




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](http://www.meritain.com) or call (800) 441-1074. 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](http://www.healthcare.gov/sbc-glossary) or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For participating providers: \$0 person / \$0 family For non-participating providers: \$1,000 person / \$2,000 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.
<b>Are there services covered before you meet your deductible?</b>	Yes. For participating providers: All services are covered before you meet a deductible. For non-participating providers: <u>Emergency medical transportation</u> , <u>emergency room care</u> and <u>urgent care</u> 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For participating providers: \$5,000 person / \$10,000 family For non-participating providers: \$5,000 person / \$10,000 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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>preauthorization</u> penalty amounts, <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 out-of-pocket limit.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind/custom/mymeritain">www.aetna.com/docfind/custom/mymeritain</a> or call (800) 343-3140 for a list of network providers.	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.
<b>Do you need a referral to see a specialist?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	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. 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	40% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge	40% <u>coinsurance</u>	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	No Charge	40% <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 \$300 of the total cost of the service.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	\$15 <u>copay</u> (30-day retail)/ \$30 <u>copay</u> (31-60 day retail)/ \$45 <u>copay</u> (61-90 day retail)/ \$20 <u>copay</u> (mail order)	40% <u>coinsurance</u> (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 applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> .
	Preferred brand drugs	\$40 <u>copay</u> (30-day retail)/ \$80 <u>copay</u> (31-60 day retail)/ \$120 <u>copay</u> (61-90 day retail)/ \$60 <u>copay</u> (mail order)	40% <u>coinsurance</u> (retail)	
	Non-preferred brand drugs	\$60 <u>copay</u> (30-day retail)/ \$120 <u>copay</u> (31-60 day retail)/ \$180 <u>copay</u> (61-90 day retail)/ \$100 <u>copay</u> (mail order)	40% <u>coinsurance</u> (retail)	
	<u>Specialty drugs</u>	\$15 <u>copay</u> (generic drugs)/ \$40 <u>copay</u> (preferred drugs)/ \$60 <u>copay</u> (non-preferred drugs)	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)	No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u> , benefits could be reduced by \$300 of the total cost of the service. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	No Charge	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	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>	No Charge	No Charge	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<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)	No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$300 of the total cost of the service.
	Physician/surgeon fees	No Charge	40% <u>coinsurance</u>	
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)	40% <u>coinsurance</u>	Includes telemedicine.
	Inpatient services	No Charge	40% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$300 of the total cost of the service.

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 (\$25 <u>copay</u> for initial visit)	40% <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 \$300 of the total cost of the service. <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 does not count toward the mother's expense; therefore the family <u>deductible</u> amount may apply.
	Childbirth/delivery professional services	No Charge	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	No Charge	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	40% <u>coinsurance</u>	Limited to 90 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$300 of the total cost of the service.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> /visit (physical therapy)/ \$40 <u>copay</u> /visit (all other therapies)	40% <u>coinsurance</u>	Physical, speech/hearing, occupational, cognitive & pulmonary therapy and cardiac rehab limited to 30 visits per each type of therapy per year.
	<u>Habilitation services</u>	\$25 <u>copay</u> /visit (physical therapy)/ \$40 <u>copay</u> /visit (occupational & speech/hearing therapy)	40% <u>coinsurance</u>	-----none-----
	<u>Skilled nursing care</u>	No Charge	40% <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 \$300 of the total cost of the service.
	<u>Durable medical equipment</u>	No Charge	40% <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 \$300 of the total cost of the service.

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>Hospice services</u>	No Charge	40% <u>coinsurance</u>	Bereavement counseling is covered if received within 6 months of death.
<b>If your child needs dental or eye care</b>	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"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Glasses (Adult &amp; Child)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (except for home health care &amp; hospice)</li> <li>• Routine eye care (Adult &amp; Child)</li> <li>• Routine foot care (except for metabolic or peripheral vascular disease)</li> </ul>
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"> <li>• Bariatric surgery (for the treatment of morbid obesity only)</li> <li>• Chiropractic care (30 visits per year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (2 aids every 5 years)</li> <li>• Infertility treatment (\$5,000 lifetime maximum)</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs (for the treatment of morbid obesity only)</li> </ul>

**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](http://www.dol.gov/ebsa/healthreform) or Infineum USA, Inc. at (800) 441-1074. 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](http://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](http://www.dol.gov/ebsa/healthreform) or Infineum USA, Inc. at (800) 441-1074.

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, 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 \$0
- Primary care physician coinsurance 0%
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$70</b>

**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 \$40
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$920</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$100
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

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