



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.Meritain.com or by calling your employer at (215) 968-4600 or Meritain Health, Inc. at (800) 925-2272.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	For participating providers \$1,000 person / \$2,000 family For non-participating providers \$5,000 person / \$15,000 family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, October 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes. \$25 individual / \$75 family for dental coverage. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers : \$2,000 person / \$4,000 family For non-participating providers : \$15,000 person / \$30,000 family (medical deductible, medical copays & coinsurance) Prescription drugs: \$2,000 person / \$4,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Precertification penalties, premiums, balance-billed charges, dental and vision benefits, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See www.aetna.com/docfind/custom/meritain or call (800) 343-3140 for a list of participating providers .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call your employer at (215) 968-4600 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating **provider** hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or an illness	\$15 copay/visit	50% coinsurance	The deductible is waived for a participating provider. Copay applies per visit regardless of what services are rendered.
	Specialist visit	\$30 copay/visit	50% coinsurance	
	Other practitioner office visit	\$30 copay/visit for chiropractor	50% coinsurance for chiropractor	Limited to 20 visits per year. The deductible is waived for a participating provider.
	Preventive care/ screening/immunization	No Charge	50% coinsurance	The deductible does not apply to participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available through your Employer.	Generic drugs	Provided by OptumRx	Not Covered	Not Applicable
	Preferred brand drugs	Provided by OptumRx	Not Covered	Not Applicable
	Non-preferred brand drugs	Provided by OptumRx	Not Covered	Not Applicable
	Specialty drugs	Provided by BriovaRx \$150 copay	Not Covered	Not Applicable

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	-----none-----
	Physician/surgeon fees	10% coinsurance	50% coinsurance	-----none-----
If you need immediate medical attention	Emergency room services	\$200 copay/visit (medical emergency)/Not Covered (non-medical emergency)	\$200 copay/visit (medical emergency)/Not Covered (non-medical emergency)	The deductible does not apply and the copay is waived if admitted. Non-participating provider paid at participating provider level of benefits for a medical emergency.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-participating provider paid at participating level of benefits.
	Urgent Care	\$30 copay/visit	50% coinsurance	The deductible does not apply to participating providers. Copay applies per visit regardless of what services are rendered
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses, up to \$250 maximum.
	Physician/surgeon fee	10% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 copay/visit	50% coinsurance	The deductible does not apply to participating providers.
	Mental/Behavioral health inpatient services	10% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses, up to \$250 maximum.
	Substance use disorder outpatient services	\$15 copay/visit	50% coinsurance	The deductible does not apply to participating providers.
	Substance use disorder inpatient services	10% coinsurance	50% coinsurance	Precertification required. Failure to precertify will result in a 50% reduction of covered expenses, up to \$250 maximum.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No Charge (\$15 copay on initial visit)	50% coinsurance	There is no charge for preventive prenatal care and certain breastfeeding support and supplies from a participating provider.
	Delivery and all inpatient services	10% coinsurance	50% coinsurance	Precertification required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section).
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 100 visits per year.
	Rehabilitation services	\$30 copay/visit	50% coinsurance	Limited to 30 visits per therapy. The deductible does not apply to participating providers.
	Habilitation services	Not Covered	Not Covered	Not Covered.
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 days per year. Precertification required. Failure to precertify will result in a 50% reduction of covered expenses, up to \$250 maximum.
	Durable medical equipment	10% coinsurance	50% coinsurance	-----none-----
	Hospice service	10% coinsurance (hospice service)/\$30 copay/visit (bereavement counseling)	50% coinsurance	The deductible does not apply to participating providers for bereavement counseling and is covered if received within 6 months of death. Precertification required. Failure to precertify will result in a 50% reduction of covered expenses, up to \$250 maximum.
If your child needs dental or eye care	Eye exam	No Charge	No Charge	The deductible does not apply. Limited to \$60 every 12 months age 19 and over.
	Glasses	No Charge	No Charge	The deductible does not apply. Limited to the following every 12 months: single vision: \$40, bifocal: \$50, trifocal: \$65, contacts: \$60. Frames limited to \$100 every 24 month period age 19 and over.
	Dental check-up	No Charge	No Charge	The deductible does not apply. Limited to 2 check ups per year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Infertility treatment (except diagnosis)
- Routine foot care
- Habilitation services
- Long-term care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (for morbid obesity only)
- Dental care (Adult & Children)
- Private-duty nursing
- Chiropractic care
- Glasses (Adult & Child)
- Routine eye care (Adult & Children)
- Weight loss programs (for morbid obesity only)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (215) 968-4600 or Meritain Health, Inc. at (800) 925-2272. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file **a grievance**. For questions about your rights, this notice, or assistance, you can contact Harold Beck & Sons, Inc. at (215) 968-4600, Meritain Health, Inc. at (800) 925-2272 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Insurance at (877) 881-6388.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

(Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

(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.

(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-378-1179.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,733
- Patient pays \$1,807

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,000
Copays	\$0
Coinsurance	\$637
Limits or exclusions	\$170
Total	\$1, 807

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$1,193
- Patient pays \$4,207

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	1,000
Copays	\$130
Coinsurance	\$147
Limits or exclusions	\$2,930
Total	\$4,207

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Coverage examples are based on single coverage only.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from participating **providers**. If the patient had received care from non-participating **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.