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 (800) 925-2272. 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 Tier 1 providers: $0 person/$0 family. For Tier 2 providers: $500 person/$1,500 family For Tier 3 providers: $1,500 person/$4,500 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 Tier 1 providers: All services are covered before you meet a deductible. For Tier 2 providers: Preventive care, mental health/substance abuse (office visit charges & inpatient professional fees), emergency room care (& Tier 3), urgent care (& Tier 3), 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. 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Tier 1 providers*: $2,900 person/ $5,800 family. For Tier 2 providers*: $3,500 person/$7,000 family. For Tier 3 providers*: Unlimited person/Unlimited family (*deductible, coinsurance, and medical copays) For prescription drug copays: $4,650 person/$9,300 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.
What is not included in the out-of-pocket limit?	Premiums, 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.
Will you pay less if you use a network provider?	Yes. See www.sghs.org/team-member for a list of super-preferred providers or 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
		Tier 1 Super Preferred Providers	Tier 2 Preferred Providers	Tier 3 Non-Preferred Providers	
		(You will pay the least)	(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	$20 copay/visit	$20 copay/visit	40% coinsurance	Copay applies per visit regardless of what services are rendered.
	Specialist visit	$20 copay/visit	$20 copay/visit	40% coinsurance	
	Preventive care/ screening/ immunization	No Charge	No Charge	Not Covered	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	$75 copay then 25% coinsurance/visit	$100 copay then 40% coinsurance/visit	Preauthorization required for PET scans and non-orthopedic CT/MRI's. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	No Charge	$75 copay then 25% coinsurance/visit	$100 copay then 40% coinsurance/visit	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mycatamaranrx.com	Generic drugs	Not Covered	$14 copay (retail)/ $28 copay (60-day mail order)/ $42 copay (90-day mail order)/ DMP related prescriptions: $7 copay (retail)/ $14 copay (60-day mail order)/ $21 copay (90-day mail order)	Not Covered	Deductible does not apply. Covers up to a 30-day supply (retail prescription); 60-day or 90-day supply (mail order prescription), 30-day supply (specialty drugs). The copay applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) and Step Therapy provisions apply. Specialty drugs must be obtained directly from the specialty pharmacy. Covered persons who are compliant participants in the Disease Management Program (DMP) offered by Southeast Georgia Health System will receive reduced copays for disease management related prescriptions.
	Preferred brand drugs	Not Covered	$45 copay (retail)/ $90 copay (60-day mail order)/ $135 copay (90-day mail order)/ DMP prescriptions: $30 copay (retail)/ $60 copay (60-day mail order)/ $90 copay (90-day mail order)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Super Preferred Providers	Tier 2 Preferred Providers	Tier 3 Non-Preferred Providers	
		(You will pay the least)	(You will pay the most)		
	Non-preferred brand drugs	Not Covered	$75 copay (retail)/ $150 copay (60-day mail order)/ $225 copay (90-day mail order/ DMP related prescriptions: $50 copay (retail)/ $100 copay (60-day mail order)/ $150 copay (90-day mail order)	Not Covered	
	Specialty drugs	Not Covered	20% copay (up to $300 maximum)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	25% coinsurance	40% coinsurance	Preauthorization for certain surgeries. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. See your plan document for a detailed listing.
	Physician/surgeon fees	10% coinsurance	25% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit then 20% coinsurance (emergency services and non-emergency services)	$150 copay then 20% coinsurance/visit (emergency services and non-emergency services)	$150 copay then 20% coinsurance/ visit (emergency services and non-emergency services)	Tier 3 providers are paid at the Tier 1 provider level of benefits for emergency services. Copay is waived if admitted to the hospital if services are related to an accident or emergency medical condition.
	Emergency medical transportation	Not Applicable	25% coinsurance (emergency services)/ 25% coinsurance (non-emergency services)	25% coinsurance (emergency services)/ 40% coinsurance (non-emergency services)	Tier 3 providers are paid at the Tier 2 provider level of benefits for emergency services.
	Urgent care	$25 copay/visit	$75 copay/visit	$75 copay/visit	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
		Tier 1 Super Preferred Providers	Tier 2 Preferred Providers	Tier 3 Non-Preferred Providers	
		(You will pay the least)	(You will pay the most)		
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	$150 copay then 25% coinsurance/admission	$200 copay then 40% coinsurance / admission	Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	10% coinsurance	25% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit (office visit)/ Not Applicable (all other outpatient)	$20 copay/visit (office visit)/20% coinsurance (all other outpatient)	40% coinsurance	----------none----------
	Inpatient services	Not Applicable (facility)/ 10% coinsurance (professional fees)	$150 copay then 25% coinsurance/admission (facility)/ 25% coinsurance (professional fees)	$200 copay then 40% coinsurance / admission	Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	$20 copay/visit	$20 copay/visit	40% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs(c section). If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Cost sharing does not apply to preventive services from a Tier 1 and Tier 2 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.
	Childbirth/delivery professional services	10% coinsurance	25% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	$150 copay then 25% coinsurance/admission	$200 copay then 40% coinsurance / admission	
If you need help recovering or have other special health needs	Home health care	Not Applicable	20% coinsurance	40% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Super Preferred Providers	Tier 2 Preferred Providers	Tier 3 Non-Preferred Providers	
		(You will pay the least)	(You will pay the most)		
	Rehabilitation services	No Charge	25% coinsurance	40% coinsurance	Includes physical, speech & occupational therapy. Inpatient services limited to 30 days per year. Preauthorization required for inpatient services. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Habilitation services	No Charge	25% coinsurance	40% coinsurance	----------none----------
	Skilled nursing care	10% coinsurance	$150 copay then 25% coinsurance/admission	$200 copay then 40% coinsurance/ admission	Limited to 100 days per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Durable medical equipment	Not Applicable	20% coinsurance	40% coinsurance	Preauthorization required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	Not Applicable	20% coinsurance	40% coinsurance	Bereavement counseling is covered if received within 12 months of death and is limited to 6 sessions per occurrence. Hospice services limited to 6 months per lifetime.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered

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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care (except for metabolic or peripheral vascular disease)

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

- Acupuncture ($250 per year and $500 per lifetime; combined with hypnosis and massage therapy)
- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Hearing aids (1 aid per ear per 24 month period)
- Private-duty nursing
- 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 Southeast Georgia Health System, Inc. at (912) 466-3102. 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 Southeast Georgia Health System, Inc. at (912) 466-3102.

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, 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 Tier 2 pre-natal care and a hospital delivery)

The plan's overall deductible	**$500**
Primary care physician copayment	**$20**
Hospital (facility) copayment	**$150**
Other coinsurance	**25%**

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	$500
Copayments	$700
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,160

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

The plan's overall deductible	**$500**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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	$500
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,520

Mia's Simple Fracture
(Tier 2 emergency room visit and follow-up care)

The plan's overall deductible	**$500**
Specialist copayment	**$20**
Hospital (facility) copayment	**$150**
Other coinsurance	**25%**

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	$500
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,100

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