

 **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 (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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call Meritain Health, Inc. at (866) 303-2689 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For participating providers: \$400 individual/\$1,200 family For non-participating providers: \$400 individual/\$1,200 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.
<b>Are there services covered before you meet your deductible?</b>	Yes. For participating providers: Preventive care, urgent care, routine eye exam and office visits 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.
<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: \$1,750 individual/\$3,500 family For non-participating providers: \$2,900 individual/\$5,800 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.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, copays, deductibles, preauthorization penalty amounts, 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). 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.
<b>Do you need a referral to see a specialist?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	30% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered. Includes telemedicine consultations.
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit	30% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	\$20 <u>copay</u> /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 <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Subject to medical necessity. There is no charge for routine lab work received from a Quest or LabCorp <u>provider</u> , and the <u>deductible</u> does not apply.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Subject to medical necessity.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	\$10 <u>copay</u> (retail)/\$20 <u>copay</u> (mail order)	Not Covered	<u>Deductible</u> 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 <u>copay</u> applies per prescription. <u>Specialty drugs</u> are subject to prior authorization.
	Brand drugs	\$30 <u>copay</u> (retail)/\$60 <u>copay</u> (mail order)	Not Covered	
	<u>Specialty drugs</u>	Paid the same as generic and brand name drugs	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Subject to medical necessity.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</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>	10% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. Subject to medical necessity.
	<u>Urgent care</u>	\$20 <u>copay</u> /visit	30% <u>coinsurance</u>	Subject to medical necessity.

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 have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<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.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <u>copay</u> /visit (office visit)/10% <u>coinsurance</u> (all other outpatient) (mental health)/Not Covered (substance abuse)	30% <u>coinsurance</u> (mental health)/Not Covered (substance abuse)	Substance abuse services are not covered.
	Inpatient services	10% <u>coinsurance</u> (mental health)/Not Covered (substance abuse)	30% <u>coinsurance</u> (mental health)/Not Covered (substance abuse)	Substance abuse services are 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.
<b>If you are pregnant</b>	Office visits	10% <u>coinsurance</u>	30% <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	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 120 visits per year.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	10% <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.

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>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <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.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <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>	10% <u>coinsurance</u>	10% <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.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$20 <u>copay</u> /visit	Not Covered	-----none-----
	Children's glasses	Not Covered	Not Covered	Glasses for children are covered under a standalone vision plan maintained by your employer.
	Children's dental check-up	Not Covered	Not Covered	Routine dental checkups for children are covered under a standalone 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"> <li>• Acupuncture</li> <li>• Contraceptives</li> <li>• Cosmetic surgery</li> <li>• Dental care (covered under stand alone dental plan)</li> </ul>	<ul style="list-style-type: none"> <li>• Experimental and investigational</li> <li>• Glasses (covered under stand alone vision plan)</li> <li>• Habilitation services</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine foot care (except for diabetes)</li> <li>• Substance abuse</li> </ul>

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"> <li>• Bariatric surgery (for the treatment of morbid obesity only)</li> <li>• Chiropractic care (20 visits per year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (\$2,000 per ear every 48 months)</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult &amp; Child)</li> <li>• Weight loss programs (for the treatment of morbid obesity only)</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 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](http://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](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 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**

[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 plan's overall deductible \$400
- Primary care physician coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 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	\$400
Copayments	\$50
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,710</b>

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

- The plan's overall deductible \$400
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 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	\$400
Copayments	\$700
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,170</b>

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

- The plan's overall deductible \$400
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 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	\$400
Copayments	\$70
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$670</b>

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