

 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 <https://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 and non-participating providers: \$3,500 person / \$7,000family	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: Preventive care 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 https://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: \$6,750person / \$13,500 family For non-participating providers: \$10,000 person / \$30,000 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.
What is not included in the out-of-pocket limit?	Premiums, preauthorization penalty amounts, 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.	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.
Is a Health Savings Account (HSA) available under this plan option?	Yes.	An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS.



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	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	20% <u>coinsurance</u> (office visits) / 10% <u>coinsurance</u> (x-ray and labs)	20% <u>coinsurance</u> (office visits) / 10% <u>coinsurance</u> (x-ray and labs)	
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	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)	10% <u>coinsurance</u> (labs & x-ray) / 20% <u>coinsurance</u> (all other <u>diagnostic tests</u>)	10% <u>coinsurance</u> (labs & x-ray) / 20% <u>coinsurance</u> (all other <u>diagnostic tests</u>)	-----none-----
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , 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 <u>prescription drug coverage</u> is available at www.magellanrx.com	Generic drugs	\$0 <u>copay</u> (retail and mail order)	Not Covered	Major medical <u>deductible</u> applies. Covers up to a 30 or 90-day supply (retail prescription); 90-day supply (mail order prescription). The <u>copay</u> applies per prescription. There is no charge or <u>deductible</u> for preventive drugs. Mandatory generic provision applies. Step Therapy provision applies. Value Formulary Program applies. Injectable medication in excess of \$1,000 per year must be obtained through <u>prescription drug coverage</u> .
	Brand drugs	\$75 <u>copay</u> (retail and mail order)	Not Covered	
	<u>Specialty drugs</u>	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required unless performed in an office setting. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	<u>Emergency services</u> : \$400 <u>copay</u> /visit, then 20% <u>coinsurance</u> <u>Non-emergency services</u> : Not Covered	<u>Emergency services</u> : \$400 <u>copay</u> /visit, then 20% <u>coinsurance</u> <u>Non-emergency services</u> : Not Covered	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.

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>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	<u>Urgent care</u>	\$50 <u>copay</u> /visit, then 20% <u>coinsurance</u>	\$50 <u>copay</u> /visit, then 20% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----none-----
	Inpatient services	30% <u>coinsurance</u> (facility charges)/20% <u>coinsurance</u> (professional fees)	30% <u>coinsurance</u> (facility charges)/20% <u>coinsurance</u> (professional fees)	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	10% <u>coinsurance</u> (prenatal care) / 20% <u>coinsurance</u> (postnatal care)	10% <u>coinsurance</u> (prenatal care) / 20% <u>coinsurance</u> (postnatal care)	<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 50% 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 counts towards the mother's expense.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	
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>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for any item in excess of \$750. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Hospice services</u>	Not Covered	Not Covered	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
- Cosmetic surgery
- Dental care (Adult & Child)
- Emergency room services for non-emergency services
- Glasses (Adult & Child)
- Habilitation services
- Home health care
- Hospice services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 plan document.)

- Acupuncture
- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Hearing aids
- 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 <https://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 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 <https://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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 \$2,041
- Primary care physician coinsurance 10%
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,041
Copayments	\$0
Coinsurance	\$1,896
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,997

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

- The plan's overall deductible \$2,041
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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	\$7,460
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,041
Copayments	\$975
Coinsurance	\$665
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$3,651

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

- The plan's overall deductible \$2,041
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 30%

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	\$2,010
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,247
Copayments	\$400
Coinsurance	\$278
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925