

 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 (816) 842-2690. 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 <u>deductible</u>? | For participating <u>providers</u> : \$2,000 person / \$4,000 family For non-participating <u>providers</u> : \$4,000 person / \$8,000 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. For participating <u>providers</u> : <u>Preventive care</u> , routine eye exam, <u>home health care</u> , outpatient <u>hospice services</u> , independent lab, prenatal and postnatal care, <u>urgent care</u> and office visit charges 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 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 person / \$12,000 family For non-participating <u>providers</u> : \$12,000 person / \$24,000 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>preauthorization</u> penalty amounts, <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 <u>network 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</u> charge 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. |

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| Do you need a referral to see a specialist ? | No. | You can see the specialist you choose without a referral . |
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 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 | \$35 copay /visit (office visit)/ 30% coinsurance (all other services) | 50% coinsurance | <u>Copay</u> applies to the physician office visit and lab services only. Includes telemedicine. |
| | <u>Specialist</u> visit | \$65 copay /visit (office visit)/ 30% coinsurance (all other services) | 50% coinsurance | |
| | <u>Preventive care</u> / <u>screening</u> /immunization | No Charge | 50% coinsurance | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need 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) | No Charge (independent lab)/30% coinsurance (all other <u>diagnostic tests</u>) | 50% coinsurance | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 50% coinsurance | <u>Preauthorization</u> required for PET scans and non-orthopedic CT/MRI's. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating providers. |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.southernscripts.net | Generic drugs | \$10 copay (30-day retail)/ \$20 copay (31-60-day retail)/\$25 copay (61-90-day retail and mail order) | Not Covered | <u>Deductible</u> does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained directly from the specialty pharmacy. |
| | Preferred brand drugs | \$35 copay (30-day retail)/ \$70 copay (31-60-day retail)/\$87.50 copay (61-90-day retail and mail order) | 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) | |
| | Non-preferred brand drugs | \$60 <u>copay</u> (30-day retail)/ \$120 <u>copay</u> (31-60-day retail)/\$150 <u>copay</u> (61-90-day retail and mail order) | Not Covered | |
| | <u>Specialty drugs</u> | \$100 <u>copay</u> (retail) | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Preauthorization required for certain surgeries. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating providers. See your <u>plan</u> document for a detailed listing. |
| | Physician/surgeon fees | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| If you need immediate medical attention | <u>Emergency room care</u> | \$200 <u>copay</u> /visit, then 30% <u>coinsurance</u> (<u>emergency services</u>)/ Not Covered (non-emergency services) | \$200 <u>copay</u> /visit, then 30% <u>coinsurance</u> (<u>emergency services</u>)/ Not Covered (non-emergency services) | Non-participating providers paid at the participating provider level of benefits for <u>emergency services</u> . <u>Copay</u> is waived if admitted to the hospital. |
| | <u>Emergency medical transportation</u> | 30% <u>coinsurance</u> | 30% <u>coinsurance</u> | Non-participating providers paid at the participating provider level of benefits. |
| | <u>Urgent care</u> | \$75 <u>copay</u> /visit (office visit)/ 30% <u>coinsurance</u> (all other services) | 50% <u>coinsurance</u> | <u>Copay</u> applies to the physician office visit only. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Preauthorization required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating providers. |
| | Physician/surgeon fees | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$35 <u>copay</u> /visit (office visit) /30% <u>coinsurance</u> (all other outpatient) | 50% <u>coinsurance</u> | Includes telemedicine. |
| | Inpatient services | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Preauthorization required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non-participating providers. |

| 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 are pregnant | Office visits | No Charge (\$35 <u>copay</u> for initial visit) | 50% <u>coinsurance</u> | <p><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 \$400 of the total cost of the service for non-<u>participating providers</u>. <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u>. 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 <u>deductible</u> amount may apply.</p> |
| | Childbirth/delivery professional services | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | \$65 <u>copay</u> /visit | 50% <u>coinsurance</u> | Limited to 3 visits per day; 1 visit equals 4 hours. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non- <u>participating providers</u> . |
| | <u>Rehabilitation services</u> | \$35 <u>copay</u> /visit (physical, speech, and occupational therapy)/30% <u>coinsurance</u> (respiratory/pulmonary and radiation therapy) | 50% <u>coinsurance</u> | Physical, occupational and speech therapy limited to a combined maximum of 60 visits per year. |
| | <u>Habilitation services</u> | \$35 <u>copay</u> /visit | 50% <u>coinsurance</u> | |
| | <u>Skilled nursing care</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Limited to 60 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non- <u>participating providers</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) | |
| | <u>Durable medical equipment</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> required for electric/motorized scooters or wheelchairs and pneumatic compression devices. If you don't get <u>preauthorization</u> , benefits could be reduced by \$400 of the total cost of the service for non- <u>participating providers</u> . |
| | <u>Hospice services</u> | \$65 <u>copay</u> /admission (outpatient)/30% <u>coinsurance</u> (inpatient) | 50% <u>coinsurance</u> | Bereavement counseling is covered. |
| If your child needs dental or eye care | Children's eye exam | No Charge | 50% <u>coinsurance</u> | Limited to 1 exam every 24 months |
| | Children's glasses | Not Covered | Not Covered | Not Covered |
| | Children's dental check-up | 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.)

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child) • Emergency room services for non-emergency services | <ul style="list-style-type: none"> • Glasses (Adult & Child) • Infertility treatment (except diagnosis) • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing (except for home health care & hospice) • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Acupuncture (as a form of anesthesia) • Chiropractic care | <ul style="list-style-type: none"> • Hearing aids (1 aid per ear every 3 years, up to \$2,500 per aid) | <ul style="list-style-type: none"> • Routine eye care (Adult & Child – 1 exam every 24 months) |
|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|

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 Kessinger Hunter & Company, LC at (816) 842-2690. 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 Kessinger Hunter & Company, LC at (816) 842-2690.

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, kwijjigo 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 plan's overall deductible \$2,000
- Primary care physician copayment \$35
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,000 |
| Copayments | \$10 |
| Coinsurance | \$3,200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$5,270 |

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

- The plan's overall deductible \$2,000
- Specialist copayment \$65
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$900 |
| Copayments | \$1,000 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,920 |

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,000
- Specialist copayment \$65
- Hospital (facility) copayment \$200
- Other coinsurance 30%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,000 |
| Copayments | \$300 |
| Coinsurance | \$30 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,330 |