Meritain Health (Aetna Network) Plan Comparision Chart

	In-Network	
	Meritain Copay Plan	Meritain CDHP Plan
Calendar Year Deductible		
Individual	$500	$1,500
Family	$1,200	$3,000
Coinsurance		
% Shared by Meritain and You	90% (Meritain) / 10% (You)	90% (Meritain) / 10% (You)
Annual Out-of-Pocket Maximum		
Individual	$3,000	$3,500
Family	$6,000	$7,000
Preventive Care		
Routine preventive physical exams,	$0	$0
Office Visits and Outpatient Services		
Primary Care Provider (PCP)	$20 copay	10% coinsurance after deductible
Specialist	$35 copay	10% coinsurance after deductible
Urgent Care	$35 copay	10% coinsurance after deductible
Hospital Services		
Emergency Room (waived if admitted)	$250 copay, then 10% coinsurance after deductible	10% coinsurance after deductible
Ambulance Services	10% coinsurance after deductible	10% coinsurance after deductible
Physician Services	10% coinsurance after deductible	10% coinsurance after deductible
Hospital Outpatient	$150 copay, then 10% coinsurance after deductible	10% coinsurance after deductible
Hospital Inpatient	$250 copay, then 10% coinsurance after deductible	10% coinsurance after deductible
Laboratory and X-Ray Services		
Physician's Office	10% coinsurance after deductible	10% coinsurance after deductible
Outpatient	10% coinsurance after deductible	10% coinsurance after deductible
Mental Health & Substance Abuse/Chemical Dependency		
Inpatient	No Charge	10% coinsurance after deductible
Outpatient — Physician's office visit	$20 copay	10% coinsurance after deductible
Outpatient — Facility	10% coinsurance after deductible	10% coinsurance after deductible
Maternity Services		
Office Visits	$20 copay 1st visit, then $0 after deductible	10% coinsurance after deductible
Childbirth/delivery professional services	10% coinsurance after deductible	10% coinsurance after deductible
Childbirth/delivery facility services	$250 copay, then 10% coinsurance after deductible	10% coinsurance after deductible
Additional Services		
Home Health Care	10% coinsurance after deductible	10% coinsurance after deductible
Rehabilitiation Services	$35 copay	10% coinsurance after deductible
Habilitation Services	$35 copay	10% coinsurance after deductible
Skilled Nursing Care	$250 copay, then 10% coinsurance after deductible	10% coinsurance after deductible
Durable Medical Equipment	10% coinsurance after deductible	10% coinsurance after deductible
Hospice Services	10% coinsurance after deductible	10% coinsurance after deductible
Retail (30-day supply)		
Generic	$10	10% coinsurance after deductible (max of $150)
Preferred Brand	$25	10% coinsurance after deductible (max of $150)
Non-Preferred Brand	$40	10% coinsurance after deductible (max of $150)
Preferred Formulary Specialty	$25	10% coinsurance after deductible (max of $150)
Non-Preferred Formulary Specialty	$40	10% coinsurance after deductible (max of $150)
Mail Order (90-day supply)		
Generic	$20	10% coinsurance after deductible (max of $450)
Preferred Brand	$50	10% coinsurance after deductible (max of $450)
Non-Preferred Brand	$80	10% coinsurance after deductible (max of $450)
Preferred Formulary Specialty	Not Covered through Mail Order	Not Covered through Mail Order
Non-Preferred Formulary Specialty	Not Covered through Mail Order	Not Covered through Mail Order

Excluded Services & Other Covered Services		
Excluded Services		
Cosmetic Surgery	Long-term care	Routine eye care (Adult & Child)
Dental Care (Adult & Child)	Non-emergency care when traveling ouside the U.S.	Routine foot care (except for metabolic or peripheral vascular disease)
Glasses (Adult & Child)	Private-duty nursing (inpatient)	Weight Loss Programs
Other Covered Services		
Accupunture (24 visits per year)	Chiropractic Care (24 visits per year	Inferility (through Progyny only)
Bariatric Surgery	Hearing Aids (1 per hearing impaired ear every 24 months)	Private-duty nursing (outpatient)