




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 (732) 560-9700. 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 <u>deductible</u>?</b>	For participating <u>providers</u> : \$750 person / \$1,500 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. For participating <u>providers</u> : <u>Preventive care</u> , <u>urgent care</u> (office visit charge), prenatal & postnatal care, outpatient mental health/substance abuse services, <u>emergency room care</u> (all <u>providers</u> ), <u>home health care</u> , <u>habilitation services</u> , routine eye exams and office visit charges are covered before you meet your <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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For participating <u>providers</u> : \$5,000 person / \$10,000 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</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 <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> . 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 <u>plan</u> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit (office visit)/10% <u>coinsurance</u> (all other services)	Not Covered	<u>Copay</u> applies to the physician office visit only. Includes telemedicine other than Teladoc. You pay a \$15 <u>copay</u> ( <u>deductible</u> does not apply) if you receive consultation services through Teladoc. 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	\$60 <u>copay</u> /visit (office visit)/10% <u>coinsurance</u> (all other services)	Not Covered	
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge	Not Covered	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge after <u>deductible</u>	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge after <u>deductible</u>	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% (\$400 maximum) of the total cost of the service.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	\$10 <u>copay</u> (retail)/ \$30 <u>copay</u> (EDSN)/ \$20 <u>copay</u> (mail order)	Not Covered	<u>Deductible</u> does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (Extended Days Supply Network (EDSN) or mail order prescription); 30-day supply ( <u>specialty drugs</u> ). The <u>copay</u> applies per prescription. There is no charge for preventive drugs or preventive maintenance drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained from the specialty pharmacy <u>network</u> . Certain <u>specialty drugs</u> are eligible for <u>copay</u> assistance programs through CVS True Accumulation Program. Step therapy provision applies. <u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.
	Preferred brand drugs	\$40 <u>copay</u> (retail)/ \$120 <u>copay</u> (EDSN)/ \$80 <u>copay</u> (mail order)	Not Covered	
	Non-preferred brand drugs	\$60 <u>copay</u> (retail)/ \$180 <u>copay</u> (EDSN)/ \$120 <u>copay</u> (mail order)	Not Covered	
	<u>Specialty drugs</u>	\$10 <u>copay</u> (generic)/ \$40 <u>copay</u> (preferred)/ \$60 <u>copay</u> (non-preferred)	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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$400 maximum) of the total cost of the service. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not Covered	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$250 <u>copay</u> /visit ( <u>emergency services</u> )/ Not Covered (non- <u>emergency services</u> )	\$250 <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>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	\$75 <u>copay</u> /visit (office visit)/10% <u>coinsurance</u> (all other services)	Not Covered	<u>Copay</u> applies to the physician office visit only.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$400 maximum) of the total cost of the service.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not Covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <u>copay</u> /visit (office visit)/No Charge (all other outpatient)	Not Covered	Includes telemedicine other than Teladoc.
	Inpatient services	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$400 maximum) of the total cost of the service.
<b>If you are pregnant</b>	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% (\$400 maximum) 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
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	10% <u>coinsurance</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)	
				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.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No Charge	Not Covered	Limited to 120 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$400 maximum) of the total cost of the service.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	Not Covered	Physical, speech/hearing & occupational therapy limited to a combined maximum of 60 visits per year.
	<u>Habilitation services</u>	No Charge	Not Covered	-----none-----
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not Covered	Limited to 60 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% (\$400 maximum) of the total cost of the service.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	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% (\$400 maximum) of the total cost of the service.
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not Covered	Bereavement counseling is limited to 5 visits per lifetime.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	Limited to 1 exam per 12 month period.
	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>• Cosmetic surgery</li><li>• Dental care (Adult &amp; Child)</li></ul>	<ul style="list-style-type: none"><li>• Emergency room services for non-emergency services</li><li>• Glasses (Adult &amp; Child)</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</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>• Acupuncture (10 visits per year)</li><li>• Bariatric surgery (for morbid obesity only)</li><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (a single purchase (including repair and/or replacement) of hearing aids for 1 or both ears every 3 years. Bone anchored hearing aid – 1 device per lifetime)</li><li>• Infertility treatment (3 cycles of in vitro fertilization per lifetime)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (70 – 8 hour shifts per year)</li><li>• Routine eye care (Adult &amp; Child – 1 exam per 12 month period)</li><li>• Weight loss programs (for 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 (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or Paulus, Sokolowski & Sartor LLC at (732) 560-9700. 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 (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or Paulus, Sokolowski & Sartor LLC at (732) 560-9700.

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, 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 <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Primary care physician coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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*)

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

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$10
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,920</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$750
Copayments	\$900
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,730</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	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*)

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

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$400
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,350</b>

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