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 (225) 924-8140. 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?	For participating providers: $900 person / $1,800 family For non-participating providers: $1,800 person / $3,600 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, diagnostic test at Woman's Hospital, mental health outpatient services, urgent care and office visits totaling less than $500 per visit 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $100 for prescription drug 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.
What is the out-of-pocket limit for this plan?	For participating providers: $6,850 person / $13,700 family For non-participating providers: $13,700 person / $27,400 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. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, non-emergent penalty of $300 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 Providers (You will pay the least)	Non-Participating Providers (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	$30 copay/visit (office visits less than $500)/20% coinsurance (office visits greater than $500 per visit)	50% coinsurance	Copay applies per visit regardless of what services are rendered. You will pay a $20 copay (deductible does not apply) if you receive telephone consultation services through Teladoc.
	Specialist visit	$30 copay/visit (office visits less than $500)/20% coinsurance (office visits greater than $500 per visit)	50% coinsurance	
	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)	No Charge (Woman's Hospital)/20% coinsurance (facility other than Woman's Hospital when not performed during an office visit)	50% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.southernscripts**	Generic drugs	$15 copay (In-House 30-day)/$20 copay (First Choice 30-day)/$30 copay (Retail (not First Choice) 30-day)/$30 copay (In house 31-90-day)/$40 copay (Mail order & First choice 31-90 day)	$20 copay (First Choice 30-day) / $30 copay (Retail (not First Choice) 30-day)/ $40 copay (First choice 31-90 day)	Separate prescription drug deductible applies. Covers up to a 30-day supply (In-House, First Choice, and retail (non-First Choice)); 31- 90-day supply (In-House and mail order prescription), 30-day supply (specialty drugs). The copay applies per prescription. There is no charge or deductible for preventive drugs. Mandatory generic provision

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	
	Preferred brand drugs	$55 copay (In-House 30-day)/$60 copay (First Choice 30-day)/$70 copay (Retail (not First Choice) 30-day)/$110 copay (In house 31-90-day)/$120 copay (Mail order & First choice 31-90 day)	$60 copay (First Choice 30-day)/ $70 copay (Retail (not First Choice)30-day)/ $120 copay (First choice 31-90 day)	
	Non-preferred brand drugs	$70 copay (In-House 30-day) / $75 copay (First Choice 30-day)/ $85 copay (Retail (not First Choice)30-day)/ $140 copay (In house 31-90-day) / $150 copay (Mail order & First choice 31-90 day)	$75 copay (First Choice 30-day)/ $85 copay (Retail (not First Choice)30-day)/ $150 copay (First choice 31-90 day)	
	Compound drugs	$70 copay (In-House 30-day) / $75 copay (First Choice 30-day) / $85 copay (Retail (not First Choice)30-day)	$75 copay (First Choice 30-day) / $85 copay (Retail (not First Choice)30-day)	
	Specialty drugs	$225 copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit, then 20% coinsurance (emergency services and non-emergency services)	$150 copay/visit. then 20% coinsurance (emergency services)/$150 copay/visit, then 50% coinsurance/(non-emergency services)	Non-participating providers are paid at the participating provider level of benefits for emergency services. A penalty of $300 will apply for all providers for non-emergency services.
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------none----------
	Urgent care	$30 copay/visit (office visits less than $500)/20% coinsurance (office visits	50% coinsurance	Copay applies per visit regardless of what services are rendered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	
		greater than $500 per visit)		
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit (mental health)/Not Covered (substance abuse services)	50% coinsurance (mental health)/Not Covered (substance abuse services)	----------none----------
	Inpatient services	20% coinsurance (mental health)/Not Covered (substance abuse services)	50% coinsurance (mental health)/Not Covered (substance abuse services)	
If you are pregnant	Office visits	Based on place and type of service	50% coinsurance	You must use Woman's Hospital for delivery services if you live within a 100-mile radius of the hospital or the services will not be covered. Cost sharing does not apply to preventive services from a participating provider. 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 deductible amount may apply. Birthing center expenses are only covered at Birth Center of Baton Rouge.
	Childbirth/delivery professional services	20% coinsurance	Not Covered	
	Childbirth/delivery facility services	20% coinsurance (hospital) / 30% coinsurance (birthing center)	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	----------none----------
	Rehabilitation services	20% coinsurance	50% coinsurance	Includes physical, speech & occupational therapy. Cardiac rehab is limited to 36 sessions per illness (phase 2 only). Inpatient has a lifetime max of 365 days
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
	Skilled nursing care	20% coinsurance	50% coinsurance	----------none----------
	Durable medical equipment	20% coinsurance	50% coinsurance	----------none----------
	Hospice services	20% coinsurance	50% coinsurance	Bereavement counseling is covered if received within 6 months of death and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	
				limited to 15 visits per family.
If your child needs dental or eye care	Children's eye exam	No Charge	50% coinsurance	Limited to 1 exam per year.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Covered under stand alone dental 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.)

- **Bariatric surgery**
- **Cosmetic surgery**
- **Dental care (covered under stand alone dental plan)**
- **Glasses (Adult & Child)**
- **Habilitation services**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S. (If you become sick or injured while traveling, the plan may cover expenses incurred up to 120 consecutive days. This 120-day time limit does not apply if you are traveling for business or are a student.)**
- **Routine foot care**
- **Substance use disorders**

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

- **Acupuncture (only for smoking cessation)**
- **Chiropractic care (20 visits per year)**
- **Hearing aids (covered dependent children only)**
- **Infertility treatment (covered at Fertility Answers only – 3 retrievals for attempts to conceive a first child, and 2 retrievals to conceive a second child)**
- **Private-duty nursing (15 shifts per admission)**
- **Routine eye care (Adult & Child – 1 exam per year)**
- **Weight loss programs (for the treatment of morbid obesity only)**

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 Woman's Hospital Foundation at (225) 924-8140. 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 Woman's Hospital Foundation at (225) 924-8140.

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	**$900**
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*	$900
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,260

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

The plan's overall deductible	**$900**
Specialist copayment	**$30**
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*	$1,000
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,220

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

The plan's overall deductible	**$900**
Specialist copayment	**$30**
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*	$900
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,300

*Note: This plan has other **deductibles** for specific services included in this coverage example. See "Are there other deductibles for specific services."

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