



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.meritain.com or call (800) 925-2272. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For participating <u>providers</u> : \$1,500 person / \$3,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. For participating <u>providers</u> : <u>Preventive care</u> , <u>urgent care</u> , <u>rehabilitation services</u> (office visit), <u>habilitation services</u> (office visit), routine eye exam, glasses and office visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For participating <u>providers</u> : \$4,000 person / \$8,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , penalty amounts, <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind/custom/my_meritain or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered. Includes telemedicine other than Teladoc. You have no costs for consultations through Teladoc. There is no charge and the <u>deductible</u> does not apply for services received at a MinuteClinic. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	Not Covered	
	<u>Preventive care</u> /screening/immunization	No Charge (<u>deductible</u> waived)	Not Covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$20 <u>copay</u> /visit (primary care office)/ \$40 <u>copay</u> /visit (<u>specialist</u> office visit)/30% <u>coinsurance</u> (outpatient)	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$20 <u>copay</u> /visit (primary care office)/ \$40 <u>copay</u> /visit (<u>specialist</u> office visit)/30% <u>coinsurance</u> (outpatient)	Not Covered	<u>Preauthorization</u> recommended for PET scans and non-orthopedic CT/MRI's.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	\$15 <u>copay</u> (retail)/ \$30 <u>copay</u> (mail order)	Not Covered	<u>Deductible</u> does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (Voluntary Smart 90 Program Only); 90-day supply (mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge for preventive drugs or preventive maintenance drugs. Mandatory generic provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> . Step therapy provision applies. Infertility drugs limited to \$10,000 per lifetime.
	Preferred brand drugs	\$35 <u>copay</u> (retail)/ \$70 <u>copay</u> (mail order)	Not Covered	
	Non-preferred brand drugs	\$70 <u>copay</u> (retail)/ \$140 <u>copay</u> (mail order)	Not Covered	
	<u>Specialty drugs</u>	20% <u>coinsurance</u> (no <u>deductible</u>)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u> (ambulatory surgery center)/ \$100 <u>copay</u> /occurrence, then 30% <u>coinsurance</u> (all other locations)	Not Covered	<u>Preauthorization</u> recommended for certain surgeries. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit, then 30% <u>coinsurance</u>	\$100 <u>copay</u> /visit, then 30% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	\$40 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /visit (office visit)/ 30% <u>coinsurance</u> (all other outpatient)	Not Covered	Includes telemedicine other than Teladoc.
	Inpatient services	30% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> recommended.
If you are pregnant	Office visits	No Charge (preventive/routine prenatal & postnatal care)/30% <u>coinsurance</u> (all other prenatal & postnatal care)	Not Covered	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Breast pumps limited to \$450 per pregnancy.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	Not Covered	Limited to 100 visits per year. <u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit (office visit)/ 30% <u>coinsurance</u> (all other outpatient)	Not Covered	Includes physical, speech/hearing & occupational therapy. Includes telemedicine other than Teladoc.
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit (office visit)/ 30% <u>coinsurance</u> (all other outpatient)	Not Covered	Includes telemedicine other than Teladoc.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	Not Covered	Limited to 100 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not Covered	Limited to 1 purchase of a type of DME every 3 years. <u>Preauthorization</u> recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices.
	<u>Hospice services</u>	30% <u>coinsurance</u>	Not Covered	Bereavement counseling is not covered.
If your child needs dental or eye care	Children's eye exam	No Charge to age 5; \$40 <u>copay</u> from age 5; <u>deductible</u> waived	Not Covered	Limited to 1 exam per year.
	Children's glasses	No Charge	No Charge	Limited to \$100 per year age 19 & over. Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
- Bariatric surgery - Bereavement counseling - Cosmetic surgery	- Dental care (Adult & Child) - Hearing aids - Long-term care	- Non-emergency care when traveling outside the U.S. - Routine foot care (except for metabolic or peripheral vascular disease)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
- Acupuncture - Chiropractic care - Glasses (Adult & Child - \$100 per year age 19 & over)	- Infertility treatment (age 26 & above only – 4 attempts at artificial reproduction up to \$10,000) - Private-duty nursing (30 visits per year)	- Routine eye care (Adult & Child - 1 exam per year) - Weight loss programs (for morbid obesity only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or EMM Loans LLC at (800) 793-9633. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or EMM Loans LLC at (800) 793-9633.

Additionally, a consumer assistance program can help you file your [appeal](#). Contact The Office of the Insurance Ombudsman NJ Department of Banking and Insurance at (800) 446-7467.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-378-1179.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Primary care physician coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

This EXAMPLE event includes services like:

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

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>coinsurance</u>	30%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$100
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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