

 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 (717) 292-3606. 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 deductible?</b>	For participating <u>providers</u> : \$2,500 person / \$5,000 family  For non-participating <u>providers</u> : \$6,000 person / \$12,000 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.
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> services 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 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> : \$6,450 person / \$12,900 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.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, <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 network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind/custom/my_meritain">www.aetna.com/docfind/custom/my_meritain</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 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.
<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> .
<b>Is a Health Savings Account (HSA) available under this plan option?</b>	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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	Copay applies per visit regardless of what services are rendered. There is no charge after the <u>deductible</u> if you receive consultation services through Teladoc.
	<u>Specialist</u> visit	\$70 <u>copay</u> /visit	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	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 after <u>deductible</u>	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge after <u>deductible</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for PET scans and non-orthopedic CT/MRIs. If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service.
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.rxbenefits.com">www.rxbenefits.com</a>	Generic drugs	\$8 <u>copay</u> (retail)/ \$16 <u>copay</u> (mail order)	\$8 <u>copay</u> (retail)	Major medical <u>deductible</u> applies. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). The <u>copay</u> applies per prescription. There is no charge or <u>deductible</u> for preventive drugs. There is no <u>deductible</u> (applicable <u>copay</u> applies) for preventative generic maintenance drugs. Dispense as Written (DAW) provision applies. <u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.
	Preferred brand drugs	\$45 <u>copay</u> (retail)/ \$90 <u>copay</u> (mail order)	\$45 <u>copay</u> (retail)	
	Non-preferred brand drugs	\$95 <u>copay</u> (retail)/ \$190 <u>copay</u> (mail order)	\$95 <u>copay</u> (retail)	
	<u>Specialty drugs</u>	Paid the same as generic, preferred and non-preferred drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after <u>deductible</u>	40% <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 \$500 of the total cost of the service. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	No charge after <u>deductible</u>	40% <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 immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit ( <u>emergency services</u> )/ Not Covered (non- <u>emergency services</u> )	\$200 <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>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	No charge after <u>deductible</u>	40% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <u>deductible</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service.
	Physician/surgeon fees	No charge after <u>deductible</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay</u> /visit (office visit)/ No charge after <u>deductible</u> (all other outpatient)	40% <u>coinsurance</u>	-----none-----
	Inpatient services	No charge after <u>deductible</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service.
If you are pregnant	Office visits	No charge after <u>deductible</u>	40% <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 \$500 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 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.
	Childbirth/delivery professional services	No charge after <u>deductible</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge after <u>deductible</u>	40% <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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge after deductible	40% <u>coinsurance</u>	Limited to 90 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service.
	<u>Rehabilitation services</u>	\$70 <u>copay</u> /visit	40% <u>coinsurance</u>	Physical, speech/hearing & occupational therapy limited to a maximum of 20 visits per each type of therapy per year.
	<u>Habilitation services</u>	Not Covered	Not Covered	This exclusion will not apply to expenses that are considered mental health or substance abuse services.
	<u>Skilled nursing care</u>	No charge after deductible	40% <u>coinsurance</u>	Limited to 100 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service.
	<u>Durable medical equipment</u>	No charge after deductible	40% <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 \$500 of the total cost of the service.
	<u>Hospice services</u>	No charge after deductible	40% <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	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Emergency room services for non-emergency services
- Glasses (Adult & Child)
- Habilitation services
- Hearing aids
- Infertility treatment
- 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 eye care (Adult & Child)
- 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.)

- 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 Johnston Construction Co. at (717) 292-3606. 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 Johnston Construction Co. at (717) 292-3606.

### 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 <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Primary care physician coinsurance</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	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	\$2,500
Copayments	\$10
Coinsurance	\$0

  

What isn't covered	
Limits or exclusions	\$60

  

The total Peg would pay is	\$2,570
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### 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>	\$2,500
■ <u>Specialist copayment</u>	\$70
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	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	\$2,500
Copayments	\$400
Coinsurance	\$0

  

What isn't covered	
Limits or exclusions	\$20

  

The total Joe would pay is	\$2,920
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### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist copayment</u>	\$70
■ <u>Hospital (facility) copayment</u>	\$200
■ <u>Other coinsurance</u>	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	\$2,500
Copayments	\$300
Coinsurance	\$0

  

What isn't covered	
Limits or exclusions	\$0

  

The total Mia would pay is	\$2,800
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The plan would be responsible for the other costs of these EXAMPLE covered services.