SL Healthplans LLC
Self Funded Marketing Experts

Midstate Chamber of Commerce

For use for January 1, 2021, and later effective dates.

Benefits available with Meritain Health, your third-party administrator

Meritain Health provides your group with efficient administrative services and support

Meritain Health, an independent subsidiary of Aetna, is one of the nation's largest administrators of health benefits. Meritain Health offers the resources of a national carrier combined with unmatched flexibility and plan options.

With Aetna's financial backing and 30-plus years of operational excellence, you can rest assured knowing Meritain Health has the experience and resources to keep your plan running smoothly.

When you select a Meritain Health plan, you get:

Broad network access

Your employees gain access to the Aetna Choice® POS II network

Plan administration

Meritain Health handles your group's claims for you

Customer service

Meritain Health handles your group members' customer service needs, helping them find plan information, check on the status of their claims, find in-network doctors, and more

Access to Teladoc® services

An affordable telehealth option that allows your employees to receive treatment anytime, anywhere, for many common, non-emergency conditions

See reverse side for benefit plan details

SL Healthplans LLC

Chamber of Commerce and Associaton Health Plan Choices

3 to 9 ee = Up to 2 Plans

Above 10 ee = Up to 3 Plans or Current Plans

	SL HP 1	
Benefit	***In Network***	***Out of Network***
Annual Deductible-Single	$500	$1,000
Annual Deductible-Family	$1,000	$2,000
Out of Pocket Maximum-Single	$2,000	$4,000
Out of Pocket Maximum-Family	$4,000	$8,000
Out of Pocket Maximum includes the Deductible	Yes	Yes
General Coinsurance	10%	20%
Physician's Office Services	$25 Copay	Deductible & Coinsurance
Specialist's Office Services	$50 Copay	Deductible & Coinsurance
Preventive Care (deductible waived for in-network)	Covered at 100%	Covered at 100%
Outpatient Surgeries	Deductible & Coinsurance	Deductible & Coinsurance
In-patient Hospital Stay	Deductible & Coinsurance	Deductible & Coinsurance
Lab/X-Ray	$35 Copay	Deductible & Coinsurance
Major Diagnostic Imaging (CT/MRI/PET)	Deductible & Coinsurance	Deductible & Coinsurance
Additional Coverages - Infertility ($15K LT Max)	Yes	Yes
Additional Coverages - Exercise Facility: Subscriber $200 Reimbursement per 6 month period Spouse $100 Reimbursement per 6 month period	Yes	Yes
Eye Exam/Supplies (one exam every 24 months)	Yes	Yes
Emergency Room Visit	$150 copay	$150 copay
Urgent Care Visit	$50 copay	Deductible & Coinsurance
Rx Deductible	$0	$0
Retail Rx Generic	$10	$10
Retail Rx Brand	$40	$40
Retail Rx Non-Formulary	$60	$60
Mail Order Rx (Gen/Brand/Non-Frm)	2 X Retail	2 X Retail

SL Healthplans LLC

Chamber of Commerce and Associaton Health Plan Choices

3 to 9 ee = Up to 2 Plans

Above 10 ee = Up to 3 Plans or Current Plans

	SL HP 2	
Benefit	***In Network***	***Out of Network***
Annual Deductible-Single	$2,000	$4,000
Annual Deductible-Family	$4,000	$8,000
Out of Pocket Maximum-Single	$4,000	$8,000
Out of Pocket Maximum-Family	$8,000	$16,000
Out of Pocket Maximum includes the Deductible	Yes	Yes
General Coinsurance	20%	30%
Physician's Office Services	$25 Copay	$50 Copay
Specialist's Office Services	$50 Copay	$100 Copay
Preventive Care (deductible waived for in-network)	Covered at 100%	Covered at 100%
Outpatient Surgeries	Deductible & Coinsurance	Deductible & Coinsurance
In-patient Hospital Stay	Deductible & Coinsurance	Deductible & Coinsurance
Lab/X-Ray	$35 Copay	$75 Copay
Major Diagnostic Imaging (CT/MRI/PET)	Deductible & Coinsurance	Deductible & Coinsurance
Additional Coverages - Infertility ($15K LT Max)	Yes	Yes
Additional Coverages - Exercise Facility: Subscriber $200 Reimbursement per 6 month period Spouse $100 Reimbursement per 6 month period	Yes	Yes
Eye Exam/Supplies (one exam every 24 months)	Yes	Yes
Emergency Room Visit	$150 copay	$150 Copay
Urgent Care Visit	$50 copay	$300 copay
Rx Deductible	$0	$0
Retail Rx Generic	$10	$10
Retail Rx Brand	$40	$40
Retail Rx Non-Formulary	$60	$60
Mail Order Rx (Gen/Brand/Non-Frm)	2 X Retail	2 X Retail

SL Healthplans LLC

Chamber of Commerce and Associaton Health Plan Choices

3 to 9 ee = Up to 2 Plans

Above 10 ee = Up to 3 Plans or Current Plans

	SL HP 3	
Benefit	***In Network***	***Out of Network***
Annual Deductible-Single	$3,000	$6,000
Annual Deductible-Family	$6,000	$12,000
Out of Pocket Maximum-Single	$5,000	$10,000
Out of Pocket Maximum-Family	$8,000	$16,000
Out of Pocket Maximum includes the Deductible	Yes	Yes
General Coinsurance	20%	30%
Physician's Office Services	$25 Copay	Deductible & Coinsurance
Specialist's Office Services	$50 Copay	Deductible & Coinsurance
Preventive Care (deductible waived for in-network)	Covered at 100%	Covered at 100%
Outpatient Surgeries	Deductible & Coinsurance	Deductible & Coinsurance
In-patient Hospital Stay	Deductible & Coinsurance	Deductible & Coinsurance
Lab/X-Ray	$35 Copay	Deductible & Coinsurance
Major Diagnostic Imaging (CT/MRI/PET)	Deductible & Coinsurance	Deductible & Coinsurance
Additional Coverages - Infertility ($15K LT Max)	Yes	Yes
Additional Coverages - Exercise Facility: Subscriber $200 Reimbursement per 6 month period Spouse $100 Reimbursement per 6 month period	Yes	Yes
Eye Exam/Supplies (one exam every 24 months)	Yes	Yes
Emergency Room Visit	$150 copay	$!50 Copay
Urgent Care Visit	$50 copay	Deductible & Coinsurance
Rx Deductible	$0	$0
Retail Rx Generic	$10	$10
Retail Rx Brand	$40	$40
Retail Rx Non-Formulary	$60	$60
Mail Order Rx (Gen/Brand/Non-Frm)	2 X Retail	2 X Retail

SL Healthplans LLC

Chamber of Commerce and Associaton Health Plan Choices

3 to 9 ee = Up to 2 Plans

Above 10 ee = Up to 3 Plans or Current Plans

	SL HP 4	
Benefit	***In Network***	***Out of Network***
Annual Deductible-Single	$4,000	$8,000
Annual Deductible-Family	$8,000	$16,000
Out of Pocket Maximum-Single	$6,000	$12,000
Out of Pocket Maximum-Family	$12,000	$24,000
Out of Pocket Maximum includes the Deductible	Yes	Yes
General Coinsurance	20%	30%
Physician's Office Services	$25 Copay	Deductible & Coinsurance
Specialist's Office Services	$50 Copay	Deductible & Coinsurance
Preventive Care (deductible waived for in-network)	Covered at 100%	Covered at 100%
Outpatient Surgeries	Deductible & Coinsurance	Deductible & Coinsurance
In-patient Hospital Stay	Deductible & Coinsurance	Deductible & Coinsurance
Lab/X-Ray	$35 Copay	Deductible & Coinsurance
Major Diagnostic Imaging (CT/MRI/PET)	Deductible & Coinsurance	Deductible & Coinsurance
Additional Coverages - Infertility ($15K LT Max)	Yes	Yes
Additional Coverages - Exercise Facility: Subscriber $200 Reimbursement per 6 month period Spouse $100 Reimbursement per 6 month period	Yes	Yes
Eye Exam/Supplies (one exam every 24 months)	Yes	Yes
Emergency Room Visit	$150 copay	$150 copay
Urgent Care Visit	$50 copay	$50 copay
Rx Deductible	$0	$0
Retail Rx Generic	$10	$10
Retail Rx Brand	$30	$40
Retail Rx Non-Formulary	$50	$60
Mail Order Rx (Gen/Brand/Non-Frm)	2 X Retail	2 X Retail

SL Healthplans LLC

Chamber of Commerce and Associaton Health Plan Choices

3 to 9 ee = Up to 2 Plans

Above 10 ee = Up to 3 Plans or Current Plans

	SL HP 5	
Benefit	***In Network***	***Out of Network***
Annual Deductible-Single	$5,000	$10,000
Annual Deductible-Family	$10,000	$20,000
Out of Pocket Maximum-Single	$6,350	$10,000
Out of Pocket Maximum-Family	$12,700	$20,000
Out of Pocket Maximum includes the Deductible	Yes	Yes
General Coinsurance	20%	30%
Physician's Office Services	$25 Copay	Deductible & Coinsurance
Specialist's Office Services	$50 Copay	Deductible & Coinsurance
Preventive Care (deductible waived for in-network)	Covered at 100%	Covered at 100%
Outpatient Surgeries	Deductible & Coinsurance	Deductible & Coinsurance
In-patient Hospital Stay	Deductible & Coinsurance	Deductible & Coinsurance
Lab/X-Ray	$35 Copay	Deductible & Coinsurance
Major Diagnostic Imaging (CT/MRI/PET)	Deductible & Coinsurance	Deductible & Coinsurance
Additional Coverages - Infertility ($15K LT Max)	Yes	Yes
Additional Coverages - Exercise Facility: Subscriber $200 Reimbursement per 6 month period Spouse $100 Reimbursement per 6 month period	Yes	Yes
Eye Exam/Supplies (one exam every 24 months)	Yes	Yes
Emergency Room Visit	$150 copay	$150 copay
Urgent Care Visit	$50 copay	Deductible & Coinsurance
Rx Deductible	$0	$0
Retail Rx Generic	$10	$10
Retail Rx Brand	$50	$50
Retail Rx Non-Formulary	$70	$70
Mail Order Rx (Gen/Brand/Non-Frm)	2 X Retail	2 X Retail

SL Healthplans LLC

Chamber of Commerce and Associaton Health Plan Choices

3 to 9 ee = Up to 2 Plans

Above 10 ee = Up to 3 Plans or Current Plans

	SL HP 6	
Benefit	***In Network***	***Out of Network***
Annual Deductible-Single	$4,200	$8,400
Annual Deductible-Family	$8,400	$16,800
Out of Pocket Maximum-Single	$6,850	$13,700
Out of Pocket Maximum-Family	$13,700	$27,400
Out of Pocket Maximum includes the Deductible	Yes	Yes
General Coinsurance	40%	50%
Physician's Office Services	$50 Copay	Deductible & Coinsurance
Specialist's Office Services	$75 Copay	Deductible & Coinsurance
Preventive Care (deductible waived for in-network)	Covered at 100%	Covered at 100%
Outpatient Surgeries	Deductible & Coinsurance	Deductible & Coinsurance
In-patient Hospital Stay	Deductible & Coinsurance	Deductible & Coinsurance
Lab/X-Ray	Deductible & Coinsurance	Deductible & Coinsurance
Major Diagnostic Imaging (CT/MRI/PET)	Deductible & Coinsurance	Deductible & Coinsurance
Additional Coverages - Infertility ($15K LT Max)	Yes	Yes
Additional Coverages - Exercise Facility: Subscriber $200 Reimbursement per 6 month period Spouse $100 Reimbursement per 6 month period	Yes	Yes
Eye Exam/Supplies (one exam every 24 months)	Yes	Yes
Emergency Room Visit	$150 copay	$150 copay
Urgent Care Visit	$75 Copay	Deductible & Coinsurance
Rx Deductible	$0	$0
Retail Rx Generic	$10	$10
Retail Rx Brand	$50	$50
Retail Rx Non-Formulary	$70	$70
Mail Order Rx (Gen/Brand/Non-Frm)	2 X Retail	2 X Retail

SL Healthplans LLC

Chamber of Commerce and Associaton Health Plan Choices

3 to 9 ee = Up to 2 Plans

Above 10 ee = Up to 3 Plans or Current Plans

	SL HP 7 HDHP	
Benefit	***In Network***	***Out of Network***
Annual Deductible-Single	$2,000	$4,000
Annual Deductible-Family	$4,000	$8,000
Out of Pocket Maximum-Single	$2,000	$4,000
Out of Pocket Maximum-Family	$4,000	$8,000
Out of Pocket Maximum includes the Deductible	Yes	Yes
General Coinsurance	0%	70%
Physician's Office Services	Deductible & Coinsurance	Deductible & Coinsurance
Specialist's Office Services	Deductible & Coinsurance	Deductible & Coinsurance
Preventive Care (deductible waived for in-network)	Covered at 100%	Covered at 100%
Outpatient Surgeries	Deductible & Coinsurance	Deductible & Coinsurance
In-patient Hospital Stay	Deductible & Coinsurance	Deductible & Coinsurance
Lab/X-Ray	Deductible & Coinsurance	Deductible & Coinsurance
Major Diagnostic Imaging (CT/MRI/PET)	Deductible & Coinsurance	Deductible & Coinsurance
Additional Coverages - Infertility ($15K LT Max)	Yes	Yes
Additional Coverages - Exercise Facility: Subscriber $200 Reimbursement per 6 month period Spouse $100 Reimbursement per 6 month period	Yes	Yes
Eye Exam/Supplies (one exam every 24 months)	Yes	Yes
Emergency Room Visit	Deductible	Deductible
Urgent Care Visit	Deductible	Deductible
Rx Deductible	$0	$0
Retail Rx Generic	$15	$15
Retail Rx Brand	$30	$30
Retail Rx Non-Formulary	$50	$50
Mail Order Rx (Gen/Brand/Non-Frm)	2 X Retail	2 X Retail

SL Healthplans LLC

Chamber of Commerce and Associaton Health Plan Choices

3 to 9 ee = Up to 2 Plans

Above 10 ee = Up to 3 Plans or Current Plans

	SL HP 8 HDHP	
Benefit	***In Network***	***Out of Network***
Annual Deductible-Single	$5,000	$10,000
Annual Deductible-Family	$10,000	$20,000
Out of Pocket Maximum-Single	$5,000	$10,000
Out of Pocket Maximum-Family	$10,000	$20,000
Out of Pocket Maximum includes the Deductible	Yes	Yes
General Coinsurance	0%	30%
Physician's Office Services	Deductible & Coinsurance	Deductible & Coinsurance
Specialist's Office Services	Deductible & Coinsurance	Deductible & Coinsurance
Preventive Care (deductible waived for in-network)	Covered at 100%	Covered at 100%
Outpatient Surgeries	Deductible & Coinsurance	Deductible & Coinsurance
In-patient Hospital Stay	Deductible & Coinsurance	Deductible & Coinsurance
Lab/X-Ray	Deductible & Coinsurance	Deductible & Coinsurance
Major Diagnostic Imaging (CT/MRI/PET)	Deductible & Coinsurance	Deductible & Coinsurance
Additional Coverages - Infertility ($15K LT Max)	Yes	Yes
Additional Coverages - Exercise Facility: Subscriber $200 Reimbursement per 6 month period Spouse $100 Reimbursement per 6 month period	Yes	Yes
Eye Exam/Supplies (one exam every 24 months)	Yes	Yes
Emergency Room Visit	Deductible	Deductible
Urgent Care Visit	Deductible	Deductible
Rx Deductible	$0	$0
Retail Rx Generic	$15	$15
Retail Rx Brand	$30	$30
Retail Rx Non-Formulary	$50	$50
Mail Order Rx (Gen/Brand/Non-Frm)	2 X Retail	2 X Retail

SL Healthplans LLC

Chamber of Commerce and Associaton Health Plan Choices

3 to 9 ee = Up to 2 Plans

Above 10 ee = Up to 3 Plans or Current Plans

	SL HP 9 HDHP HSA	
Benefit	***In Network***	***Out of Network***
Annual Deductible-Single	$2,500	$5,000
Annual Deductible-Family	$5,000	$10,000
Out of Pocket Maximum-Single	$5,000	$10,000
Out of Pocket Maximum-Family	$7,500	$15,000
Out of Pocket Maximum includes the Deductible	Yes	Yes
General Coinsurance	20%	30%
Physician's Office Services	Deductible & Coinsurance	Deductible & Coinsurance
Specialist's Office Services	Deductible & Coinsurance	Deductible & Coinsurance
Preventive Care (deductible waived for in-network)	Covered at 100%	Covered at 100%
Outpatient Surgeries	Deductible & Coinsurance	Deductible & Coinsurance
In-patient Hospital Stay	Deductible & Coinsurance	Deductible & Coinsurance
Lab/X-Ray	Deductible & Coinsurance	Deductible & Coinsurance
Major Diagnostic Imaging (CT/MRI/PET)	Deductible & Coinsurance	Deductible & Coinsurance
Additional Coverages - Infertility ($15K LT Max)	Yes	Yes
Additional Coverages - Exercise Facility: Subscriber $200 Reimbursement per 6 month period Spouse $100 Reimbursement per 6 month period	Yes	Yes
Eye Exam/Supplies (one exam every 24 months)	Yes	Yes
Emergency Room Visit	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care Visit	Deductible & Coinsurance	Deductible & Coinsurance
Rx Deductible	Deductible + 20%	Deductible + 20%
Retail Rx Generic	Deductible + 20%	Deductible + 20%
Retail Rx Brand	Deductible + 20%	Deductible + 20%
Retail Rx Non-Formulary	Deductible + 20%	Deductible + 20%
Mail Order Rx (Gen/Brand/Non-Frm)	2 X Retail	2 X Retail

SL Healthplans LLC

Chamber of Commerce and Associaton Health Plan Choices

3 to 9 ee = Up to 2 Plans

Above 10 ee = Up to 3 Plans or Current Plans

	SL HP 10 HDHP HSA	
Benefit	***In Network***	***Out of Network***
Annual Deductible-Single	$5,000	$10,000
Annual Deductible-Family	$10,000	$20,000
Out of Pocket Maximum-Single	$6,550	$13,100
Out of Pocket Maximum-Family	$13,100	$26,200
Out of Pocket Maximum includes the Deductible	Yes	Yes
General Coinsurance	20%	30%
Physician's Office Services	Deductible & Coinsurance	Deductible & Coinsurance
Specialist's Office Services	Deductible & Coinsurance	Deductible & Coinsurance
Preventive Care (deductible waived for in-network)	Covered at 100%	Covered at 100%
Outpatient Surgeries	Deductible & Coinsurance	Deductible & Coinsurance
In-patient Hospital Stay	Deductible & Coinsurance	Deductible & Coinsurance
Lab/X-Ray	Deductible & Coinsurance	Deductible & Coinsurance
Major Diagnostic Imaging (CT/MRI/PET)	Deductible & Coinsurance	Deductible & Coinsurance
Additional Coverages - Infertility ($15K LT Max)	Yes	Yes
Additional Coverages - Exercise Facility: Subscriber $200 Reimbursement per 6 month period Spouse $100 Reimbursement per 6 month period	Yes	Yes
Eye Exam/Supplies (one exam every 24 months)	Yes	Yes
Emergency Room Visit	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care Visit	Deductible & Coinsurance	Deductible & Coinsurance
Rx Deductible	Deductible + 20%	Deductible + 20%
Retail Rx Generic	Deductible + 20%	Deductible + 20%
Retail Rx Brand	Deductible + 20%	Deductible + 20%
Retail Rx Non-Formulary	Deductible + 20%	Deductible + 20%
Mail Order Rx (Gen/Brand/Non-Frm)	2 X Retail	2 X Retail