



MERITAIN[®]
HEALTH

An Aetna Company

A Quick Look at Your Health Plan

Children's Home of Bradford PA, dba Journey Health Systems

Group #AF027

When you enroll with Meritain Health[®], you're taking the next step towards a healthier, more balanced you.

It's important for you to understand how your health plan works. This way, you can make the changes you want in your health and in your life.

Get the support you need for a healthy balance

Chances are, you try every day to keep a healthy balance in your life. But time can get away from you, or you might put other details first. That's why we're here: to help you focus and to support you each step of the way. You can think of your health care benefits as your resource to protect your body, mind and spirit.

www.meritain.com

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Benefit Highlights

Protecting your healthy balance with preventive care



Question:

Which is better: Taking an hour or two out of your busy day to have your annual checkup—or missing hidden symptoms and paying the price in sick days, copays and missed events?



Answer:

Nothing makes more sense in these busy times than preventing illness before it happens. That's why your plan offers excellent benefits for preventive services.

Early detection, proper nutrition, and routine exercise are the keys to living a long and healthy life, and will also help to control long-term health care costs. Your employer encourages you to take the necessary steps—available to you right now—to ensure early detection and treatment of diseases.



Built into your health plan are preventive benefits that cover:

- Well-child care.
- Physical exams.
- Mammogram.
- Bone density test.
- Prostate blood exam.
- Pap smear.
- Fecal occult screening.

Save when you visit network providers

This plan offers a network of doctors and other health care professionals who have agreed to accept lower amounts than their standard charges, just for members of this plan. These lower amounts are negotiated and predetermined. That means when you see a network provider, your share of costs is based on a lower charge—so your costs are lower, too. Network providers are conveniently located in both urban and rural areas. Lower costs and convenient doctors and clinics are important ways that Meritain Health can support your efforts to stay well and have a healthy lifestyle—or to get care as simply as possible when you're sick.

Remember: if you go outside the network, you may still have benefits, but your share of costs will be higher, and the amount you pay will not be based on a lower rate.



Benefit Highlights

A prescription for a healthier budget

Your prescription drug benefit is administered by **Meritain Health Pharmacy Solutions**. To get the most from your benefits plan, it pays to be a wise consumer.

Generics make sense—and dollars

You can save yourself money on your prescriptions by choosing generic versions of medications, when possible. Check with your prescribing physician to see if a generic version exists. Generic equivalents go through rigorous FDA testing regularly to assure that they are just as effective as the brand-name drugs. They are a safe, smart option.

Easy on your time: Three ways to get your prescription drugs

Your plan is designed with your time in mind. Depending on the nature of your prescription, you can have your prescriptions filled at a participating pharmacy, by mail or online.

Fill prescriptions for 30 days or less at a pharmacy in your PBM network. Just show the pharmacist your Meritain Health ID card and pay your copay at the time of your purchase.

If you have a chronic condition and you take medication for it for long periods of time, you can have it filled by mail or online. Ask your doctor for 2 prescriptions—one for 30 days and one for 90 days. Fill the 30-day prescription at a network pharmacy, to use while waiting for your 90-day prescription to arrive. To use the mail order service, complete a mail order form and send it, along with the original 90-day prescription signed by your doctor and your copay, to the address on the form.

You can also fill 90-day prescriptions online at **www.meritain.com**. Send (or ask your doctor to send) the 90-day prescription to the address shown on the website. Simply use a credit card to pay your copay.

Certain drugs must be approved

If your prescription is for a very expensive drug, or one that can be easily abused, prior authorization may be required. For more information, see your Plan Document or contact Meritain Health Pharmacy Solutions customer service at **1.866.475.7589**.

Support for your health journey

Your employer wants you to get the best, most appropriate care, when and where you need it. That's why your plan includes the extra expertise of **Meritain Health's Medical Management program**. The Medical Management nurses are like personal health consultants who can help you make decisions about certain types of care you and your doctor may be considering. Registered nurses review treatment plans, then help to assure that you get the right treatment in the right setting, when you need it.

Some of these services include:

- Before admission to the hospital for elective or non-emergency services.
- Within 48 hours (two working days) after an emergency or urgent hospital admission.
- Before elective inpatient, outpatient or ambulatory surgery.
- Before inpatient substance-abuse treatment or treatment for a mental health disorder.
- Before entering an extended-care, rehabilitation or skilled-nursing facility.

Consult your Summary Plan Description for a complete listing of health care services that require precertification with a medical management nurse.

Benefit Highlights

Nationwide provider access at a discount

When you and your family seek health care services, you have access to Aetna's broad national provider network of health care providers and facilities. Aetna's network contains more than 664,000 participating physicians and ancillary providers, with 5,667 hospitals.¹ When you visit providers in the Aetna network, you will receive services at strong, negotiated rates, helping you to save on the cost of health care.

¹ <https://www.aetna.com/about-us/aetna-facts-and-subsidiaries/aetna-facts.html>


Locate your preferred providers

With Aetna's comprehensive provider participation, many of your preferred doctors may already be in the Aetna network. To verify whether or not a doctor or health care facility participates, visit <http://www.aetna.com/docfind/custom/mymeritain/>.



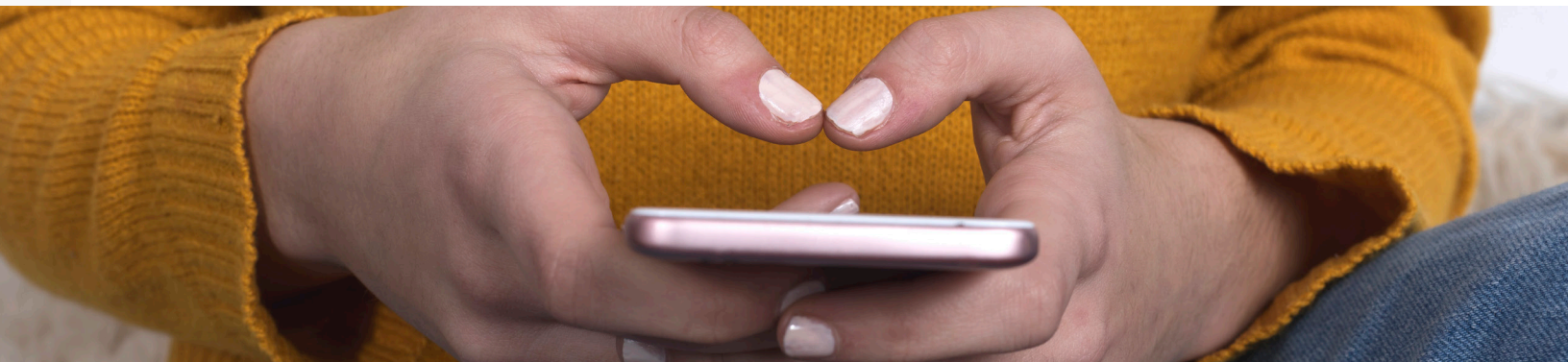
How to access your mobile web app

iPhone®

- Once you log in to your member portal through www.meritain.com, click the  icon at the bottom of the page.
- Then, scroll through the menu options and select *Add to Home Screen*.
- Click *Add* in the upper right-hand corner.
- Your Meritain Health app logo will then be installed and added to your home screen.
- Then, you'll be able to log in through the app instead of going through the web page.

Android™

- Once you log in to your member portal through www.meritain.com, you'll be prompted with the pop-up message *Add Meritain Health to Home Screen* at the bottom of the page. Click this message.
- Then, you can click *Add* to add the logo to the home page or *Cancel* to opt-out.
- Your Meritain Health app logo will then be installed and added to your home screen.
- Launch the app from your home screen and log in.



Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Providers are independent contractors and are not agents of Meritain Health. Provider participation may change without notice. Meritain Health and Aetna do not provide care or guarantee access to health services.

MEDICAL SCHEDULE OF BENEFITS: \$500 PLAN

\$500 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN YEAR DEDUCTIBLE		
Single	\$500	\$3,000
Family	\$1,000	\$6,000
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Coinsurance)		
Single	N/A	\$2,000
Family	N/A	\$4,000
TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	\$8,150	Unlimited
Family	\$16,300	Unlimited
MEDICAL BENEFITS		
Ambulance Services	100% after Deductible	Paid at the Participating Provider level of benefits
Chiropractic Care/Spinal Manipulation	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	100% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	100% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	100% after Deductible	50% after Deductible
Emergency Services/Emergency Room Services	\$200 Copay, then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Foot Orthotics	100% after Deductible	50% after Deductible
Plan Year Maximum Benefit	1 orthotic per foot	
NOTE: Plan Year maximum does not apply to foot orthotics for diabetes.		
Home Health Care	100% after Deductible	50% after Deductible
Hospice Care	100% after Deductible	50% after Deductible

\$500 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	100% after Deductible	50% after Deductible
Room and Board Allowance	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	100% after Deductible	50% after Deductible
Outpatient	100% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	100% after Deductible	50% after Deductible
Outpatient (includes Telemedicine)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Morbid Obesity	Paid based on place of service	Paid based on place of service
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Supplements	100%; Deductible waived	50% after Deductible
Occupational Therapy (Outpatient) (OT)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Physical Therapy (Outpatient) (PT)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Physician's Services		
Inpatient/Outpatient Services	100% after Deductible	50% after Deductible
Office Visit Charge & Telemedicine	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During an Office Visit	100% after Deductible	50% after Deductible
Physician Office Surgery	100% after Deductible	50% after Deductible
NOTE: The Copay will be waived for services rendered at OB-GYN Associates of Erie, P.C. (TIN 25-1653555) and Primary Care Associates of Erie (TIN 25-1653555).		

\$500 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	50% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	50% after Deductible
Private Duty Nursing	100% after Deductible	Paid at the Participating Provider level of benefits
Plan Year Maximum Benefit	240 hours	
Regenexx Stem Cell Treatment (received by Regenexx Corporate Provider Network only)	100%; Deductible waived	N/A
Respiratory/Pulmonary Therapy	100% after Deductible	Paid at the Participating Provider level of benefits
Plan Year Maximum Benefit	20 visits	
Retail Clinic		
Retail Clinic Visit	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During a Visit	100% after Deductible	50% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	100% after Deductible	50% after Deductible
Combined Plan Year Maximum Benefit	N/A	100 days
Speech Therapy (Outpatient) (ST)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Transplants	100% after Deductible (Aetna IOE Program)* 50% after Deductible (All Other Network Providers)	50% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other illness.		
Urgent Care Facility		
Facility Visit Charge	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During a Visit	100% after Deductible	50% after Deductible
Wig (see Eligible Medical Expenses)	100% after Deductible	50% after Deductible
Maximum Benefit	\$500 per course of treatment	
All Other Eligible Medical Expenses	100% after Deductible	50% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: \$500 PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket)	
Single	\$8,150
Family	\$16,300
Retail Pharmacy: 30-day supply	
Generic Drug	\$15 Copay
Formulary Drug	\$30 Copay
Non-Formulary Drug	\$50 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
Mandatory Specialty Pharmacy Program: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through the PrudentRx Copay Program	
Generic Drug	\$15 Copay
Formulary Drug	\$30 Copay
Non-Formulary Drug	\$50 Copay
Enrolled and Available in the PrudentRx Copay Program	\$0 Copay
Not Enrolled and Available in the PrudentRx Copay Program	30% Copay
NOTE: Specialty drugs MUST be obtained directly from the Specialty Pharmacy Program. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
NOTE: The PrudentRx Copay Program assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Co-Pay Program.	
CVS Maintenance Choice Voluntary: 90-day supply	
Generic Drug	\$30 Copay
Formulary Drug	\$60 Copay
Non-Formulary Drug	\$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply	
Generic Drug	\$30 Copay
Formulary Drug	\$60 Copay
Non-Formulary Drug	\$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)

CVS Maintenance Choice Voluntary

This Plan allows for purchase of a 30-day supply of maintenance drugs at any retail pharmacy. A 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy only or through the mail order program. For additional information, please contact the Prescription Drug Card Program Administrator.

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Advanced Control Specialty Formulary

Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

CVS True Accumulation Program

Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out-of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

PrudentRx Copay Program for Specialty Medications

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Copay Program will assist individuals in obtaining copay assistance from drug manufacturers to reduce an individual's cost share for eligible medications thereby reducing out-of-pocket expenses.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible persons will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call (800) 578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications, in that case, you must speak to someone at PrudentRx at (800) 578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take.

If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copays for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your Deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copay assistance program, do not count towards your Out-of-Pocket Maximum. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

Mandatory Specialty Pharmacy Program

Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

MEDICAL SCHEDULE OF BENEFITS: \$750 PLAN

\$750 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN YEAR DEDUCTIBLE		
Single	\$750	\$3,000
Family	\$1,500	\$6,000
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Coinsurance)		
Single	N/A	\$2,000
Family	N/A	\$4,000
TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	\$8,150	Unlimited
Family	\$16,300	Unlimited
MEDICAL BENEFITS		
Ambulance Services	100% after Deductible	Paid at the Participating Provider level of benefits
Chiropractic Care/Spinal Manipulation	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	100% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	100% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	100% after Deductible	50% after Deductible
Emergency Services/Emergency Room Services	\$200 Copay, then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Foot Orthotics	100% after Deductible	50% after Deductible
Plan Year Maximum Benefit	1 orthotic per foot	
NOTE: Plan Year maximum does not apply to foot orthotics for diabetes.		
Home Health Care	100% after Deductible	50% after Deductible
Hospice Care	100% after Deductible	50% after Deductible

\$750 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	100% after Deductible	50% after Deductible
Room and Board Allowance	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	100% after Deductible	50% after Deductible
Outpatient	100% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	100% after Deductible	50% after Deductible
Outpatient (includes Telemedicine)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Morbid Obesity	Paid based on place of service	Paid based on place of service
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Supplements	100%; Deductible waived	50% after Deductible
Occupational Therapy (Outpatient) (OT)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Physical Therapy (Outpatient) (PT)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Physician's Services		
Inpatient/Outpatient Services	100% after Deductible	50% after Deductible
Office Visit Charge & Telemedicine	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During an Office Visit	100% after Deductible	50% after Deductible
Physician Office Surgery	100% after Deductible	50% after Deductible
NOTE: The Copay will be waived for services rendered at OB-GYN Associates of Erie, P.C. (TIN 25-1653555) and Primary Care Associates of Erie (TIN 25-1653555).		

\$750 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	50% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	50% after Deductible
Private Duty Nursing	100% after Deductible	Paid at the Participating Provider level of benefits
Plan Year Maximum Benefit	240 hours	
Regenexx Stem Cell Treatment (received by Regenexx Corporate Provider Network only)	100%; Deductible waived	N/A
Respiratory/Pulmonary Therapy	100% after Deductible	Paid at the Participating Provider level of benefits
Plan Year Maximum Benefit	20 visits	
Retail Clinic		
Retail Clinic Visit	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During a Visit	100% after Deductible	50% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	100% after Deductible	50% after Deductible
Combined Plan Year Maximum Benefit	N/A	100 days
Speech Therapy (Outpatient) (ST)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Transplants	100% after Deductible (Aetna IOE Program)* 50% after Deductible (All Other Network Providers)	50% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other illness.		
Urgent Care Facility		
Facility Visit Charge	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During a Visit	100% after Deductible	50% after Deductible
Wig (see Eligible Medical Expenses)	100% after Deductible	50% after Deductible
Maximum Benefit	\$500 per course of treatment	
All Other Eligible Medical Expenses	100% after Deductible	50% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: \$750 PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket)	
Single	\$8,150
Family	\$16,300
Retail Pharmacy: 30-day supply	
Generic Drug	\$15 Copay
Formulary Drug	\$30 Copay
Non-Formulary Drug	\$50 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
Mandatory Specialty Pharmacy Program: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through the PrudentRx Copay Program	
Generic Drug	\$15 Copay
Formulary Drug	\$30 Copay
Non-Formulary Drug	\$50 Copay
Enrolled and Available in the PrudentRx Copay Program	\$0 Copay
Not Enrolled and Available in the PrudentRx Copay Program	30% Copay
NOTE: Specialty drugs MUST be obtained directly from the Specialty Pharmacy Program. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
NOTE: The PrudentRx Copay Program assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Co-Pay Program.	
CVS Maintenance Choice Voluntary: 90-day supply	
Generic Drug	\$30 Copay
Formulary Drug	\$60 Copay
Non-Formulary Drug	\$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply	
Generic Drug	\$30 Copay
Formulary Drug	\$60 Copay
Non-Formulary Drug	\$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)

CVS Maintenance Choice Voluntary

This Plan allows for purchase of a 30-day supply of maintenance drugs at any retail pharmacy. A 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy only or through the mail order program. For additional information, please contact the Prescription Drug Card Program Administrator.

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Advanced Control Specialty Formulary

Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

CVS True Accumulation Program

Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out-of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

PrudentRx Copay Program for Specialty Medications

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Copay Program will assist individuals in obtaining copay assistance from drug manufacturers to reduce an individual's cost share for eligible medications thereby reducing out-of-pocket expenses.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible persons will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call (800) 578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications, in that case, you must speak to someone at PrudentRx at (800) 578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take.

If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copays for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your Deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copay assistance program, do not count towards your Out-of-Pocket Maximum. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

Mandatory Specialty Pharmacy Program

Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

MEDICAL SCHEDULE OF BENEFITS: \$1,500 PLAN

\$1,500 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN YEAR DEDUCTIBLE		
Single	\$1,500	\$3,000
Family	\$3,000	\$6,000
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Coinsurance)		
Single	N/A	\$2,000
Family	N/A	\$4,000
TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	\$8,150	Unlimited
Family	\$16,300	Unlimited
MEDICAL BENEFITS		
Ambulance Services	100% after Deductible	Paid at the Participating Provider level of benefits
Chiropractic Care/Spinal Manipulation	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	100% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	100% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	100% after Deductible	50% after Deductible
Emergency Services/Emergency Room Services	\$200 Copay, then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Foot Orthotics	100% after Deductible	50% after Deductible
Plan Year Maximum Benefit	1 orthotic per foot	
NOTE: Plan Year maximum does not apply to foot orthotics for diabetes.		
Home Health Care	100% after Deductible	50% after Deductible
Hospice Care	100% after Deductible	50% after Deductible

\$1,500 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	100% after Deductible	50% after Deductible
Room and Board Allowance	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	100% after Deductible	50% after Deductible
Outpatient	100% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	100% after Deductible	50% after Deductible
Outpatient (includes Telemedicine)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Morbid Obesity	Paid based on place of service	Paid based on place of service
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Supplements	100%; Deductible waived	50% after Deductible
Occupational Therapy (Outpatient) (OT)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Physical Therapy (Outpatient) (PT)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Physician's Services		
Inpatient/Outpatient Services	100% after Deductible	50% after Deductible
Office Visit Charge & Telemedicine	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During an Office Visit	100% after Deductible	50% after Deductible
Physician Office Surgery	100% after Deductible	50% after Deductible
NOTE: The Copay will be waived for services rendered at OB-GYN Associates of Erie, P.C. (TIN 25-1653555) and Primary Care Associates of Erie (TIN 25-1653555).		

\$1,500 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	50% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	50% after Deductible
Private Duty Nursing	100% after Deductible	Paid at the Participating Provider level of benefits
Plan Year Maximum Benefit	240 hours	
Regenexx Stem Cell Treatment (received by Regenexx Corporate Provider Network only)	100%; Deductible waived	N/A
Respiratory/Pulmonary Therapy	100% after Deductible	Paid at the Participating Provider level of benefits
Plan Year Maximum Benefit	20 visits	
Retail Clinic		
Retail Clinic Visit Charge	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During a Visit	100% after Deductible	50% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	100% after Deductible	50% after Deductible
Combined Plan Year Maximum Benefit	N/A	100 days
Speech Therapy (Outpatient) (ST)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Transplants	100% after Deductible (Aetna IOE Program)* 50% after Deductible (All Other Network Providers)	50% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other illness.		
Urgent Care Facility		
Facility Visit Charge	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During a Visit	100% after Deductible	50% after Deductible

\$1,500 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Wig (see Eligible Medical Expenses)	100% after Deductible	50% after Deductible
Maximum Benefit	\$500 per course of treatment	
All Other Eligible Medical Expenses	100% after Deductible	50% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: \$1,500 PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket)	
Single	\$8,150
Family	\$16,300
Retail Pharmacy: 30-day supply	
Generic Drug	\$15 Copay
Formulary Drug	\$30 Copay
Non-Formulary Drug	\$50 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
Mandatory Specialty Pharmacy Program: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through the PrudentRx Copay Program	
Generic Drug	\$15 Copay
Formulary Drug	\$30 Copay
Non-Formulary Drug	\$50 Copay
Enrolled and Available in the PrudentRx Copay Program	\$0 Copay
Not Enrolled and Available in the PrudentRx Copay Program	30% Copay
NOTE: Specialty drugs MUST be obtained directly from the Specialty Pharmacy Program. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
NOTE: The PrudentRx Copay Program assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Co-Pay Program.	
CVS Maintenance Choice Voluntary: 90-day supply	
Generic Drug	\$30 Copay
Formulary Drug	\$60 Copay
Non-Formulary Drug	\$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply	
Generic Drug	\$30 Copay
Formulary Drug	\$60 Copay
Non-Formulary Drug	\$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)

CVS Maintenance Choice Voluntary

This Plan allows for purchase of a 30-day supply of maintenance drugs at any retail pharmacy. A 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy only or through the mail order program. For additional information, please contact the Prescription Drug Card Program Administrator.

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Advanced Control Specialty Formulary

Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

CVS True Accumulation Program

Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out-of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

PrudentRx Copay Program for Specialty Medications

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Copay Program will assist individuals in obtaining copay assistance from drug manufacturers to reduce an individual's cost share for eligible medications thereby reducing out-of-pocket expenses.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible persons will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call (800) 578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications, in that case, you must speak to someone at PrudentRx at (800) 578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take.

If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copays for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your Deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copay assistance program, do not count towards your Out-of-Pocket Maximum. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

Mandatory Specialty Pharmacy Program

Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

MEDICAL SCHEDULE OF BENEFITS: \$3,000 PLAN

\$3,000 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN YEAR DEDUCTIBLE		
Single	\$3,000	\$6,000
Family	\$6,000	\$12,000
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Coinsurance)		
Single	N/A	\$2,000
Family	N/A	\$4,000
TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	\$8,150	Unlimited
Family	\$16,300	Unlimited
MEDICAL BENEFITS		
Ambulance Services	100% after Deductible	Paid at the Participating Provider level of benefits
Chiropractic Care/Spinal Manipulation	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	100% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	100% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	100% after Deductible	50% after Deductible
Emergency Services/Emergency Room Services	\$200 Copay, then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Foot Orthotics	100% after Deductible	50% after Deductible
Plan Year Maximum Benefit	1 orthotic per foot	
NOTE: Plan Year maximum does not apply to foot orthotics for diabetes.		
Home Health Care	100% after Deductible	50% after Deductible
Hospice Care	100% after Deductible	50% after Deductible

\$3,000 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	100% after Deductible	50% after Deductible
Room and Board Allowance	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	100% after Deductible	50% after Deductible
Outpatient	100% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	100% after Deductible	50% after Deductible
Outpatient (includes Telemedicine)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Morbid Obesity	Paid based on place of service	Paid based on place of service
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Supplements	100%; Deductible waived	50% after Deductible
Occupational Therapy (Outpatient) (OT)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Physical Therapy (Outpatient) (PT)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Physician's Services		
Inpatient/Outpatient Services	100% after Deductible	50% after Deductible
Office Visit Charge & Telemedicine	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During an Office Visit	100% after Deductible	50% after Deductible
Physician Office Surgery	100% after Deductible	50% after Deductible
NOTE: The Copay will be waived for services rendered at OB-GYN Associates of Erie, P.C. (TIN 25-1653555) and Primary Care Associates of Erie (TIN 25-1653555).		

\$3,000 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	50% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	50% after Deductible
Private Duty Nursing	100% after Deductible	Paid at the Participating Provider level of benefits
Plan Year Maximum Benefit	240 hours	
Regenexx Stem Cell Treatment (received by Regenexx Corporate Provider Network only)	100%; Deductible waived	N/A
Respiratory/Pulmonary Therapy	100% after Deductible	Paid at the Participating Provider level of benefits
Plan Year Maximum Benefit	20 visits	
Retail Clinic		
Retail Clinic Visit Charge	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During a Visit	100% after Deductible	50% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	100% after Deductible	50% after Deductible
Combined Plan Year Maximum Benefit	N/A	100 days
Speech Therapy (Outpatient) (ST)	\$25 Copay, then 100%; Deductible waived	50% after Deductible
Plan Year Maximum Benefit	20 visits	
Transplants	100% after Deductible (Aetna IOE Program)* 50% after Deductible (All Other Network Providers)	50% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other illness.		
Urgent Care Facility		
Facility Visit Charge	\$25 Copay, then 100%; Deductible waived	50% after Deductible
All Other Services and Supplies Rendered During a Visit	100% after Deductible	50% after Deductible

\$3,000 PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Wig (see Eligible Medical Expenses)	100% after Deductible	50% after Deductible
Maximum Benefit	\$500 per course of treatment	
All Other Eligible Medical Expenses	100% after Deductible	50% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: \$3,000 PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket)	
Single	\$8,150
Family	\$16,300
Retail Pharmacy: 30-day supply	
Generic Drug	\$15 Copay
Formulary Drug	\$30 Copay
Non-Formulary Drug	\$50 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
Mandatory Specialty Pharmacy Program: 30-day supply	
Specialty Drug	
Specialty Drugs Not Available Through the PrudentRx Copay Program	
Generic Drug	\$15 Copay
Formulary Drug	\$30 Copay
Non-Formulary Drug	\$50 Copay
Enrolled and Available in the PrudentRx Copay Program	\$0 Copay
Not Enrolled and Available in the PrudentRx Copay Program	30% Copay
NOTE: Specialty drugs MUST be obtained directly from the Specialty Pharmacy Program. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
NOTE: The PrudentRx Copay Program assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Co-Pay Program.	
CVS Maintenance Choice Voluntary: 90-day supply	
Generic Drug	\$30 Copay
Formulary Drug	\$60 Copay
Non-Formulary Drug	\$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply	
Generic Drug	\$30 Copay
Formulary Drug	\$60 Copay
Non-Formulary Drug	\$100 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)

CVS Maintenance Choice Voluntary

This Plan allows for purchase of a 30-day supply of maintenance drugs at any retail pharmacy. A 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy only or through the mail order program. For additional information, please contact the Prescription Drug Card Program Administrator.

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Advanced Control Specialty Formulary

Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

CVS True Accumulation Program

Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out-of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

PrudentRx Copay Program for Specialty Medications

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Copay Program will assist individuals in obtaining copay assistance from drug manufacturers to reduce an individual's cost share for eligible medications thereby reducing out-of-pocket expenses.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible persons will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call (800) 578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications, in that case, you must speak to someone at PrudentRx at (800) 578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take.

If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copays for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your Deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copay assistance program, do not count towards your Out-of-Pocket Maximum. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

Mandatory Specialty Pharmacy Program

Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Maintenance Choice

Meritain Health Pharmacy Solutions

Now, you have two ways to save

CVS Caremark Mail Service Pharmacy:

- Enjoy convenient, reliable delivery to the location of your choice.
- Receive your medications in unmarked, tamper-resistant and (when needed) temperature-controlled packaging.
- Talk to a pharmacist by phone toll free, 24/7, from the privacy of your home.

Plus, you can easily order refills and manage your prescriptions anytime from your computer or mobile device at www.caremark.com.

CVS Pharmacy:

Pick up your medication at a time that is convenient for you.

- Enjoy same-day prescription availability.
- Talk with a pharmacist face to face.

Getting started

Pick up at CVS Pharmacy

Please let us know by one of the three ways below:

- Sign in or register at www.caremark.com. Then, select a CVS Pharmacy location for pick up.
- Visit your local CVS Pharmacy and talk to the pharmacist.
- Call using the toll-free number on your member ID card, and we'll handle the rest.



Before you reach your 30-day fill limit and your out-of-pocket cost increases, we will contact you to help you get started with Maintenance Choice. We'll then help you get a 90-day prescription (may vary by plan) from your doctor so you can choose to fill it through the CVS Caremark Mail Service Pharmacy or at a CVS Pharmacy. **Please Note: You're eligible to fill your prescription two times at a retail pharmacy before beginning this program.**

If you have any questions concerning eligible medications, you may contact Meritain Health Pharmacy Solutions customer service at 1.866.475.7589.

Your Guide to Enrollment



Completing your enrollment

Complete, sign and return your enrollment form to your employer within 30 days of your eligibility date whether you're enrolling or declining benefits.

- **Write clearly.** If your form is unreadable, your enrollment may be delayed, or incorrect.
- **Don't forget the back side.** Missing or incomplete information will delay your enrollment.
- **Sign and date your enrollment form.** Remember to sign and date the form, even if you're declining benefits.

Helpful tips

- Your health care plan includes a network of providers you can visit for health care services. When you visit providers in this network, you will receive the best service rate. Call the provider information number for participating providers.
- Your name, identification number, medical group number and your group name, are used to identify you and your covered dependents' benefits.
- Your medical copays are listed for you and your providers.
- Your pharmacy coverage information is listed on the front of your card.
- Please ensure that you precertify with medical management, if required.
- All claims should be submitted to Meritain Health at the address listed on the back of your card.
- You or your provider can call Meritain Health to verify eligibility of benefits or check on your claims status.
- You can call for information on a doctor or specialist who is close to you and serves your specific needs.



All eligible employees must complete the enrollment form, whether you're choosing this plan or declining benefits. Your enrollment form is included in the back of this packet.

Your Guide to Enrollment


The final step toward better balance and better living

After you've completed enrollment, your employer has approved it and after any waiting period has passed, your benefits will be effective.


Your Meritain Health ID card will be on its way to you soon. The card shows Meritain Health as your health plan administrator. Keep it in your wallet and carry it with you. If you misplace your ID card, use the Meritain Health mobile app to access your member portal to get a copy of your ID on the go!

Sample ID card

Card front

 MERITAIN[™] HEALTH <small>An Aetna Company</small>		Customer Service and Eligibility Inquiries 800.925.2272 www.MERITAIN.com	
Member		Medical Plan	
ABC Company		Coverage:	
Group #: 12345		Network	
Member: JOHN Q SAMPLE		by aetna	
Member ID: 123456789123		Plan: Aetna Choice POS II	
Division: 003			
Dependent(s):			
JANE W SAMPLE			
JOHN Q SAMPLE JR			
		Pharmacy Plan	
		RXBIN: 004336	
		RXPCN: ADV	
		RXGRP: RX2738	
		Member: 866.475.7589	
		Pharmacy: 800.364.6331	

Card back

Claims Submission	Eligibility
Mail ALL Claims & Correspondence to: Meritain Health PO Box 853921 Richardson TX 75085-3921 EDI: WebMD/Emdeon 41124 or McKesson/Relay Health 1761	Call 800.925.2272 or visit www.MERITAIN.com for inquiries regarding eligibility, claims and plan benefits.
NY Electing	Precertification
Aetna participating Doctors and Hospitals are independent providers and are neither agents nor employees of Aetna.	For Precertification call: 800.242.1199. Failure to comply with your plan's precertification requirements may result in a reduction of benefits.
Contact 800.343.3140 for assistance in locating an In-Network Provider.	24-Hour Automated Customer Service: 800.566.9311 or www.MERITAIN.com
Printed:	 PHCS INDEX #: 009



Convenient Tools and Resources

Your personalized member website

Once enrolled as a Meritain Health member, you will have access to the **Meritain Health member portal**. When you log in, you'll find everything you need to know about your benefits—from eligibility, to enrollment, to what's covered. It's another way we're working with you to help you get the most from your benefits—so you can live a life that's balanced and informed.

Registration for the member website is easy

If you're already registered to access your online account, simply enter www.meritain.com into your browser and login from the homepage.

If you're not yet registered, it's OK. Registration is an easy three-step process.

1

Go to www.meritain.com. Then, in the top right corner, click *Register*.

2

Next, select *Member* under *I am a* and enter your group ID. You can find your group ID on the front of your member ID card. (If you are new to the plan, you will soon receive your member ID card in the mail.) Then, click *Continue*.

Please note: You may set up a login for yourself, as well as any children under age 18 who are covered by your plan. For privacy purposes, your spouse and dependents over the age of 18, covered by the plan, must each establish logins to access their individual information.

3

You will need to fill in your:

- Group ID (located on your member ID card).
- Member ID (located on your member ID card).
- Date of birth.
- Name.
- ZIP code.
- Email address.

You can then create a username and password. After that, you will be asked to confirm your email address—then you're done! The next time you log in, just use the same username and password.



Members have the right to ask their health plan to place restrictions on (i) the way the health plan uses or discloses their PHI for treatment, payment or health care operations; and (ii) the health plan's disclosure of their PHI to persons who may be involved in their health care or payment thereof (e.g., family members, or close friends).

Convenient Tools and Resources

Important plan contacts

What do you need help with?

My medical benefits

In-network doctors or hospitals

Meritain Health Customer Service **1.800.925.2272**

Access your Meritain Health member portal at
www.meritain.com

The Aetna Choice® POS II provider network

Aetna provider line **1.800.343.3140**

www.aetna.com/docfind/custom/mymeritain

My prescription drug benefits

Meritain Health Pharmacy Solutions Customer Service

1.866.475.7589

Precertification

Meritain Health Medical Management

1.800.242.1199



Notes

COMPANY NAME: Children's Home of Bradford, PA dba Journey Health Systems GROUP #: AF027	BENEFIT ENROLLMENT FORM  <small>An Aetna Company</small>
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THIS FORM IS TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES

PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM
 (ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED				
LAST NAME		FIRST NAME		MI
SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
MAILING ADDRESS		CITY	STATE	ZIP
EMAIL ADDRESS				
PRIMARY PHONE NUMBER		PHONE TYPE <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK		
ARE YOU THE EMPLOYEE COVERED UNDER ANY OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO (i.e. Medicare, Tricare, spouse's plan)				
IF YES, NAME OF INSURANCE: _____		EFFECTIVE DATE: _____		
TYPE OF POLICY (Retiree, COBRA, Spouse): _____		POLICY HOLDER (Self, Spouse): _____		
IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A _____ PART B _____		MEDICARE ID _____		
ENTITLEMENT TO MEDICARE DUE TO: <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> END STAGE RENAL DISEASE (ESRD)				

EMPLOYER USE ONLY	
DATE OF HIRE	EFFECTIVE DATE
DIVISION #	DEPT. # / CLOCK #
ANNUAL SALARY: \$	
<input type="checkbox"/> HOURLY <input type="checkbox"/> SALARY	
<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> COBRA	
<input type="checkbox"/> ENROLLMENT CHANGE <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Reinstatement <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Other: _____	
Employer Representative Signature: _____	
Date: _____	

BENEFIT SELECTION		
COVERAGE TYPE	PLAN ELECTED (IF APPLICABLE)	COVERAGE LEVEL
<input type="checkbox"/> MEDICAL/RX	<input type="checkbox"/> \$500 PLAN <input type="checkbox"/> \$750 PLAN <input type="checkbox"/> \$1,500 PLAN <input type="checkbox"/> \$3,000 PLAN	<input type="checkbox"/> SINGLE <input type="checkbox"/> EMPLOYEE + SPOUSE <input type="checkbox"/> EMPLOYEE + CHILD <input type="checkbox"/> FAMILY <input type="checkbox"/> DECLINE

DEPENDENT INFORMATION (ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED. PROVIDE THE CONTACT INFORMATION FOR ALL ADULT DEPENDENTS AGE 18 AND OVER.)				
Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP). If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances: a. The employee or eligible dependent loses their eligibility status to participate in Medicaid or CHIP; or b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides. The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.				
DEPENDENT 1 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE		SOCIAL SECURITY NO (REQUIRED)	RELATIONSHIP (REQUIRED)	CHECK COVERAGE <input type="checkbox"/> MEDICAL/RX
DATE OF BIRTH (MM/DD/YY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	PHONE NUMBER	<input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK	EMAIL ADDRESS
DEPENDENT 2 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE		SOCIAL SECURITY NO (REQUIRED)	RELATIONSHIP (REQUIRED)	CHECK COVERAGE <input type="checkbox"/> MEDICAL/RX
DATE OF BIRTH (MM/DD/YY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	PHONE NUMBER	<input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK	EMAIL ADDRESS
DEPENDENT 3 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE		SOCIAL SECURITY NO (REQUIRED)	RELATIONSHIP (REQUIRED)	CHECK COVERAGE <input type="checkbox"/> MEDICAL/RX
DATE OF BIRTH (MM/DD/YY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	PHONE NUMBER	<input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK	EMAIL ADDRESS
DEPENDENT 4 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE		SOCIAL SECURITY NO (REQUIRED)	RELATIONSHIP (REQUIRED)	CHECK COVERAGE <input type="checkbox"/> MEDICAL/RX
DATE OF BIRTH (MM/DD/YY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	PHONE NUMBER	<input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK	EMAIL ADDRESS
DEPENDENT 5 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE		SOCIAL SECURITY NO (REQUIRED)	RELATIONSHIP (REQUIRED)	CHECK COVERAGE <input type="checkbox"/> MEDICAL/RX
DATE OF BIRTH (MM/DD/YY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	PHONE NUMBER	<input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK	EMAIL ADDRESS
*IF ANY OF THE DEPENDENTS LISTED ABOVE HAVE A MAILING ADDRESS THAT DIFFERS FROM THE EMPLOYEE, PLEASE COMPLETE THE INFORMATION BELOW:				
DEPENDENT	MAILING ADDRESS		CITY	STATE
*IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION. LIST THE NAME(S) OF ANY DISABLED DEPENDENTS:				
DEPENDENT	DEPENDENT		DEPENDENT	

COMPANY NAME: Children's Home of Bradford, PA dba Journey Health Systems

COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, ☐ FULL TIME ☐ PART TIME SPOUSE EMPLOYER NAME: SPOUSE DATE OF BIRTH:

INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS **ENROLLED** IN WITH HIS/HER EMPLOYER

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER RETIREE, COBRA)	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
<input type="checkbox"/> MEDICAL					
<input type="checkbox"/> PRESCRIPTION					
<input type="checkbox"/> DENTAL					
<input type="checkbox"/> VISION					

COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? ☐ YES ☐ NO

EMPLOYER PROVIDING COVERAGE:

IF YES, COMPLETE THE QUESTIONS BELOW

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DECREE, QMCSO)*	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
<input type="checkbox"/> MEDICAL						
<input type="checkbox"/> PRESCRIPTION						
<input type="checkbox"/> DENTAL						
<input type="checkbox"/> VISION						

*COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.

COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID, TRICARE, ETC.)

IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE BELOW

LIST ALL FAMILY MEMBERS ENROLLED	TYPE OF COVERAGE	EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE	PART B EFFECTIVE DATE (IF APPLICABLE)	MEDICARE ID NUMBER	IS MEDICARE COVERAGE DUE TO:
					<input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> ESRD
					<input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> ESRD

PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Human Resources representative.

SIGNATURE AND AUTHORIZATION

EMPLOYEE SIGNATURE	PRINT EMPLOYEE NAME	DATE



We are Meritain Health

As Advocates for Healthier Living, we provide easy-to-use health care benefits you can use to live well. We also take steps to help you save on the cost of your care. Contact us at the number on your ID card if you have any questions about your plan.

