**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 (785) 889-4272. 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: |
|---|---|---|
| **What is the overall deductible?** | For Tier 1 providers:<br>$1,000 person / $2,000 family<br>For Tier 2 providers:<br>$2,000 person / $4,000 family<br>For Tier 3 providers:<br>$7,500 person / $15,000 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. For Tier 1 and Tier 2 providers: Preventive care (Tier 1 only), office visit charges, 1st $350 per year for routine lab/x-ray charges (Tier 1 only), outpatient mental health/substance abuse services, routine eye exam (all Tiers) and routine hearing exam (all Tiers) are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| **Are there other deductibles for specific services?** | Yes. $100 for prescription drug coverage. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For Tier 1 providers:<br>$2,000 person / $4,000 family<br>For Tier 2 providers:<br>$4,000 person / $8,000 family<br>For Tier 3 providers:<br>Unlimited | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, copays, preauthorization penalty amounts, balance-billing charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| | | |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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 |
|---|---|---|---|---|---|
| | | Tier 1 Core Providers (CHCS) | Tier 2 Participating Providers | Tier 3 Non-Participating Providers | |
| | | (You will pay the least) | (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 | $20 copay/visit (office visit)/20% coinsurance (all other services) | $40 copay/visit (office visit)/ 40% coinsurance (all other services) | 50% coinsurance | Copay applies to the physician office visit only. |
| | Specialist visit | $20 copay/visit (office visit)/20% coinsurance (all other services) | $40 copay/visit (office visit)/ 40% coinsurance (all other services) | 50% coinsurance | |
| | Preventive care/ screening/ immunization | $20 copay/visit (office visit)/ No charge 1st $350 routine lab/xray, then 20% coinsurance | Not Covered | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | 50% coinsurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization recommended. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Core Providers (CHCS) | Tier 2 Participating Providers | Tier 3 Non-Participating Providers | |
| | | (You will pay the least) | (You will pay the most) | | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.express-scripts.com | Generic drugs | 40% copay (retail & mail order) | | Not Covered | Prescription drug deductible applies. Covers up to a 90-day supply (retail & mail order prescription), 30-day supply (specialty drugs) . The copay applies per prescription. Dispense as Written (DAW) provision applies. Specialty drugs must be obtained directly from the specialty pharmacy. |
| | Formulary brand drugs | 40% copay (retail & mail order) | | Not Covered | |
| | Non-formulary brand drugs | 40% copay (retail & mail order) | | Not Covered | |
| | Specialty drugs | 40% copay (retail) | | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization recommended unless performed in an office setting. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $75 copay/visit, then 20% coinsurance | $100 copay/visit, then 40% coinsurance | $100 copay/visit, then 40% coinsurance | Tier 3 providers are paid at the Tier 2 provider level of benefits. Copay is waived if admitted to the hospital. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | 20% coinsurance | Tier 3 providers are paid at the Tier 2 provider level of benefits. |
| | Urgent care | 20% coinsurance | 40% coinsurance | 50% coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay/visit | $40 copay/visit | 50% coinsurance | ----------none---------- |
| | Inpatient services | 20% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Core Providers (CHCS) | Tier 2 Participating Providers | Tier 3 Non-Participating Providers | |
| | | (You will pay the least) | (You will pay the most) | | |
| **If you are pregnant** | Office visits | $20 copay/visit | $40 copay/visit | 50% coinsurance | Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. 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% coinsurance | 40% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization recommended. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | 50% coinsurance | Includes physical, speech & occupational therapy. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | 50% coinsurance | ----------none---------- |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization recommended for any item in excess of $1,500. |
| | Hospice services | No Charge | No Charge | Not Covered | Bereavement counseling is covered if received within 6 months of death. Preauthorization recommended. |
| **If your child needs dental or eye care** | Children's eye exam | 40% coinsurance | 40% coinsurance | 40% coinsurance | Limited to 1 exam per year. |
| | Children's glasses | Not Covered | Not Covered | Not Covered | Not Covered |
| | Children's dental check-up | Not Covered | 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<br>• Cosmetic surgery<br>• Dental care (Adult & Child) | • Glasses (Adult & Child)<br>• Long-term care | • Routine foot care (except for metabolic or peripheral vascular disease) |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • Bariatric surgery (for the treatment of morbid obesity only)<br>• Chiropractic care | • Hearing aids<br>• Infertility treatment<br>• Private-duty nursing | • Routine eye care (Adult & Child)<br>• 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 https://www.dol.gov/agencies/ebsa/healthreform or Community HealthCare System, Inc. (785) 889-4272. 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 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/agencies/ebsa /healthreform or Community HealthCare System, Inc. (785) 889-4272.

Additionally, a consumer assistance program can help you file your appeal. Contact the Kansas Insurance Department, Consumer Assistance Division at (800) 432-2484 (in state)/ (785) 296-7829.

**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, kwiijigo 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 Tier 1 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)*

| **Total Example Cost** | **$12,840** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $120 |
| Coinsurance | $880 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $2,060 |

### Managing Joe's Type 2 Diabetes
(a year of routine Tier 1 care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$1,000** |
| **Specialist copayment** | **$20** |
| **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** | **$7,460** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $855 |
| Copayments | $120 |
| Coinsurance | $1,025 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | $2,055 |

### Mia's Simple Fracture
(Tier 1 emergency room visit and follow-up care)

| | |
|---|---|
| **The plan's overall deductible** | **$1,000** |
| **Specialist coinsurance** | **20%** |
| **Hospital (facility) copayment** | **$75** |
| **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** | **$2,010** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $135 |
| Coinsurance | $272 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $1,407 |

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