




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: \$5,000 person / \$0 family For non-participating providers: \$5,000 person / \$0 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.
Are there services covered before you meet your deductible?	Yes. Preventive care, emergency medical transportation, emergency room care (emergency services), urgent care, office visits, diagnostic tests, durable medical equipment, prenatal & postnatal care, rehabilitation services 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers: \$9,450 person / \$18,900 family For non-participating providers: Unlimited person/family	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 have to 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?	Premiums, balance billing charges and health care this plan doesn't cover.	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. 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	\$25 <u>copay</u> /visit	No Charge	<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	\$50 <u>copay</u> /visit	No Charge	
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	No Charge	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$25 <u>copay</u> /visit	No Charge	-----none-----
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	<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	No Charge (retail & mail order)	Not Covered	<u>Deductible</u> does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription). There is no charge for preventive drugs. Mandatory generic provision applies. Step Therapy provision applies. Injectable medication in excess of \$1,000 per year must be obtained through <u>prescription drug coverage</u> .
	Brand name drugs	Not Covered	Not Covered	
	<u>Specialty drugs</u>	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	<u>Preauthorization</u> recommended unless performed in an office setting.
	Physician/surgeon fees	No Charge	No Charge	
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>copay</u> /visit (emergency services)/Not Covered (non-emergency services)	\$500 <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.

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 a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	<u>Preauthorization</u> recommended.
	Physician/surgeon fees	No Charge	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit (office visit) /No Charge (all other outpatient)	No Charge	Includes telemedicine consultations.
	Inpatient services	No Charge	No Charge	<u>Preauthorization</u> recommended.
If you are pregnant	Office visits	\$50 <u>copay</u> /visit	No Charge	<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	No Charge	No Charge	
	Childbirth/delivery facility services	No Charge	No Charge	
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>	\$50 <u>copay</u> /visit (outpatient)/Not Covered (inpatient)	No Charge (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	No Charge	<u>Preauthorization</u> recommended for any item in excess of \$750.
	<u>Hospice services</u>	No Charge	No Charge	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

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

- | | | |
|--|---|---------------------|
| • Acupuncture | • Chiropractic care | • Routine foot care |
| • Bariatric surgery (for the treatment of morbid obesity only) | • Hearing aids (1 aid per, ear every 48 months) | |

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, kwijigo 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 \$5,000
- Primary care physician copayment \$50
- Hospital (facility) coinsurance 0%
- 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:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,460

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

- The plan's overall deductible \$5,000
- Specialist copayment \$50
- 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:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$3,100
The total Joe would pay is	\$4,300

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$5,000
- Specialist copayment \$50
- Hospital (facility) copayment \$500
- 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:

<i>Cost Sharing</i>	
Deductibles	\$40
Copayments	\$1,500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,540

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