



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 (610) 449-7795. 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> : \$1,700 person / \$3,400 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 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 <u>deductible</u>?</b>	Yes. For participating and non-participating <u>providers</u> : <u>Preventive care</u> and routine eye exams 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> : \$6,450 person / \$12,900 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>Copays</u> & <u>deductibles</u> for non-participating <u>providers</u> , 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 <u>network provider</u>?</b>	Yes. See <a href="http://www.aetna.com/docfind/custom/mymeritain">http://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> .
<b>Is a Health Savings Account (HSA) available under this <u>plan</u> 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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	No charge after <u>deductible</u>	50% <u>coinsurance</u>	Includes telemedicine.
	<u>Specialist</u> visit	No charge after <u>deductible</u>	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	50% <u>coinsurance</u>	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)	No charge after <u>deductible</u>	50% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge after <u>deductible</u>	50% <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 20% of the total cost of the service.
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	\$20 <u>copay</u> (retail)/ \$40 <u>copay</u> (mail order)	50% <u>coinsurance</u> (retail)	Major medical <u>deductible</u> applies. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription), 30-day supply ( <u>specialty drugs</u> ). The <u>copay</u> applies per prescription. There is no charge or <u>deductible</u> for preventive drugs. Mandatory generic provision applies. Certain drugs are subject to the Payer Matrix Program. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> . Certain <u>specialty drugs</u> are eligible for <u>copay</u> assistance programs through CVS True Accumulation Program. Effective April 1, 2026: Step therapy provision applies. <u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.
	<u>Formulary</u> drugs	\$40 <u>copay</u> (retail)/ \$80 <u>copay</u> (mail order)	50% <u>coinsurance</u> (retail)	
	Non- <u>Formulary</u> drugs	\$60 <u>copay</u> (retail)/ \$120 <u>copay</u> (mail order)	50% <u>coinsurance</u> (retail)	
	<u>Specialty drugs</u>	No charge after <u>deductible</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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after <u>deductible</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% of the total cost of the service.
	Physician/surgeon fees	No charge after <u>deductible</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</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>Emergency medical transportation</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u> ( <u>emergency services</u> )/50% <u>coinsurance</u> ( <u>non-emergency services</u> )	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> .
	<u>Urgent care</u>	No charge after <u>deductible</u>	50% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <u>deductible</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	No charge after <u>deductible</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after <u>deductible</u>	50% <u>coinsurance</u>	Includes telemedicine.
	Inpatient services	No charge after <u>deductible</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
If you are pregnant	Office visits	No charge after <u>deductible</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% 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>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge after <u>deductible</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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge after <u>deductible</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	<u>Rehabilitation services</u>	No charge after <u>deductible</u>	50% <u>coinsurance</u>	Physical & occupational therapy limited to a combined maximum of 30 visits per year. Speech/hearing therapy limited to 20 visits per year. Cardiac & pulmonary rehabilitation limited to 36 visits each per year. Day rehabilitation programs limited to 30 visits per year. Orthoptic/Pleoptic therapy limited to 8 visits per lifetime. Private duty nursing limited to 360 hours 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 <u>deductible</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% of the total cost of the service.
	<u>Durable medical equipment</u>	No charge after <u>deductible</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for any item in excess of \$1,500. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	<u>Hospice services</u>	No charge after <u>deductible</u>	50% <u>coinsurance</u>	Bereavement counseling is not covered. Respite care limited to 7 days per 6-month period.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	No Charge	Limited to 1 exam per 24 month period.
	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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|-------------------------------|--|---|
| • Acupuncture                 | • Glasses (Adult & Child)                  | • Non-emergency care when traveling outside the U.S.                      |
| • Bereavement counseling      | • Habilitation services                    | • Routine foot care (except for metabolic or peripheral vascular disease) |
| • Cosmetic surgery            | • Hearing aids                             | • Weight loss programs  |
| • Dental care (Adult & Child) | • Infertility treatment (except diagnosis) |   |
|                               | • Long-term care                           |   |

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

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|--|---|---|
| • Bariatric surgery (for morbid obesity only - 1 surgery per lifetime) | • Chiropractic care (20 visits per year)    | • Routine eye care (Adult & Child - 1 exam per 24 month period) |
|  | • Private-duty nursing (360 hours 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 Nolan Painting, Inc. at (610) 449-7795. 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 Nolan Painting, Inc. at (610) 449-7795.

### 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, kwiiijigo 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>	\$1,700
■ <u>Primary care physician coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>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*)

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

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,770</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>	\$1,700
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>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*)

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

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,220</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,700
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>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*)

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

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,710</b>

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