




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?	For participating providers: \$250 person / \$500 family For non-participating providers: \$1,250 person / \$2,500 family	Generally, you must pay all of 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 meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. For participating providers: <u>Preventive care</u> , <u>emergency medical transportation</u> (all providers), <u>emergency room care</u> (emergency services – all providers), <u>diagnostic tests</u> , <u>urgent care</u> (all providers), office visits, <u>diagnostic tests</u> , <u>durable medical equipment</u> , prenatal/postnatal care and outpatient <u>rehabilitation services</u> are covered before you meet your 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$100 person / \$300 family for <u>prescription drug coverage</u> . There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For participating providers: \$3,000 person / \$6,000 family (deductible & coinsurance) \$9,450 person / \$18,900 family (deductible, coinsurance & all copays) For non-participating providers: \$20,000 person / \$40,000 family (deductible, coinsurance & copays)	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 plan, 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 out-of-pocket limit?	<u>Premiums</u> , <u>balance billing</u> charges and health care this plan 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 network provider?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of <u>network providers</u> . Client pays 100% of Medicare for <u>out-of-network providers</u> . See your plan for more information.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 plan 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> .
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 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	40% <u>coinsurance</u>	<u>Copay</u> applies per visit regardless of what services are rendered. Includes telemedicine consultations. 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	\$35 <u>copay</u> /visit	40% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	40% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$35 <u>copay</u> /visit	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.magellanrx.com	Generic drugs	\$10 <u>copay</u> (retail 30-day)/\$25 <u>copay</u> (retail 90-day & mail order)	Not Covered	<u>Prescription drug deductible</u> applies. 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 or <u>deductible</u> for preventive drugs. Mandatory generic provision applies. <u>Specialty drugs</u> must be obtained directly from the specialty pharmacy program. Failure to enroll in the Select Drugs and Products Program for a <u>prescription drug</u> or product listed on the Select Drugs and Products List will result in a penalty equal to 100% reduction in benefits payable. All <u>specialty drugs</u> are subject to prior authorization and step therapy. Injectable medication in excess of \$1,000 per year must be obtained through <u>prescription drug coverage</u> .
	Preferred brand drugs	\$30 <u>copay</u> (retail 30-day)/\$75 <u>copay</u> (retail 90-day & mail order)	Not Covered	
	Non-preferred brand drugs	\$75 <u>copay</u> (retail 30-day)/\$187.50 <u>copay</u> (retail 90-day & mail order)	Not Covered	
	<u>Specialty drugs</u>	\$150 <u>copay</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)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended unless performed in an office setting.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit (emergency services)/Not Covered (non-emergency services)	\$200 <u>copay</u> /visit (emergency services)/Not Covered (non-emergency services)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for emergency services. <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	\$500 <u>copay</u> /trip	\$500 <u>copay</u> /trip	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for air ambulance.
	<u>Urgent care</u>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	<u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit (office visit) /10% <u>coinsurance</u> (all other outpatient)	40% <u>coinsurance</u>	Includes telemedicine consultations.
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
If you are pregnant	Office visits	\$35 <u>copay</u> /visit	40% <u>coinsurance</u>	<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). Baby counts towards the mother's expense.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</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 need help recovering or have other special health needs	<u>Home health care</u>	Not Covered	Not Covered	Not Covered
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit (outpatient)/Not Covered (inpatient)	40% <u>coinsurance</u> (outpatient)/Not Covered (inpatient)	Includes physical, speech & occupational therapy.
	<u>Habilitation services</u>	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD
	<u>Skilled nursing care</u>	Not Covered	Not Covered	Not Covered
	<u>Durable medical equipment</u>	\$25 <u>copay</u> /item	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for any item in excess of \$750.
	<u>Hospice services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Bereavement counseling is not 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"> Bereavement counseling Cosmetic surgery Dental care (Adult & Child) Emergency room services for non-emergency services Glasses (Adult & Child) 	<ul style="list-style-type: none"> Habilitation services Home health care Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private-duty nursing Rehabilitation services (inpatient) Routine eye care (Adult & Child) Skilled nursing care 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"> Acupuncture Bariatric surgery (for the treatment of morbid obesity only) 	<ul style="list-style-type: none"> Chiropractic care Hearing aids (1 aid per ear every 48 months) 	<ul style="list-style-type: none"> 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: 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 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, 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 plan's overall deductible \$250
- Primary care physician copayment \$35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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*	\$300
Copayments	\$500
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,960

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$250
- Specialist copayment \$35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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*	\$100
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
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 \$250
- Specialist copayment \$35
- Hospital (facility) copayment \$200
- Other coinsurance 10%

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	\$50
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,250

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services."