MERITAIN HEALTH
An Aetna Company

PROTECT HSA PLANS

HSA-compatible plans with a wellness twist.

Health Rewards	**Preventive Reward:** Early detection saves lives and reduces costs. Members completing an annual biometric screening will receive a $100 cash reward. **Chronic Condition Compliance Rewards:** Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain who completing specified, proven steps will receive a reward of up to $100 per year.		
Plan Name	**PROTECT HSA 3000**	**PROTECT HSA 4000**	**PROTECT HSA 5000**
Maximum Lifetime In-Network Benefits	No Lifetime Maximum (Unlimited)		
Annual Deductible	In-Network / Out-of-Network		
Single	$3,000 / $5,000	$4,000 / $6,000	$5,000 / $7,000
Family	$6,000 / $10,000 (Aggregate)	$8,000 / $12,000 (Aggregate)	$10,000 / $14,000 (Aggregate)
Annual Out-of-Pocket Maximum	In-Network / Out-of-Network		
Single (Includes Deductible)	$5,000 / $7,000	$5,500 / $8,000	$6,000 / $9,000
Family (Includes Deductible)	$10,000 / $14,000	$11,000 / $16,000	$12,000 / $18,000
Office Visits	In-Network / Out-of-Network		
	20% / 30%	20% / 30%	20% / 30%
Telemedicine through Teladoc	$10 Co-pay	$10 Co-pay	$10 Co-pay
Professional Services	In-Network / Out-of-Network		
• Lab & X-Ray • Maternity	20% / 30%	20% / 30%	20% / 30%
Hospital & Facility Services	In-Network / Out-of-Network		
Hospital Inpatient	20% / 30%	20% / 30%	20% / 30%
Emergency Room Facility	$250 Co-pay (waived if admitted)		
Emergency Room Physician Services	20% / 30%	20% / 30%	20% / 30%
Urgent Care Center (Physician Services)	$150 Co-pay then covered 100% / 30%		
Prescription Drugs • 30-Day Retail Supply • Mail Order available • In-Network Only Prescription Drug Benefit: Covered Prescription Drug costs apply towards the Network Out-of-Pocket Maximum	**Co-pays apply only after satisfying the Annual Deductible:** Tier 1–Generic Drugs: $10 Tier 2–Preferred Brand-Name Drugs: $35 Tier 3–Non-Preferred Drugs (Non-Formulary): 50% Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to $300 Co-pay per prescription		
Preventive Care (In-Network Only) • Well Baby & Well Child: 100% coverage • Adult Preventive/Wellness Exam: 100% Coverage	0% Not Subject to Deductible		

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PROTECT CO-PAY PLANS

Comprehensive benefits with low-cost office visits.

Healthier Plans	**Preventive Reward:** Early detection saves lives and reduces costs. Members completing an annual biometric screening will receive a $100 cash reward. **Chronic Condition Compliance Rewards:** Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain who completing specified, proven steps will receive a reward of up to $100 per year.				
Plan Name	**PROTECT 500 CO-PAY**	**PROTECT 1000 CO-PAY**	**PROTECT 2000 CO-PAY**	**PROTECT 3000 CO-PAY**	**PROTECT 4000 CO-PAY**
Maximum Lifetime In-Network Benefits	No Lifetime Maximum (Unlimited)				
Annual Deductible	In-Network / Out-of-Network				
Single	$500 / $2,500	$1,000 / $3,000	$2,000 / $4,000	$3,000 / $6,000	$4,000 / $6,000
Family	$1,000 / $5,000 (Embedded)	$2,000 / $6,000 (Embedded)	$4,000 / $8,000 (Embedded)	$6,000 / $8,000 (Embedded)	$8,000 / $12,000 (Embedded)
Annual Out-of-Pocket Maximum					
Single (Includes Deductible)	$1,500 / $4,500	$3,000 / $5,000	$4,000 / $6,000	$5,000 / $7,000	$6,000 / $8,000
Family (Includes Deductible)	$3,000 / $9,000	$6,000 / $10,000	$8,000 / $12,000	$10,000 / $14,000	$12,000 / $16,000
Office Visits					
	Primary Care $25 Co-pay / 40% Specialty $50 Co-pay / 40%	Primary Care $25 Co-pay / 40% Specialty $50 Co-pay / 40%	Primary Care $25 Co-pay / 40% Specialty $50 Co-pay / 40%	Primary Care $25 Co-pay / 40% Specialty $50 Co-pay / 40%	Primary Care $25 Co-pay / 40% Specialty $50 Co-pay / 40%
Telemedicine through Teladoc	$10 Co-pay	$10 Co-pay	$10 Co-pay	$10 Co-pay	$10 Co-pay
Professional Services	In-Network / Out-of-Network				
• Lab & X-Ray • Maternity	10% / 30%	20% / 40%			
Hospital & Facility Services	In-Network / Out-of-Network				
Hospital Inpatient	10% / 30%	20% / 40%			
Emergency Room Facility	10% / 30%	20% / 40%			
Emergency Room Physician Services	10% / 30%	20% / 40%			
Urgent Care Center (Physician Services)	$150 Co-pay (Deductible waived) then covered 100% / 40%				
Prescription Drugs • 30-Day Retail Supply • Mail Order available • In-Network Only Prescription Drug Benefit: Covered Prescription Drug costs apply towards the Network Out-of-Pocket Maximum	Tier 1–Generic Drugs (Deductible waived): $10 Tier 2–Preferred Brand-Name Drugs: $35 Tier 3–Non-Preferred Drugs (Non-Formulary): 50% Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to $300 Co-pay per prescription				
Preventive Care (In-Network Only) • Well Baby & Well Child: 100% coverage • Adult Preventive/Wellness Exam: 100% Coverage	0% Not Subject to Deductible				

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Exclusions & Limitations

Following is an abbreviated list of exclusions and limitations. Please refer to the Summary Plan Description ("SPD") for comprehensive details. Defined terms are "Capitalized" and can be found in the SPD. Please note that in listing services or examples, we do not intend to limit a list of services or examples unless we state specifically that the list "is limited to".

- Any amounts in excess of maximum amounts stated in the SPD.
- Charges in excess of Eligible Expenses as detailed in the SPD.
- Services or supplies that are not medically necessary.
- Services received before your effective date.
- Services received after your coverage ends.
- Any conditions for which benefits can be recovered under any workers' compensation law or similar law.
- Services provided by a local, state or federal government agency, unless you have to pay for them.
- Services you receive for which you are not legally obligated to pay.
- Services for which no charge is made to you in the absence of insurance coverage.
- Services not listed as covered in the SPD.
- Alternative Treatments such as acupressure, aromatherapy, hypnotism, Rolfing and art therapy.
- Cosmetic Procedures.
- Custodial care.
- Dental and orthodontic services except as specifically stated in the SPD.
- Devices, appliances and prosthetics except as specifically stated in the SPD. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo esophageal voice prosthetics.
- Replacement of prosthetics and Durable Medical Equipment ("DME") due to misuse, malicious damage, gross neglect or when lost or stolen.
- Domiciliary care.
- Experimental or Investigational Services, except for services for persons who have been accepted into an approved clinical trial for cancer, or a life threatening Sickness or condition.
- Eye surgery performed solely for the purpose of correcting refractive errors (such as intact corneal implants). Also, Surgery that is intended to allow you to see better without glasses or other vision correction such as LASIK.
- Eyewear including the purchase cost and fitting charge for eyeglasses and contact lenses unless specifically stated in the SPD.
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Foot care that is routine. Examples include the cutting and removal of corns or calluses; hygienic and preventive maintenance foot care; treatment of flat feet; shoe orthotics; shoe inserts; and arch supports. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which benefits are provided under the diabetes services in the SPD. This exclusion does not apply to preventive foot care for those who are at risk of neurological or vascular disease arising from diseases such as diabetes.
- Foreign language and sign language interpreters, except as required by law.
- Genetic testing, except as specifically stated in the SPD.
- Growth hormone therapy.
- Health club memberships.
- Infertility services (including sterilization reversal).
- Medical supplies, except as specifically listed in the SPD.
- Non-injectable medications given in an outpatient or office setting.
- Nutritional counseling except as specified listed as covered in the SPD.
- Obesity reduction services through surgical and non-surgical treatment, except as specifically stated in the SPD.
- Over-the-counter medications and treatments.
- Pain management services using multi-disciplinary pain management programs provided on an inpatient basis.
- Personal care attendant's services.
- Personal comfort items.
- Pharmaceutical products and prescription medication products beyond the specified supply limits and/or specifically excluded in the SPD.
- Pharmaceutical Products or prescription medication products for outpatient use that are filled by a prescription order or refill except as specifically stated in the SPD.
- Pregnancy through a surrogate and any services or supplies provided in connection with a surrogate Pregnancy.
- Private duty nursing.
- Psychosurgery.
- Respite care.
- Sex transformation operations.
- Smoking cessation programs that are stand-alone multi-disciplinary smoking cessation programs, except as covered in the SPD.
- Snoring treatments, both medical and surgical treatment, except as when provided as part of treatment for documented obstructive sleep apnea. Also limited is upper and lower jawbone surgery including that for obstructive sleep apnea.
- Travel or transportation expenses, even if prescribed by a Physician.
- Weight loss programs.
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. This exclusion does not apply to mammography.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.
- Health services for organ and tissue transplants, except those described under Transplantation Services in the SPD.
- Out-of-Network health services provided in a foreign country, unless as required as Emergency Health Services.
- Out-of-Network Preventive Care except as required by law.
- Medicare eligibility results in Benefit payment pursuant to Medicare rules.
- Claims submitted for health services beyond 12 months from the date of service, except as required by law.
- Services performed by a Provider who is a family member by birth or marriage or resides at same residence.
- Dental and orthodontic services except as specifically stated in the SPD.

The Protect Plans enable a partnership between you, your physicians and with Meritain Health. To make this partnership effective, however, we need to work a specified Network of Physicians, Hospitals and other Providers of medical services. At the same time we recognize that you may wish to obtain treatment from a Provider outside of this Network. Therefore, we provide some coverage for the Out-of- Network Providers, but much less than the coverage provided when you remain in our Network. Specifically, the Out-of-Network Benefits have separate Deductibles and Out-of-Pocket Maximums than the Network Benefits. The allowed amount for Out-of-Network Claims is equal to 110% of Medicare allowable rates. Only the allowed amount is applied to the Out-of-Network Deductible and/or Out-of-Pocket Maximum. You will be responsible for any billed charges in excess of the Medicare allowed rate. The difference in billed charges from a Network Provider compared to an Out-of-Network Provider can be substantial and these excess amounts are the responsibility of the insured. These amounts are NOT SUBJECT to any Out-of-Pocket Maximum limitations. Please be sure to verify if your Provider is in the Aetna Network prior to receiving services.

For complete Benefits information visit www.ProtectPlans.Info

This brochure provides abridged information about benefits, exclusions, and limitations. For costs and complete information on coverage, you must refer to the SPD about how the Protect Plans work, accessing benefits, benefit limits, service area benefit limitations, pre-service benefit confirmation, compliance rules, and eligible expenses. ***It is recommended that plans consult with their own experts or legal counsel to review all applicable federal and state legal requirements that may apply to their group health plan. By providing this publication and any attachments, Meritain Health is not exercising discretionary authority over the plan and is not assuming a plan fiduciary role, nor is Meritain Health providing legal advice.***