



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) 363-1992. 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> : \$0 person / \$0 family For non-participating <u>providers</u> : \$500 person / \$1,000 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> : All services are covered before you meet a <u>deductible</u> . For non-participating <u>providers</u> : <u>Urgent care</u> , <u>emergency medical transportation</u> (<u>emergency services</u> only), and <u>emergency room care</u> (<u>emergency services</u> only) 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> : \$1,000 person / \$2,000 family For non-participating <u>providers</u> : \$2,000 person / \$4,000 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> , <u>preauthorization</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/mymeritain 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	\$15 <u>copay</u> /visit	20% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered. Includes telemedicine other than Teladoc. You pay a \$15 <u>copay</u> if you receive consultation services through Teladoc. There is no charge for services received at a MinuteClinic.
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	20% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge	20% <u>coinsurance</u>	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	20% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> required for PET scans and non-orthopedic CT/MRI's. If you don't get <u>preauthorization</u> , benefits could be reduced by the lesser of 50% or \$750 of the total cost of the service for non-participating <u>providers</u> .
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	\$10 <u>copay</u> (30-day retail)/ \$20 <u>copay</u> (90-day retail or mail order)	\$10 <u>copay</u> (30-day retail)/ \$20 <u>copay</u> (90-day retail)	<u>Deductible</u> does not apply. Covers up to a 90-day supply (retail prescription); 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. Dispense as Written (DAW) provision does not apply. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> . Step therapy provision applies.
	Preferred brand drugs	\$20 <u>copay</u> (30-day retail)/ \$40 <u>copay</u> (90-day retail or mail order)	\$20 <u>copay</u> (30-day retail)/ \$40 <u>copay</u> (90-day retail)	
	Non-preferred brand drugs	\$35 <u>copay</u> (30-day retail)/ \$70 <u>copay</u> (90-day retail or mail order)	\$35 <u>copay</u> (30-day retail)/ \$70 <u>copay</u> (90-day retail)	
	<u>Specialty drugs</u>	\$10 <u>copay</u> (generic)/ \$20 <u>copay</u> (preferred)/ \$35 <u>copay</u> (non-preferred)	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)	\$200 <u>copay</u> /occurrence	20% <u>coinsurance</u>	<u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u> , benefits could be reduced by the lesser of 50% or \$750 of the total cost of the service for non-participating <u>providers</u> . See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay</u> /visit (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	\$50 <u>copay</u> /visit (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> . <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	No Charge (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	No Charge (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> .
	<u>Urgent care</u>	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. <u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /admission	20% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by the lesser of 50% or \$750 of the total cost of the service for non-participating <u>providers</u> .
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> /visit (office visit)/ No Charge (all other outpatient)	20% <u>coinsurance</u>	Includes telemedicine other than Teladoc.
	Inpatient services	\$500 <u>copay</u> /admission (facility charge)/ No Charge (professional fees)	20% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by the lesser of 50% or \$750 of the total cost of the service for non-participating <u>providers</u> .

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 are pregnant	Office visits	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section). If you don't get <u>preauthorization</u> , benefits could be reduced by the lesser of 50% or \$750 of the total cost of the service for non-participating <u>providers</u> . <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). Baby counts toward the mother's expense; therefore the family <u>deductible</u> amount may apply.
	Childbirth/delivery professional services	No Charge	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 <u>copay</u> /admission	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	20% <u>coinsurance</u>	Limited to 100 visits per year (does not apply to mental health or substance abuse disorders). <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by the lesser of 50% or \$750 of the total cost of the service for non-participating <u>providers</u> .
	<u>Rehabilitation services</u>	\$25 <u>copay</u> /visit	20% <u>coinsurance</u>	Includes telemedicine other than Teladoc. Physical therapy limited to 30 visits per year. Speech, hearing & occupational therapy limited to a combined maximum of 30 visits per year. The maximums do not apply to mental health or substance abuse disorders.
	<u>Habilitation services</u>	Not Covered	Not Covered	This exclusion will not apply to expenses that are considered mental health or substance abuse services.

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)	
	<u>Skilled nursing care</u>	No Charge	20% <u>coinsurance</u>	Limited to 100 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by the lesser of 50% or \$750 of the total cost of the service for non-participating providers.
	<u>Durable medical equipment</u>	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> required for electric/motorized scooters or wheelchairs and pneumatic compression devices. If you don't get <u>preauthorization</u> , benefits could be reduced by the lesser of 50% or \$750 of the total cost of the service for non-participating providers.
	<u>Hospice services</u>	No Charge (outpatient)/\$500 <u>copay</u> /admission (inpatient)	20% <u>coinsurance</u>	Bereavement counseling is covered.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	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> .)			
<ul style="list-style-type: none"> Acupuncture Ambulance transportation for non-emergency services Bariatric surgery Cosmetic surgery Dental care (Adult & Child) 	<ul style="list-style-type: none"> Emergency room services for non-emergency services Glasses (Adult & Child) Habilitation services Hearing aids (except for cochlear implants) Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Private-duty nursing (except for home health care & hospice) Routine eye care (Adult & Child) Routine foot care (except for metabolic or peripheral vascular disease) Weight loss programs 	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
<ul style="list-style-type: none"> Chiropractic care (30 visits per year) 	<ul style="list-style-type: none"> Infertility treatment 		

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 Edmund Optics at (800) 363-1992. 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 Edmund Optics at (800) 363-1992.

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, kwíijigo 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>	\$0
■ <u>Primary care physician copayment</u>	\$0
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>coinsurance</u>	0%

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	\$0
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$560

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>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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	\$0
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$620

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	\$50
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

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

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$200

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