

 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 (404) 920-7486. 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 Meritain Health, Inc. at (866) 303-2689 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For participating <u>providers</u> : \$450 person/\$1,350 family For non-participating <u>providers</u> : \$450 person/\$1,350 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. For participating <u>providers</u> : <u>Preventive care</u> , <u>urgent care</u> , routine eye exam and office visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For participating <u>providers</u> : \$2,250 person/\$4,500 family For non-participating <u>providers</u> : \$3,900 person/\$7,800 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>copays</u> , <u>deductibles</u> , <u>preauthorization</u> penalty amounts, <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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	\$25 copay /visit	40% coinsurance	Copay applies per visit regardless of what services are rendered.
	Specialist visit	\$25 copay /visit	40% coinsurance	
	Preventive care/screening/immunization	\$25 copay /visit (routine care)/No Charge (cancer screenings, x-ray and lab services)	Not Covered	Age appropriate. 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)	20% coinsurance	40% coinsurance	Subject to medical necessity. There is no charge for lab work received from a Quest or LabCorp provider , and the deductible does not apply.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Subject to medical necessity.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	\$10 copay (retail)/\$20 copay (mail order)	Not Covered	Deductible does not apply. Covers up to a 34-day supply or 100 unit dose whichever is greater (retail prescription); 90-day supply or 300 unit dose whichever is greater (mail order prescription). The copay applies per prescription. Specialty drugs are subject to prior authorization.
	Brand drugs	\$30 copay (retail)/\$60 copay (mail order)	Not Covered	
	Specialty drugs	Paid the same as generic and brand name drugs	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Subject to medical necessity.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Non-participating providers paid at the participating provider level of benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-participating providers paid at the participating provider level of benefits. Subject to medical necessity.
	Urgent care	\$25 copay /visit	40% coinsurance	Subject to medical necessity.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit (office visit)/20% <u>coinsurance</u> (all other outpatient) (mental health)/Not Covered (substance abuse)	40% <u>coinsurance</u> (mental health)/Not Covered (substance abuse)	Substance abuse is not covered.
	Inpatient services	20% <u>coinsurance</u> (mental health)/Not Covered (substance abuse)	40% <u>coinsurance</u> (mental health)/Not Covered (substance abuse)	Substance abuse is not covered. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Only female employees and spouses have this coverage. <u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 120 visits per year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. Includes physical, speech & occupational therapy.
	<u>Habilitation services</u>	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service.

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)	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. Review and approval of medical necessity required.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. Bereavement counseling is covered if received within 12 months of death.
If your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u> /visit	Not Covered	-----none-----
	Children's glasses	Not Covered	Not Covered	Glasses for children are covered under a stand alone vision plan maintained by your employer.
	Children's dental check-up	Not Covered	Not Covered	Routine dental checkups for children are covered under a stand alone dental plan maintained by your employer.

Excluded Services & Other Covered Services:

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> .)		
<ul style="list-style-type: none"> • Acupuncture • Contraceptives • Cosmetic surgery • Dental care (covered under stand alone dental plan) 	<ul style="list-style-type: none"> • Experimental and investigational • Glasses (covered under stand alone vision plan) • Habilitation services • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Routine foot care (except for diabetes) • Substance abuse

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Bariatric surgery (for the treatment of morbid obesity only) • Chiropractic care 	<ul style="list-style-type: none"> • Hearing aids • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult & Child) • 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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or www.cciio.cms.gov, or the Roman Catholic Archdiocese of Atlanta at (404) 920-7486. 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 the Roman Catholic Archdiocese of Atlanta at (404) 920-7486 or Meritain at (866) 303-2689

Additionally, a consumer assistance program can help you file your appeal. Contact the Georgia Office of Insurance and Safety Fire Commissioner at (800) 656-2298.

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 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, kwijjigo 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>	\$450
■ <u>Primary care physician coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$450
Copayments	\$150
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,760

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>	\$450
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$7,460
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$450
Copayments	\$1,050
Coinsurance	\$372
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,928

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$450
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$2,010
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$450
Copayments	\$75
Coinsurance	\$326
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$851

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