




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.simplepayhealth.com](http://www.simplepayhealth.com) or call (402) 507-4899. 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](http://www.healthcare.gov/sbc-glossary) or call Meritain Health, Inc. at (800) 606-3564 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your deductible?</b>	Yes. All services are covered before you meet a <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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For participating <u>providers</u> : \$3,500 person / \$7,000 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.
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.simplepayhealth.com">www.simplepayhealth.com</a> or call (800) 606-3564 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.
<b>Do you need a referral to see a specialist?</b>	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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	Tier 1: \$25 <u>copay</u> /visit Tier 2: \$40 <u>copay</u> /visit Tier 3: \$60 <u>copay</u> /visit	Not Covered	Includes telemedicine. You pay \$0 <u>copay</u> if you receive consultation services through Teladoc.
	<u>Specialist</u> visit	Tier 1: \$50 <u>copay</u> /visit Tier 2: \$70 <u>copay</u> /visit Tier 3: \$120 <u>copay</u> /visit	Not Covered	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	Not Covered	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Basic labs: Tier 1: \$20 <u>copay</u> /visit Tier 2: \$30 <u>copay</u> /visit Tier 3: \$40 <u>copay</u> /visit Advanced labs, x-rays & other <u>diagnostic tests</u> : Tier 1: \$50 <u>copay</u> /visit Tier 2: \$70 <u>copay</u> /visit Tier 3: \$120 <u>copay</u> /visit	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	Tier 1: \$230 <u>copay</u> /scan Tier 2: \$400 <u>copay</u> /scan Tier 3: \$600 <u>copay</u> /scan	Not Covered	<u>Preauthorization</u> recommended for PET scans.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.medone-rx.com">www.medone-rx.com</a>	Generic drugs	Retail: Tier 1: \$0 <u>copay</u> Tier 2: \$15 <u>copay</u> Tier 3: \$20 <u>copay</u> Mail order: \$0 <u>copay</u>	Not Covered	Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. *Specialty Drugs are managed through the RxAllly Program. Members can reach a Patient Care Coordinator at (877) 794-2218 for
	Preferred brand drugs	Retail: Tier 1: \$40 <u>copay</u> Tier 2: \$60 <u>copay</u> Tier 3: \$80 <u>copay</u> Mail order: \$70 <u>copay</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)	
	Non-preferred brand drugs	Retail: Tier 1: \$60 <u>copay</u> Tier 2: \$80 <u>copay</u> Tier 3: \$120 <u>copay</u> Mail order: \$120 <u>copay</u>	Not Covered	assistance with acquiring Specialty Drugs.
	<u>Specialty drugs</u>	Not Covered*	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1: \$880 <u>copay</u> /occurrence Tier 2: \$1,170 <u>copay</u> /occurrence Tier 3: \$1,950 <u>copay</u> / occurrence	Not Covered	<u>Preauthorization</u> recommended for certain surgeries. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$450 <u>copay</u> /visit ( <u>emergency services</u> )/ Not Covered (non- <u>emergency services</u> )	\$450 <u>copay</u> /visit ( <u>emergency services</u> )/ Not Covered (non- <u>emergency services</u> )	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>	\$650 <u>copay</u> /trip	\$650 <u>copay</u> /trip	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	\$55 <u>copay</u> /visit	Not Covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1: \$2,700 <u>copay</u> /admission Tier 2: \$3,000 <u>copay</u> /admission Tier 3: \$3,500 <u>copay</u> /admission	Not Covered	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: Tier 1: \$25 <u>copay</u> /visit Tier 2: \$40 <u>copay</u> /visit Tier 3: \$60 <u>copay</u> /visit All other outpatient: Tier 1: \$880 <u>copay</u> /occurrence Tier 2: \$1,170 <u>copay</u> /occurrence	Not Covered	Includes telemedicine.

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)	
		Tier 3: \$1,950 <u>copay</u> /occurrence (facility charge)/ No Charge (professional fees)		
	Inpatient services	Facility Charge: Tier 1: \$2,700 <u>copay</u> /admission Tier 2: \$3,000 <u>copay</u> /admission Tier 3: \$3,500 <u>copay</u> /admission Professional fees: No Charge	Not Covered	<u>Preauthorization</u> recommended.
If you are pregnant	Office visits	Initial office visit: Tier 1: \$25 <u>copay</u> /visit Tier 2: \$40 <u>copay</u> /visit Tier 3: \$60 <u>copay</u> /visit All other prenatal & postnatal: your cost varies depending on the type of service and place where received	Not Covered	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <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 counts towards the mother's expense.
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	Tier 1: \$2,700 <u>copay</u> /admission Tier 2: \$3,000 <u>copay</u> /admission Tier 3: \$3,500 <u>copay</u> /admission	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	Tier 1: \$55 <u>copay</u> /visit Tier 2: \$80 <u>copay</u> /visit Tier 3: \$120 <u>copay</u> /visit	Not Covered	Limited to 60 visits per year.
	<u>Rehabilitation services</u>	Tier 1: \$55 <u>copay</u> /visit Tier 2: \$80 <u>copay</u> /visit Tier 3: \$120 <u>copay</u> /visit	Not Covered	Physical, speech/hearing, occupational, pulmonary and post-cochlear implant aural therapy, as well as cardiac and

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>Habilitation services</u>	Tier 1: \$55 <u>copay</u> /visit Tier 2: \$80 <u>copay</u> /visit Tier 3: \$120 <u>copay</u> /visit	Not Covered	cognitive rehab are limited to 20 visits per each type of therapy per year.
	<u>Skilled nursing care</u>	Tier 1: \$2,700 <u>copay</u> /admission Tier 2: 3,000 <u>copay</u> /admission Tier 3: \$3,500 <u>copay</u> /admission	Not Covered	Limited to 160 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	Tier 1: \$100 <u>copay</u> /item Tier 2: \$135 <u>copay</u> /item Tier 3: \$230 <u>copay</u> /item	Not Covered	<u>Preauthorization</u> recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices.
	<u>Hospice services</u>	Tier 1: \$245 <u>copay</u> /services Tier 2: \$330 <u>copay</u> /services Tier 3: \$550 <u>copay</u> /services	Not Covered	You pay a \$245- \$550 <u>copay</u> /visit for bereavement counseling.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Some pediatric eye screenings are covered under preventive services.
	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"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> <li>• Emergency room services for non-emergency services</li> </ul>	<ul style="list-style-type: none"> <li>• Glasses (Adult &amp; Child)</li> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (outpatient - except for home health care &amp; hospice)</li> <li>• Routine eye care (Adult &amp; Child)</li> <li>• Routine foot care (except for metabolic or peripheral vascular disease)</li> <li>• Weight loss programs</li> </ul>

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

- Acupuncture (limited to 10 visits per year)
- Private-duty nursing (inpatient)
- Chiropractic care (limited to 20 visits per year)

**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](http://www.dol.gov/ebsa/healthreform) or Immanuel at (402) 507-4899. 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](http://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 the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or Immanuel at (402) 507-4899.

**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, kwijijigo 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 \$0
- Primary care physician copayment \$25-\$60
- Hospital (facility) copayment \$2,700-\$3,500
- Other coinsurance 0%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$3,500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,560</b>

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$0
- Specialist copayment \$50-\$120
- Hospital (facility) copayment \$880-\$1,950
- Other coinsurance 0%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$3,300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,320</b>

### Mia's Simple Fracture

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

- The plan's overall deductible \$0
- Specialist copayment \$50-\$120
- Hospital (facility) copayment \$450
- Other coinsurance 0%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$2,200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,200</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.