**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, call (800) 252-9653. 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 com or call 1-800-318-2596 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **Care Navigation Services:** $1,750/Individual; $3,500/Family<br>**All Other Services:** $3,500/Individual; $7,000/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 the deductible expenses paid by all family members meets the overall family deductible.<br>Care Navigation Services deductible amounts apply to the overall plan deductible. |
| **Are there services covered before you meet your deductible?** | Yes, preventive care is covered before the deductible is met. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **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?** | **Medical Benefits:** $3,500/Individual; $7,000/Family<br>**Prescription Drug Benefits:** $1,350/Individual; $2,700/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, balance-billing charges, penalties, prescription drug expenses (out-of-pocket limits, copays, discounts, coupons, etc.), excess 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/asa or call 1-800-252-9653 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 |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | | 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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network 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 | 0% coinsurance, after deductible. | | Your plan includes telemedicine services at no cost. Contact Teladoc at 1-800 Teladoc (835-2362). |
| | Specialist visit | 0% coinsurance, after deductible. | | None. |
| | Preventive care/screening/ immunization | No charge. | | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% coinsurance, after deductible. | | None. |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance, after deductible. | | None. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.mysmithrx.com or call (844) 454-5201. | Generic drugs | **1-30 Day Supply (retail or mail order):** $30 copay/drug. | **1-30 Day Supply:** 50% coinsurance, after deductible. | Copays apply after the medical deductible is met. Prescriptions filled at non-participating pharmacies are limited to 30 days. |
| | | **31-90 Day Supply (retail or mail order):** $60 copay/drug. | | |

*For more information about limitations and exceptions, see the plan or policy document at https://www.mcun.coop/members/health-benefit-trust/.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Preferred brand drugs | **1-30 Day Supply (retail or mail order):** $40 copay/drug.<br>**31-90 Day Supply (retail or mail order):** $80 copay/drug. | **1-30 Day Supply:** 50% coinsurance, after deductible. | Dispense as written penalty: If a brand name drug is requested by the covered person instead of a generic drug (and a generic is available), the covered person will be responsible for the difference in cost (between generic and applicable brand name drug) in additional to the applicable brand name drug copayment.<br><br>Prescriptions filled at non-participating pharmacies are limited to 30 days. |
| | Non-preferred brand drugs | **1-30 Day Supply (retail or mail order):** $70 copay/drug.<br>**31-90 Day Supply (retail or mail order):** $140 copay/drug. | **1-30 Day Supply:** 50% coinsurance, after deductible. | |
| | Specialty drugs | $250 copay/drug. | Not covered. | Limited to a 30-day supply & requires purchase through the specialty pharmacy program. Only first fill will be eligible through a retail pharmacy. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance, after deductible. | | Pre-certification is required prior to service. |
| | Physician/surgeon fees | 0% coinsurance, after deductible. | | None. |
| **If you need immediate medical attention** | Emergency room care | 0% coinsurance, after deductible. | | Pre-certification is required within two days of an inpatient admission from the Emergency Room. |
| | Emergency medical transportation | 0% coinsurance, after deductible. | | None. |
| | Urgent care | 0% coinsurance, after deductible. | | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance, after deductible. | | Pre-certification is required prior to service. |
| | Physician/surgeon fees | 0% coinsurance, after deductible. | | None. |
| **If you need mental health, behavioral** | Outpatient services | 0% coinsurance, after deductible. | | Your plan includes telemedicine services with a $0 consultation fee. Contact Teladoc at 1-800 Teladoc (835-2362). |

*For more information about limitations and exceptions, see the plan or policy document at https://www.mcun.coop/members/health-benefit-trust/.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **health, or substance abuse services** | Inpatient services | 0% coinsurance, after deductible. | | Pre-certification is required prior to service. |
| **If you are pregnant** | Office visits | 0% coinsurance, after deductible. | | Cost sharing does not apply to preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 0% coinsurance, after deductible. | | None. |
| | Childbirth/delivery facility services | 0% coinsurance, after deductible. | | Pre-certification of a routine maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required. |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance, after deductible. | | Pre-certification is required prior to service. Limited to 180 visits per calendar year. |
| | Rehabilitation services | 0% coinsurance, after deductible. | | Inpatient rehabilitation therapy is limited to 30 days per calendar year. Alternative care includes acupuncture, acupressure, massage therapy and spinal manipulation/chiropractic services are covered up to $750 per calendar year combined. |
| | Habilitation services | 0% coinsurance, after deductible. | | None. |
| | Skilled nursing care | 0% coinsurance, after deductible. | | Pre-certification is required prior to service. Limited to 60 days per calendar year. |
| | Durable medical equipment | 0% coinsurance, after deductible. | | Pre-certification is required for DME over $2,000. |
| | Hospice services | 0% coinsurance, after deductible. | | Pre-certification is required prior to service. Limited to 6 months per 3 calendar years. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered. | | Vision may be available as a separate election. |
| | Children's glasses | Not covered. | | Vision may be available as a separate election. |
| | Children's dental check-up | No charge. | | Limited to 2 exams and cleanings per |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | calendar year for covered persons up to age 19. |

**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.)**

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture (Limited to $750 per calendar year combined with acupressure, massage therapy & spinal manipulation/chiropractic care)
- Chiropractic care (Limited to $750 per calendar year combined with acupuncture, acupressure, & massage therapy)
- Routine foot care (Limited to 1 pair custom foot orthotics per calendar year. This includes impression casting for orthotic appliances, padding, strapping & fabrication)

**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: Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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: (888) 653-3508 or the Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform..

**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 (800) 252-9653.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 252-9653.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 252-9653.

*For more information about limitations and exceptions, see the plan or policy document at https://www.mcun.coop/members/health-benefit-trust/.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 252-9653.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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** **$3,500**
- **Primary care physician coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

**This EXAMPLE event includes services like:**
Primary care physician office 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** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $3,500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,500** |

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

- **The plan's overall deductible** **$3,500**
- **Primary care physician coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $3,500 |
| Copayments | $320 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$3,820** |

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

- **The plan's overall deductible** **$3,500**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

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