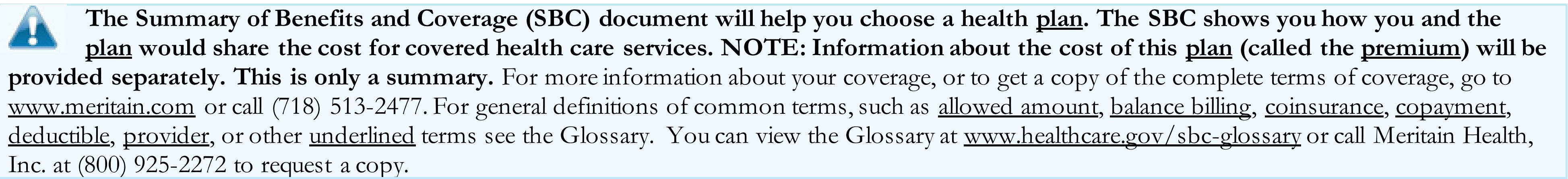

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.meritain.com or call (718) 513-2477. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. All services are covered before you meet a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of network providers. Client pays 100% of Medicare for out-of-network providers. See your plan for more information.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		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	$5 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	$5 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	Copay applies per visit regardless of what services are rendered. Includes telemedicine consultations.
	Specialist visit	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	
	Preventive care/screening/ immunization	$5 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	$5 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	Limited to 6 visits birth to 6 months of age, 2 visits 6 months to 1 year of age, 4 visits 1 to 3 years of age and 1 exam per year ages 3 and over. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$5 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	$5 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	---------------none---------------
	Imaging (CT/PET scans, MRIs)	$5 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	$5 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Generic drugs	$5 copay ($5,000 maximum/year/family) then $5 copay + 40% (30-day & 90-day retail)/$20 copay ($5,000 maximum/ year/family) then $20 copay + 40% (mail order)	Not Covered	Covers up to a 30-day (generic & brand name prescription); 90-day supply (generic retail prescription); 90-day supply (mail order prescription). The copay applies per prescription. Mandatory generic provision applies. Step Therapy provision applies. Injectable medication in excess of $1,000 per year must be obtained through prescription drug coverage.
	Brand name drugs	$30 copay ($5,000 maximum/year/family) then $30 copay + 40% (30-day retail)/ $70 copay ($5,000 maximum/year/ family) then $70 copay + 40% (mail order)	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)	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/occurrence ($30,000 maximum/year/ family) then 40% coinsurance	$500 copay/occurrence ($30,000 maximum/year/ family) then 40% coinsurance	Preauthorization required unless performed in an office setting. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	No Charge ($30,000 maximum/year/family) then 40% coinsurance	No Charge ($30,000 maximum/year/family) then 40% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay/visit ($30,000 maximum/year/family) then 40% coinsurance (emergency services)/Not Covered (non-emergency services)	$250 copay/visit ($30,000 maximum/year/family) then 40% coinsurance (emergency services)/Not Covered (non-emergency services)	Copay is waived if admitted to the hospital.
	Emergency medical transportation	No Charge ($30,000 maximum/year/family) then 40% coinsurance	No Charge ($30,000 maximum/year/family) then 40% coinsurance	---------------none---------------
	Urgent care	$55 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	$55 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission ($30,000 maximum/year/ family) then 40% coinsurance	$500 copay/admission ($30,000 maximum/year/ family) then 40% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	No Charge ($30,000 maximum/year/family) then 40% coinsurance	No Charge ($30,000 maximum/year/family) then 40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	Not Covered
	Inpatient services	Not Covered	Not Covered	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 are pregnant	Office visits	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby counts towards the mother's expense.
	Childbirth/delivery professional services	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	
	Childbirth/delivery facility services	$500 copay/admission ($30,000 maximum/year/ family) then 40% coinsurance	$500 copay/admission ($30,000 maximum/year/ family) then 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	Limited to 200 visits per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance (outpatient)/ Not Covered (inpatient)	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance (outpatient)/ Not Covered (inpatient)	Physical, speech & occupational therapy limited to a combined maximum of 15 visits per year.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Not Covered	Not Covered	Not Covered
	Durable medical equipment	$5 copay/item ($30,000 maximum/year/family) then 40% coinsurance	$5 copay/item ($30,000 maximum/year/family) then 40% coinsurance	Preauthorization required for any item in excess of $750. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Non-essential durable medical equipment is limited to $1,500 per year.
	Hospice services	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	$45 copay/visit ($30,000 maximum/year/family) then 40% coinsurance	Bereavement counseling is not covered. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Limited to 210 days per lifetime

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 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bereavement counseling
- Cosmetic surgery
- Dental care (Adult & Child)
- Emergency room services for non-emergency services
- Glasses (Adult & Child)
- Habilitation services
- Infertility treatment
- Long-term care
- Mental health and behavioral health
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Skilled nursing care
- Substance abuse
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (15 visits per year, combined with chiropractic care & podiatry)
- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care (15 visits per year, combined with chiropractic care & podiatry)
- Hearing aids (1 aid per ear every 48 month period)
- Routine foot care

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: For ERISA plans: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or United Benefit Fund at (718) 513-2477. 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 1-866-444-3272 or www.dol.gov/ ebsa /healthreform or United Benefit Fund at (718) 513-2477.

Additionally, a consumer assistance program can help you file your appeal. Contact the (New York) Community Service Society of New York, Community Health Advocates at (888) 614-5400.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-378-1179.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

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

About these Coverage Examples:

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

Peg is Having a Baby

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

- **The plan's overall deductible** **$0**
- **Primary care physician copayment** **$45**
- **Hospital (facility) copayment** **$500**
- **Other coinsurance** **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$760

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,020

Mia's Simple Fracture

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$45**
- **Hospital (facility) copayment** **$250**
- **Other coinsurance** **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$600

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