



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, www.meritain.com or call (866) 300-8449. 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 <https://www.healthcare.gov/sbc-glossary> or call Meritain Health, Inc. at (866) 300-8449 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u>? | For participating <u>providers</u> : \$1,350 individual / \$2,700 family For non-participating <u>providers</u> : \$2,500 individual / \$5,000 family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your <u>deductible</u>? | Yes. <u>Preventive care</u> , flu shots, pneumonia and shingles immunizations are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | For participating <u>providers</u> : \$6,000 individual / \$12,000 family For non-participating <u>providers</u> : \$18,000 individual / \$28,000 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of participating <u>providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |
| Is a Health Savings Account (HSA) available under this <u>plan option</u>? | Yes. | An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS. |



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) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----none----- |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| | <u>Preventive care/screening/immunization</u> | <u>Preventive care:</u> No Charge Routine care: No charge for the first \$300 per year, then 90% <u>coinsurance</u> Flu, pneumonia & shingles immunization: No Charge Hearing exam: 20% <u>coinsurance</u> | <u>Preventive care:</u> Not Covered Routine care: No charge for flu, pneumonia & shingles immunizations Hearing exam: 50% <u>coinsurance</u> All other routine care: Not Covered | <u>Deductible</u> does not apply for participating <u>providers</u> . <u>Deductible</u> does not apply for flu, pneumonia and shingles immunizations for non-participating <u>providers</u> . Hearing exams limited to 1 per year. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com | Generic drugs | 20% <u>coinsurance</u> | Not Covered | Major medical <u>deductible</u> applies. Covers up to a 30-day supply (retail prescription); 90-day supply (available only by mail order). <u>Plan</u> requires pharmacies to dispense generic drugs when available. Mandatory generic provision applies. No charge or <u>deductible</u> for preventive drugs. This <u>plan</u> will allow maintenance medications to be filled at retail in 30-day quantities only. Maintenance medications are subject to the retail or mail order supply limit and <u>copays</u> . <u>Specialty drugs</u> must be obtained directly from the specialty pharmacy. |
| | Preferred drugs | 20% <u>coinsurance</u> | Not Covered | |
| | Non-preferred drugs | 20% <u>coinsurance</u> | Not Covered | |
| | <u>Specialty drugs</u> | 20% <u>coinsurance</u> | Not Covered | |

| 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) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> required unless performed in an office setting. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> (medical emergency)/50% <u>coinsurance</u> (non-medical emergency) | Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> . |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> /trip (ground) \$200 <u>copay</u> /trip + 20% <u>coinsurance</u> (air) | 20% <u>coinsurance</u> /trip (ground) \$200 <u>copay</u> /trip + 20% <u>coinsurance</u> (air) | Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. |
| | <u>Urgent care</u> | \$50 <u>copay</u> /visit+ 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Copay</u> applies per visit regardless of what services are rendered. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$250 <u>copay</u> /admission + 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----none----- |
| | Inpatient services | \$250 <u>copay</u> /admission + 20% <u>coinsurance</u> (facility charge)/20% <u>coinsurance</u> (professional fees) | 50% <u>coinsurance</u> | <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service. |
| If you are pregnant | Office visits | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <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 20% of the total cost of the service. <u>Cost sharing</u> does not apply to <u>preventive services</u> . Depending on the |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |

| 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) | |
| | Childbirth/delivery facility services | \$250 <u>copay</u> /admission + 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | type of services, a <u>copay</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense. |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Limited to 60 visits per year. <u>Home health care</u> supplies not subject to the calendar year maximum. |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Includes physical, speech & occupational therapy. Limited to 60 visits per each type of therapy, per year. |
| | <u>Habilitation services</u> | Not Covered | Not Covered | This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism and to expenses covered as <u>preventive care</u> . |
| If you need help recovering or have other special health needs | <u>Skilled nursing care</u> | \$250 <u>copay</u> /admission + 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Limited to 60 days per 12 month period. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> required for any item in excess of \$1,500. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> (outpatient)/ \$250 <u>copay</u> /admission + 20% <u>coinsurance</u> (inpatient) | 50% <u>coinsurance</u> | Bereavement counseling is not covered. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service. |
| If your child needs dental or eye care | Children's eye exam | Not Covered | Not Covered | Covered under stand alone vision plan. |
| | Children's glasses | Not Covered | Not Covered | Covered under stand alone vision plan. |
| | Children's dental check-up | Not Covered | Not Covered | Covered under stand alone dental plan. |

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.)

- Acupuncture
- Bereavement counseling
- Cosmetic surgery
- Dental care (covered under stand alone dental plan)
- Glasses (covered under stand alone vision plan)
- Habilitation services (except autism & preventive services)
- Infertility treatment (except diagnosis)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except for home health care & hospice)
- Routine eye care (covered under stand alone vision plan)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Hearing aids

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 <https://www.dol.gov/agencies/ebsa> or Meritain Health, Inc. at (866) 300-8449. 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 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 Meritain Health, Inc. at (866) 300-8449 or The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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, kwiiijigo 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 <u>plan's</u> overall <u>deductible</u> | \$1,350 |
| ■ <u>Primary Care Physician coinsurance</u> | 20% |
| ■ Hospital (facility) <u>copayment</u> | \$250 |
| ■ Other <u>coinsurance</u> | 20% |

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,840 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,350 |
| Copayments | \$250 |
| Coinsurance | \$735 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,395 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,350 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,460 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,350 |
| Copayments | \$0 |
| Coinsurance | \$1,437 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$2,842 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,350 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

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 | \$2,010 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,350 |
| Copayments | \$0 |
| Coinsurance | \$385 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,735 |