



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 (845) 437-5820. 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 <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. All services are covered before you meet a <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$200 for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For participating <u>providers</u> : \$5,080 person / \$12,700 family	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 <u>plan</u> , 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>preauthorization</u> penalty amounts, <u>balance billing</u> charges and health care this <u>plan</u> 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 <u>network provider</u> ?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . <u>Out-of-network providers</u> are not covered, except for <u>emergency services</u> , subject to <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> .

 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	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered. There is no charge for telemedicine.
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	Not Covered	
	<u>Preventive care/screening</u> /immunization	No Charge	Not Covered	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)	No Charge	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	<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 50% up to \$500 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.optumrx.com	Generic drugs	\$10 <u>copay</u> (retail)/ \$20 <u>copay</u> (mail order)	Not Covered	<u>Prescription drug deductible</u> applies to preferred brand and non-preferred brand drugs purchased at retail pharmacy. Covers up to a 30-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. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> . Step Therapy provision applies.
	Preferred brand drugs	\$35 <u>copay</u> (retail)/ \$70 <u>copay</u> (mail order)	Not Covered	
	Non-preferred brand drugs	\$70 <u>copay</u> (retail)/ \$140 <u>copay</u> (mail order)	Not Covered	
	<u>Specialty drugs</u>	\$10 <u>copay</u> (generic)/ \$35 <u>copay</u> (preferred)/ \$70 <u>copay</u> (non-preferred)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	<u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$500 of the total

	Physician/surgeon fees	No Charge	Not Covered	cost of the service. See your <u>plan</u> document for a detailed listing.
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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 immediate medical attention	<u>Emergency room care</u>	\$75 <u>copay</u> /visit (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	\$75 <u>copay</u> /visit (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	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.
	<u>Emergency medical transportation</u>	No Charge (<u>emergency services</u> and non- <u>emergency services</u>)	No Charge (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> .
	<u>Urgent care</u>	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> . <u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /admission up to \$625 max per year, then no charge	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$500 of the total cost of the service.
	Physician/surgeon fees	No Charge	Not Covered	
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)	Not Covered	There is no charge for telemedicine.
	Inpatient services	\$250 <u>copay</u> /admission up to \$625 max per year, then no charge (facility)/ No Charge (professional fees)	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$500 of the total cost of the service.
If you are pregnant	Office visits	No Charge	Not Covered	<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% up to \$500 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
	Childbirth/delivery professional services	No Charge	Not Covered	

	Childbirth/delivery facility services	\$250 <u>copay</u> /admission up to \$625 max per year, then no charge	Not Covered	tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense.
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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>	No Charge	Not Covered	Limited to 200 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$500 of the total cost of the service.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> /visit (outpatient physical, occupational & speech therapy)/ \$250 <u>copay</u> /admission up to \$625 max per year, then no charge (inpatient)	Not Covered	Physical therapy limited to 60 visits per year. Speech/hearing & occupational therapy limited to a combined maximum of 60 visits per year. Inpatient rehab limited to 60 days. <u>Preauthorization</u> required for inpatient. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$500 of the total cost of the service.
	<u>Habilitation services</u>	\$25 <u>copay</u> /visit	Not Covered	-----none-----
	<u>Skilled nursing care</u>	No Charge	Not Covered	Limited to 120 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$500 of the total cost of the service.
	<u>Durable medical equipment</u>	No Charge	Not Covered	<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 50% up to \$500 of the total cost of the service.

	<u>Hospice services</u>	No Charge	Not Covered	Bereavement counseling is covered if received within 6 months of death.
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.)

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| • Cosmetic surgery | • Glasses (Adult & Child) | • Private-duty nursing (except for home health care & hospice) |
| • Dental care (Adult & Child) | • Hearing aids | • Routine eye care (Adult & Child) |
| • Emergency room services for non-emergency services | • Long-term care | • Routine foot care (except for metabolic or peripheral vascular disease) |
| | • Non-emergency care when traveling outside the U.S. | |

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

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| • Acupuncture | • Chiropractic care | • Weight loss programs |
| • Bariatric surgery (for the treatment of morbid obesity only) | • Infertility treatment (lifetime maximum of 3 cycles for in-vitro fertilization) | |

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 Vassar College at (845) 437-5820. 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 Vassar College at (845) 437-5820.

Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Community Health Advocates, Community Service Society of New York 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 \$0
- Primary care physician coinsurance 0%
- Hospital (facility) copayment \$250
- 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
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I n this example, Peg would pay:

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 \$25
- 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
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I n this example, Joe would pay:

Mia's Simple Fracture

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

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$75
- 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
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I n this example, Mia would pay:

Cost Sharing

Deductibles*	\$0
Copayments	\$300
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$360
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<i>Cost Sharing</i>	
Deductibles*	\$200
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

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

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