u> applies per prescription. There is no charge or <u>deductible</u> for preventive drugs or preventive maintenance drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> . Step therapy provision applies.
	Preferred brand drugs	\$20 <u>copay</u> after <u>deductible</u> (30-day retail) / \$60 <u>copay</u> after <u>deductible</u> (90-day retail or mail order)	Not Covered	
	Non-preferred brand drugs	\$40 <u>copay</u> after <u>deductible</u> (30-day retail) / \$120 <u>copay</u> after <u>deductible</u> (90-day retail or mail order)	Not Covered	
	<u>Specialty drugs</u>	\$10 <u>copay</u> after <u>deductible</u> (generic) / \$20 <u>copay</u> after <u>deductible</u> (preferred) / \$40 <u>copay</u> after <u>deductible</u> (non-preferred)	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> required for certain surgeries. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> after <u>deductible</u>	10% <u>coinsurance</u> after <u>deductible</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> after <u>deductible</u>	10% <u>coinsurance</u> after <u>deductible</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> required.
	Physician/surgeon fees	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Includes telemedicine other than Teladoc.
	Inpatient services	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> required.
If you are pregnant	Office visits	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . 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 <u>deductible</u> amount may apply.
	Childbirth/delivery professional services	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	

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	<u>Home health care</u>	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Limited to 100 visits per year. <u>Preauthorization</u> required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Physical therapy limited to 60 visits per year. Speech/hearing & occupational therapy limited to a combined maximum of 60 visits per year. Includes telemedicine other than Teladoc.
	<u>Habilitation services</u>	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Includes telemedicine other than Teladoc.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Limited to 60 days per year. <u>Preauthorization</u> required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> required for certain <u>durable medical equipment</u> . See your <u>plan</u> document for details.
	<u>Hospice services</u>	10% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	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	30% <u>coinsurance</u> after <u>deductible</u>	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:

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> <li>• Glasses (Adult &amp; Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment (except diagnosis or treatment of underlying medical condition)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (except for home health care &amp; hospice)</li> <li>• Routine foot care (except for metabolic or peripheral vascular disease)</li> <li>• Weight loss programs</li> </ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>		
<ul style="list-style-type: none"> <li>• Chiropractic care (20 visits per year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (\$1,500 per ear every 3 years)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult &amp; Child – limited to 1 exam per year)</li> </ul>

**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](http://www.dol.gov/ebsa/healthreform) or CATIC Financial, Inc. at (860) 257-0606. 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 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](http://www.dol.gov/ebsa/healthreform) or CATIC Financial, Inc. at (860) 257-0606.

Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Connecticut State of Connecticut Office of the Healthcare Advocate at (866) 466-4446.

**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, 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 <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Primary care physician coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,170</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Specialist office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$500
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,420</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,080</b>