2023 Summary of Benefits & Coverage:
What this Plan covers and what it costs.

Coverage Period: 01/01/2023 – 12/31/2023
Coverage For: Individual, Family
Plan Type: PPO

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 (573) 635-6121. 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?	$500 person / $1,000 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 – preventative care is now covered at 100% prior to meeting any deductible limits.	You will have to meet the deductible before the plan pays for any other service.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers (In-Network): $1,500 individual/$3,000 family.	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, 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. Links for these resources are located in Self-Service under Myself/Benefits/Helpful Tools.	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 and Exceptions
		Participating Provider (You will pay the least)	Non-Participating Provider (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% coinsurance	30% coinsurance	---------------none-------------
	Specialist visit	20% coinsurance	30% coinsurance	
	Preventive care/screening/ immunization	100%	100%	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	---------------none-------------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.meritain.com	Generic drugs	20% coinsurance	20% coinsurance	Major medical deductible applies.
	Brand name drugs	20% coinsurance	20% coinsurance	
	Specialty drugs	20% coinsurance	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	---------------none-------------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	

If you need immediate medical attention	Emergency room care	$150 copay/visit, then 20% coinsurance	$100 copay/visit, then 30% coinsurance	----------------none--------------
	Emergency medical transportation	20% coinsurance	30% coinsurance	
	Urgent care	20% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	----------------none--------------
	Inpatient services	20% coinsurance	30% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service
If you are pregnant	Office visits	20% coinsurance	30% 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 $200 of the total cost of the service. 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 deductible amount may apply.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	

If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Limited to 100 visits per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
	Rehabilitation services	20% coinsurance	30% coinsurance	Includes physical, speech & occupational therapy.
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism.
	Skilled nursing care	20% coinsurance	30% coinsurance	Limited to 30 days per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
	Durable medical equipment	20% coinsurance	30% coinsurance	----------------none--------------
	Hospice services	20% coinsurance	30% coinsurance	Bereavement counseling is covered if received within 6 months of death.
If your child needs dental or eye care	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	Habilitation services	Non-emergency care while traveling outside the U.S.	Bariatric surgery	Hearing aids
Cosmetic surgery	Infertility treatment (except diagnosis)	Routine eye care (Adult & Child)	Dental care (Adult & Child)	Long-term care
Routine foot care (except for metabolic or peripheral vascular disease)	Glasses (Adult or Child)	Weight loss programs		

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)	
Chiropractic care	Private-duty nursing

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 DeLong's, Inc. at (573) 635-6121. 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 DeLong's, Inc. at (573) 635-6121.
Additionally, a consumer assistance program can help you file your appeal. Contact the Missouri Department of Insurance at (800) 726-7390.

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 in-network pre-natal care and a hospital delivery)		**Managing Joe's Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
▪ The plan's overall deductible	$500	▪ The plan's overall deductible	$500	The plan's overall deductible	$500
▪ Primary care physician coinsurance	20%	▪ Specialist coinsurance	20%	Specialist coinsurance	20%
▪ Hospital (facility) coinsurance	20%	▪ Hospital (facility) coinsurance	20%	Hospital (facility) coinsurance	20%
▪ Other coinsurance	20%	▪ Other coinsurance	20%	Other coinsurance	20%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Primary care physician visits *(prenatal care)*		Specialist office visits *(including disease education)*		Emergency room care *(including medical supplies)*	
Childbirth/Delivery Professional Services				Diagnostic tests *(x-ray)*	
Childbirth/Delivery Facility Services		Diagnostic tests *(bloodwork)*		Durable medical equipment *(crutches)*	
Diagnostic tests *(ultrasounds and bloodwork)*		Prescription drugs		Rehabilitation services *(physical therapy)*	
Specialist visit *(anesthesia)*		Durable medical equipment *(glucose meter)*			
Total Example Cost	**$12,840**	**Total Example Cost**	**$7,460**	**Total Example Cost**	**$2,010**
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$500	Deductibles	$500	Deductibles	$500
Copayments	$0	Copayments	$0	Copayments	$150
Coinsurance (20% of remaining charges up to a max of $900)	$1,000	Coinsurance (20% of remaining charges up to a max of $900)	$1,000	Coinsurance (20% of remaining charges up to a max of $900)	$302
What is not covered		*What is not covered*		*What is not covered*	
Limits or exclusions	$60	Limits or exclusions	$55	Limits or exclusions	$0
Total Peg would pay	$1,560	Total Joe would pay	$1,555	Total Mia would pay	$952
Total the Plan would pay	$11,280	Total the Plan would pay	$5,905	Total the Plan would pay	$1,058
Plan pays **87.85%** of total	Peg pays **12.15%** of total	Plan pays **79.16%** of total	Joe pays **20.84%** of total	Plan pays **52.64%** of total	Mia pays **47.36%** of total

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