

Summary of Benefits and Coverage: What this Plan Covers & What You Pay
 For Covered Services: **MEC + Indemnity**

Coverage Period: 01/01/2026 - 12/31/2026
 Coverage for: All Coverage Levels | Plan Type: MEC

The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. Note: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-711-4959. 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.dol.gov/ebsa/healthreform.com or www.cms.gov

Important Questions	Answers	Why this Matters
What is the overall deductible ?	\$0 There is no deductible .	Generally, you must pay all 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 needs the overall family deductible.
Are there services covered before you meet your deductible ?	Yes, Preventive care services are covered before you meet your deductible	No benefits before deductible is met, except for Preventive care services
Are there other deductibles for specific services?	None	No other deductibles for specific services
What is the out-of-pocket limit for this plan ?	The Plan is a Minimum Essential Coverage (MEC) Plan and has no out-of-pocket limit for covered services.	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 must 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 ?	This plan does not have an out-of-pocket limit.	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, you will pay less if you use network providers	Using network Providers for covered services can protect against balance billing. This plan offers First Health for covered services. Look up at: https://providersearch.multiplan.com
Do you need a referral to see a specialist ?	No, you don't need a referral to see a specialist	You can see the specialist you choose without permission from this plan
Are there services this plan doesn't cover?	Yes.	See Plan Document for details

[* For more information about limitation and exceptions, see the plan or policy document at www.M3tpa.com]

Common Medical Event	Services You May Need	Member Out of Pocket	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	\$25 copay /visit	4 Visits Per Year for Single 8 Visits for Other Family members (Maximum \$150) Subject to Plan Allowable
	Specialist Visit	\$50 copay /visit	1 Visit Per Year for Single (Maximum \$300 per Visit) Subject to Plan Allowable
	Preventive Care / Screening / Immunization	\$0 copay /visit	1 Visit Per Year for Single (Maximum \$150 per Visit) Subject to Plan Allowable
If you have a test	Diagnostic Test (X-Ray, Blood work)	Not Covered	Discount Lab Services Available through Quest Select Labs Program Only
	Imaging (CT, PET scans, MRIs)	Not Covered	Discount Services Available through Green Imaging Only
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Symphony Rx	Generic Drugs	Available through Symphony Rx	Please refer to the Symphony Rx Formulary (click link)
	Preferred Brand Drugs	Not Covered	Specialty & High-Cost meds are available through PAP only. Note, PAP requires members to meet certain financial criteria.

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Common Medical Event	Services You May Need	Member Out of Pocket	Limitations, Exceptions, & Other Important Information
If you have an outpatient surgery	Facility fee (e.g., ambulatory, surgery center) & Physician Surgery Fees	Not Covered	n/a
If you need immediate medical attention	Emergency room care	Not Covered	n/a
	Emergency medical transportation	Not Covered	n/a
	Urgent Care	\$0 copay for visit when utilizing Cash for Care	3 Visits Per Year - Covered by Cash for Care Subject to Plan Allowable, office visit only, all other services are patient responsibility
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 Per Event	\$3,000 Year Maximum Subject to Plan Allowable
If you need mental health, behavioral, health, and substance abuse services	Outpatient services	Available through Clever Health : https://www.cleverhealth.ai only	Subject to Plan Allowable
	Inpatient services	Not Covered	n/a

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services)		
Acupuncture	Infertility treatments	Private-duty nursing
Cosmetic Surgery	Long-term care	Routine foot care
Dental Care (Adult)	Non-emergency care when	Weight loss programs
Vision Care (Adult)	traveling outside the U.S.	

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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 are: Department of Labor's Employee Benefits Security Administration at 1-866-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). 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 information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact M3 at 1-888-711-4959.

Financial Assistance with CGA: Tier One Providers: For all medical care over \$5,000 received at a hospital, if the patient qualifies for financial assistance, especially for non-profit hospitals, the financial assistance policy (FAP) is the primary payer of care. This care payment policy is in accordance with the Affordable Care Act (ACA) and Internal Revenue Service (IRS) 501(r) statues to help hospitals honor and fulfill their federal non-profit obligation to serve their communities. This provision applies to for-profit hospitals that also have similar FAPs. The plan member completes the hospital financial assistance application upon request. The plan member will be responsible for any co-pay, coinsurance, and deductible if he or she fails to complete the financial assistance application. The member can also be disqualified from the health plan for failure to cooperate with financial assistance application. In the event of a partial financial assistance reward, the health plan will pay the lesser of the partial financial assistance award or the usual and customary plan discount applied below the individual stop loss attachment point. This provision is in accordance with the provisions of the Affordable Care Act (ACA) and required by the plan sponsor as fiduciary, to ensure that the plan is protecting their members to the fullest extent of publicly known applicable law. **Tier Two Providers:** For all hospital care that falls outside the scope of Tier One, the medical provider is considered Tier Two and the payment for care will be in accordance with the contracted in-network or reference-based pricing.

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 [866-815-6001]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [866-815-6001]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[866-815-6001]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [866-815-6001]

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

[* For more information about limitation and exceptions, see the plan or policy document at www.M3tpa.com]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just example 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 may 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 example are based on self-only coverage.

Peg is Having a Baby (9months of pre-natal care and a hospital Delivery)

The plan's overall deductible	\$0
Specialist	\$0
Hospital (facility) [<i>Cost Sharing</i>]	100%
Other [<i>Cost Sharing</i>]	100%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal Care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$8,000
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$8,000
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The total Peg would pay is	\$8,000
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Managing Joe's Type 2 Diabetes (A year of routine care of a well controlled condition)

The plan's overall deductible	\$0
Specialist [<i>Cost Sharing</i>]	\$0
Hospital (facility) [<i>Cost Sharing</i>]	100%
Other [<i>Cost Sharing</i>]	100%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$300
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$50
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$300
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The total Joe would pay is	\$350
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Mia's Simple Fracture (emergency room visit and follow up care)

The plan's overall deductible	\$0
Specialist [<i>Cost Sharing</i>]	\$0
Hospital (facility)[<i>Cost Sharing</i>]	100%
Other [<i>Cost Sharing</i>]	100%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic tests (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,500
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$

What isn't covered

Limits or exclusions	\$1,500
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The total Mia would pay is	\$1,500
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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MEC Plan Pricing

Plan Tier/Type	Plan Price per Month
Employee ONLY	\$200.00
Employee & Spouse	\$325.00
Employee & Child(ren)	\$315.00
Family	\$425.00