

 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 (206) 433-6766. 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 deductible?	For participating <u>providers</u> : \$300 person / \$600 family For non-participating <u>providers</u> : \$600 person / \$1,800 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 deductible?	Yes. For participating <u>providers</u> : Preventive care, outpatient mental health/substance abuse services, 1 st mammogram per year, <u>emergency room services (emergency services)</u> , <u>urgent care</u> and office visits are covered before you meet your <u>deductible</u> . For non-participating <u>providers</u> : Well child care (up to age 18), routine physical exam (age 18 and over), immunizations (includes flu vaccines) and <u>emergency room services (emergency services)</u> 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.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For participating <u>providers</u> : \$3,000 person / \$9,000 family For non-participating <u>providers</u> : \$6,000 person / \$18,000 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 out-of-pocket limit?	<u>Premiums</u> , <u>copays</u> , <u>deductibles</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 network provider?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 231-6935 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 referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered, except x-ray and lab services. Includes telemedicine.
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / immunization	Well Child Care (up to age 18): \$25 <u>copay</u> /visit Routine Physical Exam (18 and over): \$25 <u>copay</u> /visit GYN Exam: \$25 <u>copay</u> /visit Immunizations (includes flu vaccines & Covid-19 vaccine): No Charge Mammograms: No Charge (first mammogram) / 20% <u>coinsurance</u> (all subsequent mammograms) Routine X-ray & Lab Services/Sigmoidoscopy/Colonoscopy : No Charge	Well Child Care (up to age 18): 50% <u>coinsurance</u> Routine Physical Exam (18 and over): 50% <u>coinsurance</u> GYN Exam: 50% <u>coinsurance</u> Immunizations (includes flu vaccines): 50% <u>coinsurance</u> Covid-19 vaccine: No Charge Mammograms: 50% <u>coinsurance</u> Routine X-ray & Lab Services/ Sigmoidoscopy/Colonoscopy: 50% <u>coinsurance</u>	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. Routine physical exams and GYN exams are limited to 1 exam per each year. Sigmoidoscopy is limited to 1 per 60-month period. Colonoscopy is limited to 1 per 120-month period. Routine mammograms are covered age 40 and over. Please see your <u>plan</u> document for additional information and/or limitations.
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> recommended for PET scans and non-orthopedic CT/MRI's.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com	Generic drugs	No Charge (retail)/ \$30 <u>copay</u> (mail order)	No Charge (retail)	<u>Deductible</u> does not apply. Covers up to a 30-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 over-the-counter drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> . <u>Preauthorization</u> recommended for injectables costing over \$2,000 per drug per month. Certain drugs
	<u>Formulary</u> brand drugs	\$25 <u>copay</u> (retail)/ \$50 <u>copay</u> (mail order)	\$25 <u>copay</u> (retail)	
	Non- <u>Formulary</u> brand drugs	\$50 <u>copay</u> (retail)/ \$80 <u>copay</u> (mail order)	\$50 <u>copay</u> (retail)	
	<u>Specialty drugs</u>	Paid the same as generic, <u>formulary</u> and non- <u>formulary</u> drugs		

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)	
				are subject to the Payer Matrix Program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> recommended for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. See your <u>plan</u> document for a detailed listing
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit, then 20% <u>coinsurance</u> (<u>emergency services</u>)/50% <u>coinsurance</u> (<u>non-emergency services</u>)	\$100 <u>copay</u> /visit, then 20% <u>coinsurance</u> (<u>emergency services</u>)/50% <u>coinsurance</u> (<u>non-emergency services</u>)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	<u>Urgent care</u>	\$50 <u>copay</u> /visit, then 20% <u>coinsurance</u>	\$50 <u>copay</u> /visit, then 50% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered, except x-ray and lab services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	Includes telemedicine.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility 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)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Includes physical, speech/hearing, occupational and neurodevelopmental therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 120 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> recommended for electric/ motorized scooters or wheelchairs and pneumatic compression devices.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Bereavement counseling is covered.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Adult & Child) 	<ul style="list-style-type: none"> • Hearing aids • 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 eye care (Adult & Child) • Routine foot care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture 	<ul style="list-style-type: none"> • Chiropractic care (20 visits per year) 	<ul style="list-style-type: none"> • Habilitation services • Weight loss programs (for the treatment of morbid obesity only)

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 CMC Investments Inc. at (206) 433-6766. 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 CMC Investments Inc. at (206) 433-6766.

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, kwijigo 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 \$300
- Primary care physician coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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	\$300
Copayments	\$50
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,910

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

- The plan's overall deductible \$300
- Specialist copayment \$25
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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	\$300
Copayments	\$700
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

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

- The plan's overall deductible \$300
- Specialist copayment \$25
- Hospital (facility) copayment \$100
- Other coinsurance 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 \$2,800

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900