

 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](http://www.meritain.com) or call (541) 928-7232. 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) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For participating <u>providers</u> : \$3,000 person / \$6,000 family For non-participating <u>providers</u> : \$5,000 person / 10,000 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. For participating <u>providers</u> : <u>Preventive care</u> , <u>diagnostic tests</u> , <u>emergency room care</u> – <u>emergency services</u> only (all <u>providers</u> ), surgery at an ambulatory surgery center, <u>urgent care</u> office visit charges (all <u>providers</u> ), routine eye exams, <u>rehabilitation services</u> , prenatal care, 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For participating <u>providers</u> : \$6,000 person / \$12,000 family For non-participating <u>providers</u> : \$10,000 person / \$20,000 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 <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.aetna.com/docfind/custom/mymeritain">www.aetna.com/docfind/custom/mymeritain</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</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	\$25 <u>copay</u> /visit (office visit)/No Charge (lab and x-ray)/30% <u>coinsurance</u> (all other services)	50% <u>coinsurance</u>	<p><u>Copay</u> applies to the physician office visit only. Includes telemedicine consults at no charge and the <u>deductible</u> does not apply. There is no charge and the <u>deductible</u> does not apply if you receive consultation services through Teladoc. There is no charge and the <u>deductible</u> does not apply for services received at a Minute Clinic.</p> <p>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.</p>
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit (office visit)/No Charge (lab and x-ray)/30% <u>coinsurance</u> (all other services)	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	50% <u>coinsurance</u>	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$50 <u>copay</u> /visit	50% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<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 50% of the total cost of the service.
<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.magellanrx.com">www.magellanrx.com</a>	Generic drugs	\$10 <u>copay</u> (31-day retail) \$30 <u>copay</u> (90-day retail) \$25 <u>copay</u> (mail order)	Not Covered	<p><u>Deductible</u> does not apply. Covers up to a 90-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.</p> <p><u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.</p>
	Preferred brand drugs	\$45 <u>copay</u> (31-day retail) \$135 <u>copay</u> (90-day retail) \$112.50 <u>copay</u> (mail order)	Not Covered	
	Non-preferred brand drugs	\$75 <u>copay</u> (31-day retail) \$225 <u>copay</u> (90-day retail) \$187.50 <u>copay</u> (mail order)	Not Covered	
	<u>Specialty drugs</u>	\$100 <u>copay</u> (31-day supply)	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)	\$250 <u>copay</u> /occurrence (ambulatory surgery center)/30% <u>coinsurance</u> (hospital)	50% <u>coinsurance</u>	<u>Preauthorization</u> required for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	No Charge (ambulatory surgery center)/30% <u>coinsurance</u> (all other locations)	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>copay</u> /visit ( <u>emergency services</u> )/Not Covered (non- <u>emergency services</u> )	\$500 <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. <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 <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	\$25 <u>copay</u> /visit (office visit)/ No Charge (lab and x-ray)/30% <u>coinsurance</u> (all other services)	\$25 <u>copay</u> /visit (office visit)/30% <u>coinsurance</u> (all other services)	<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>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	30% <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 (office visit) /30% <u>coinsurance</u> (all other outpatient)	50% <u>coinsurance</u>	Includes telemedicine consults at no charge and the <u>deductible</u> does not apply by <u>providers</u> other than Teladoc.
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	No Charge (\$25 <u>copay</u> on initial visit) (prenatal)/ 30% <u>coinsurance</u> (postnatal)	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 50% of the total cost of the service. <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Maternity care may include tests
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <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)	
				and services described elsewhere in the SBC (i.e. ultrasound). Baby counts toward the mother's expense.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 130 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	Physical, speech, occupational therapy & pulmonary rehab are limited to 20 visits per each type of therapy per year. Cardiac rehab limited to 36 visits per year. Post cochlear implant aural therapy limited to 30 visits 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, ADD or ADHD.
	<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 50% of the total cost of the service.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to a single purchase of a type of DME every 3 years. <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 50% of the total cost of the service.
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Bereavement counseling is covered if received within 6 months of death.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$25 <u>copay</u> /visit	Not Covered	Limited to 1 exam every 2 years.
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Emergency room services for non-emergency services
- Glasses (Adult & Child)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S. (If you become sick or injured while traveling, the plan may cover expenses incurred up to 120 consecutive days. This 120-day time limit does not apply if you are traveling for business or are a student.)
- Private-duty nursing (except for home health care & hospice)
- Routine foot care

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

- Acupuncture (20 visits per year; \$1,500 max)
- Chiropractic care (20 visits per year)
- Hearing aids (1 aid per ear every 3 years)
- Infertility treatment
- Routine eye care (Adult & Child- 1 exam every 2 years)
- 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](http://www.dol.gov/ebsa/healthreform) or Mennonite Management Services, Inc. dba Mennonite Services Northwest at (541) 928-7232. 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 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](http://www.dol.gov/ebsa/healthreform) or Mennonite Management Services, Inc. dba Mennonite Services Northwest at (541) 928-7232.

Additionally, a consumer assistance program can help you file your [appeal](#). Contact Oregon Health Connect at (866) 698-6155.

**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 <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Primary care physician coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	600
Coinsurance	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,060</b>

### 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>	\$3,000
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$1,100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,920</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>

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