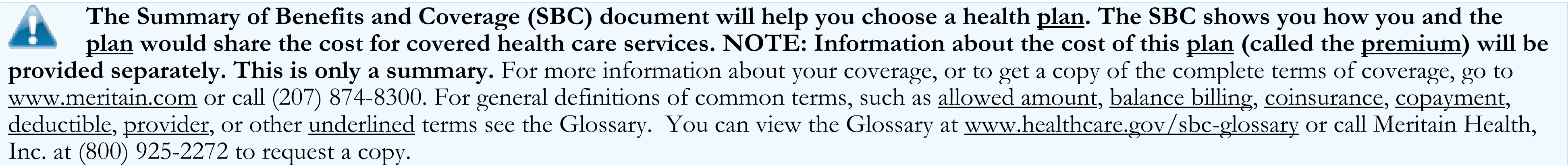

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.meritain.com or call (207) 874-8300. 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 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: $400 person / $800 family For Tier 2 and Tier 3 providers: $1,000 person / $2,000 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, emergency room care – emergency services only (all providers), urgent care – office visit charges, hospice services, prenatal care, outpatient mental health and substance abuse services, rehabilitation services, habilitation services, routine eye exams, primary care provider (Tier 1 providers only) and specialist services 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. 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 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?	For Tier 1 providers: $1,500 person / $3,000 family For Tier 2 and Tier 3 providers: $2,500 person / $5,000 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. https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=directlinknologin&planValue=STMMC|Value_Based_Health_Plan 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: Tier 1 Designated Providers (You will pay the least)	Tier 2 Non-Designated Participating Providers (You will pay the most)	Tier 3 Non-Participating Providers	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	30% coinsurance	30% coinsurance	Includes telemedicine other than Teladoc. There is no charge and the deductible does not apply if you receive consultation services through Teladoc.
	Specialist visit	$20 copay/visit (deductible does not apply)	$20 copay/visit (deductible does not apply)	30% coinsurance	Copay applies per visit regardless of what services are rendered (includes telemedicine other than Teladoc). There is no charge and the deductible does not apply if you receive consultation services through Teladoc.
	Preventive care/ screening/ immunization	No Charge	No Charge	30% coinsurance	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)	10% coinsurance	10% coinsurance	30% coinsurance	----------------none----------------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	30% coinsurance	Preauthorization required for PET scans and non-orthopedic CT/MRI's. If you don't get preauthorization, benefits could be reduced by $500 per occurrence of the total cost of the service for Tier 3 providers only.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 copay (30-day retail)/$15 copay (90-day retail & mail order)		$10 copay (30-day retail)/$15 copay (90-day retail)	Deductible does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (specialty drugs). The copay applies per prescription. There is no charge for preventive drugs. Step therapy provision applies. See plan document for coverage of certain maintenance drugs dispensed at a retail pharmacy or through the mail order program.
	Preferred brand drugs	$30 copay (30-day retail)/$45 copay (90-day retail & mail order)		$30 copay (30-day retail)/$45 copay (90-day retail)	
	Non-preferred brand drugs	$60 copay (30-day retail)/$90 copay (90-day retail & mail order)		$60 copay (30-day retail)/$90 copay (90-day retail)	

Common Medical Event	Services You May Need	What You Will Pay: Tier 1 Designated Providers (You will pay the least)	Tier 2 Non-Designated Participating Providers (You will pay the most)	Tier 3 Non-Participating Providers	Limitations, Exceptions, & Other Important Information
	Specialty drugs	Paid the same as generic, preferred brand and non-preferred brand drugs (retail)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	30% coinsurance	Tier 2 providers are paid at the Tier 1 provider level of benefits. Preauthorization required for certain surgeries. If you don't get preauthorization, benefits could be reduced by $500 per occurrence of the total cost of the service for Tier 3 providers only. See plan document for coverage of certain surgeon professional fees.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay/visit (emergency services/Not Covered (non- emergency services)	$100 copay/visit (emergency services/Not Covered (non-emergency services)	$100 copay/visit (emergency services/Not Covered (non-emergency services)	Tier 2/Tier 3 providers are paid at the Tier 1 provider level of benefits for emergency services. Copay is waived if admitted to the hospital.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	Tier 2/Tier 3 providers are paid at the Tier 1 provider level of benefits.
	Urgent care	$20 copay/visit (office visit)/10% coinsurance (all other services)	$20 copay/visit (office visit)/10% coinsurance (all other services)	30% coinsurance	Copay applies to the physician office visit only.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	30% coinsurance	Tier 2 providers are paid at the Tier 1 provider level of benefits. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence of the total cost of the service for Tier 3 providers only. See plan document for coverage of certain surgeon professional fees.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	No Charge	No Charge (mental health)/ 30% coinsurance (substance abuse)	Tier 2/Tier 3 mental health providers are paid at the Tier 1 provider level of benefits. Includes telemedicine other than Teladoc. Includes Teladoc behavioral health consultations.

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Designated Providers (You will pay the least)	Tier 2 Non-Designated Participating Providers (You will pay the most)	Tier 3 Non-Participating Providers	Limitations, Exceptions, & Other Important Information
	Inpatient services	10% coinsurance	10% coinsurance	30% coinsurance	Tier 2 providers are paid at the Tier 1 provider level of benefits. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence of the total cost of the service for Tier 3 providers only.
If you are pregnant	Office visits	No Charge (prenatal visits)/10% coinsurance (postnatal visits)	No Charge (prenatal visits)/10% coinsurance (postnatal visits)	30% coinsurance	Tier 2 providers are paid at the Tier 1 provider level of benefits for facility and professional services. 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 per occurrence of the total cost of the service for Tier 3 providers only. Cost sharing does not apply to preventive services from a Tier 1/Tier 2 provider. 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	10% coinsurance	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	30% coinsurance	Tier 2 providers are paid at the Tier 1 provider level of benefits. Limited to 90 visits per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence of the total cost of the service for Tier 3 providers only.
	Rehabilitation services	$10 copay/visit	$10 copay/visit	30% coinsurance	Tier 2 providers are paid at the Tier 1 provider level of benefits. A medical necessity review will need to be completed after the 25th visit per year for physical, speech & occupational therapy. You pay a $10 copay (deductible waived) for massage therapy and is limited to 12 visits per year up to an $70 maximum.

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Designated Providers (You will pay the least)	Tier 2 Non-Designated Participating Providers (You will pay the most)	Tier 3 Non-Participating Providers	Limitations, Exceptions, & Other Important Information
	Habilitation services	$10 copay/visit	$10 copay/visit	30% coinsurance	----------------none----------------
	Skilled nursing care	10% coinsurance	10% coinsurance	30% coinsurance	Tier 2 providers are paid at the Tier 1 provider level of benefits. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence of the total cost of the service for Tier 3 providers only.
	Durable medical equipment	10% coinsurance	10% coinsurance	30% coinsurance	Tier 2 providers are paid at the Tier 1 provider level of benefits. Preauthorization required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you don't get preauthorization, benefits could be reduced by $500 per occurrence of the total cost of the service for Tier 3 providers only.
	Hospice services	No Charge	No Charge	30% coinsurance	Bereavement counseling is covered.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	30% coinsurance	Limited to 1 exam every 2 years.
	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.)

- **Cosmetic surgery**
- **Dental care (Adult & Child)**
- **Emergency room services for non-emergency services**
- **Glasses (Adult & Child)**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing (except for home health care & hospice)**
- **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.)		
• Acupuncture ($70 per visit; 12 visits per year) • Bariatric surgery (for morbid obesity only - 1 surgical procedure per lifetime) • Chiropractic care (25 visits per year)	• Hearing aids ($6,000 every 36 months) • Infertility treatment ($20,000 per lifetime - comprehensive and advanced reproductive technology procedures combined)	• Massage Therapy ($70 per visit; 12 visits per year) • Routine eye care (Adult & Child – 1 exam every 2 years) • Weight loss programs (for 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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at (877) 267-2323 x 61565 or www.cciio.cms.gov or City of Portland, Maine at (207) 874-8300. 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 City of Portland, Maine at (207) 874-8300 or Meritain Health, Inc. at (800) 925-2272.

Additionally, a consumer assistance program can help you file your appeal. Contact the Bureau of Insurance State of Maine Consumer Service Division at (800) 965-7476.

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, 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** $400
- **Primary care physician coinsurance** 0%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,470

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

- **The plan's overall deductible** **$400**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$600
Coinsurance	$50
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,070

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

- **The plan's overall deductible** **$400**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$100**
- **Other coinsurance** **10%**

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	$400
Copayments	$200
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$690

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