

 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 (660) 827-2100. 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 <https://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> : \$1,000 person / \$2,000 family For non-participating <u>providers</u> : \$3,000 person / \$6,000 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> , routine care (1 <sup>st</sup> \$750/year), mental health/substance abuse outpatient services, <u>urgent care</u> , <u>rehabilitation services</u> , <u>primary care provider</u> and <u>specialist</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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://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> : \$4,100 person / \$8,200 family For non-participating <u>providers</u> : \$8,200 person / \$16,400 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.phpkc.com">www.phpkc.com</a> or call (800) 544-3014 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 provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit (office visit)/20% <u>coinsurance</u> (all other services)	50% <u>coinsurance</u>	<u>Copay</u> applies to the physician office visit only.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit (office visit)/20% <u>coinsurance</u> (all other services)	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge ( <u>preventive care</u> )/No charge for the 1 <sup>st</sup> \$750/year, then 20% <u>coinsurance</u> (routine care)	Not Covered	
<b>If you have a test</b>	<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> required for PET scans and non-orthopedic CT/MRI's. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% up to \$1,000 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.caremark.com">www.caremark.com</a>	Generic drugs	\$8 <u>copay</u> (retail)/ \$16 <u>copay</u> (CVS or mail order)	50% <u>coinsurance</u> (retail)	<u>Deductible</u> does not apply to participating <u>providers</u> . Covers up to a 30-day supply or 100-unit dose, whichever is greater (retail prescription); 90-day supply (CVS or mail order prescription). The <u>copay</u> applies per prescription. There is no charge or <u>deductible</u> for preventive drugs. After 2 fills, maintenance drugs must be purchased as a 90-day supply and must be purchased at either a CVS retail pharmacy or mail order program. Value Formulary Program with step therapy applies. *A formulary exception is required and the non- <u>formulary</u> drug must be <u>medically necessary</u> . <u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.
	<u>Formulary</u> brand drugs	\$30 <u>copay</u> (retail)/ \$60 <u>copay</u> (CVS or mail order)	50% <u>coinsurance</u> (retail)	
	Non- <u>formulary</u> brand drugs	\$30 <u>copay</u> * (retail)/ \$60 <u>copay</u> * (CVS or mail order)	50% <u>coinsurance</u> (retail)	
	<u>Specialty</u> drugs	Paid the same as generic, <u>Formulary</u> and non- <u>formulary</u> drugs	50% <u>coinsurance</u> (retail)	

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 have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	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 20% up to \$1,000 of the total cost of the service. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> /visit, then 20% <u>coinsurance</u>	\$150 <u>copay</u> /visit, then 20% <u>coinsurance</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>	50% <u>coinsurance</u>	-----none-----
	<u>Urgent care</u>	\$75 <u>copay</u> /visit	50% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	\$500 <u>copay</u> /admission, then 50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% up to \$1,000 of the total cost of the service.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <u>copay</u> /visit	50% <u>coinsurance</u>	-----none-----
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% up to \$1,000 of the total cost of the service.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	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 20% up to \$1,000 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 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>	\$500 <u>copay</u> /admission, then 50% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 180 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% up to \$1,000 of the total cost of the service.
	<u>Rehabilitation services</u>	\$50 <u>copay</u> /visit	50% <u>coinsurance</u>	Includes physical, speech & occupational therapy.

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>	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 120 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% up to \$1,000 of the total cost of the service.
	<u>Durable medical equipment</u>	20% <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 20% up to \$1,000 of the total cost of the service.
	<u>Hospice services</u>	20% <u>coinsurance</u> ( <u>hospice services</u> ) / 50% <u>coinsurance</u> (bereavement counseling)	50% <u>coinsurance</u> ( <u>hospice services</u> ) / 50% <u>coinsurance</u> (bereavement counseling)	Bereavement counseling is covered if received within 6 months of death and is limited to 15 visits per family per lifetime.
<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.)

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|---|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> <li>• Glasses (Adult &amp; Child)</li> <li>• Habilitation services</li> <li>• Hearing aids</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• 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.)</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing (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> </ul> |
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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"> <li>• Bariatric surgery (for the treatment of morbid obesity only)</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Weight loss programs (for the treatment of morbid obesity only)</li> </ul> |
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**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 <https://www.dol.gov/ebsa/healthreform> or Center for Human Services, Inc. at (660) 827-2100. 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 <https://www.dol.gov/ebsa/healthreform> or Center for Human Services, Inc. at (660) 827-2100.

Additionally, a consumer assistance program can help you file your appeal. Contact the Missouri Department of Insurance at (800) 726-7390.

**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, kwijigo holne' 1-800-378-1179.

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*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 \$1,000
- Primary care physician copayment 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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$82
Coinsurance	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,622</b>

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

- The plan's overall deductible \$1,000
- Specialist copayment \$50
- 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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$938
Coinsurance	\$372
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,366</b>

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

- The plan's overall deductible \$1,000
- Specialist copayment \$50
- Hospital (facility) copayment \$150
- 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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$500
Coinsurance	\$229
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,729</b>