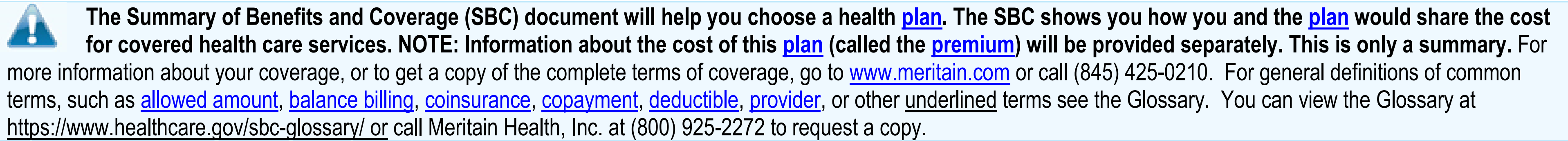
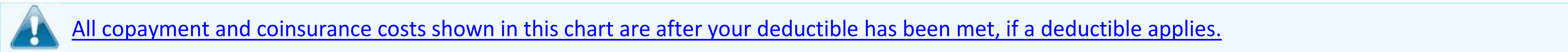

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. 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) 425-0210. 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 providers: **$500**/individual **/$1,000** 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.
Are there services covered before you meet your deductible?	Yes. For participating providers: Preventive care, urgent care, emergency care (emergency services only) (all providers), prenatal and postnatal care, mental health/substance abuse services, rehabilitation services, eye exams and glasses, and office visit 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.
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: **$3,000**/individual **/$6,000** 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, copays, deductibles, balance-billing charges and health care this plan doesn't cover.	Even though you may 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.


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
		Network Provider (You will pay the least)	Out-of-Network 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 copay/visit	Not Covered	Copay applies per visit regardless of what services are rendered
	Specialist visit	$25 copay/visit	Not Covered	
	Preventive care/screening/ immunization	$25 copay/exam (routine hearing)/ No charge (all other preventative care)	Not Covered	You may have to pay services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Routine hearing examinations limited to 1 exam per 24-month period.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	Diagnostic tests rendered as part of a physician office visit and billed by the physician, will be subject to the physician office visit cost share.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$25 copay retail; $50 copay mail	$25 copay, then 40% coinsurance retail	Deductible does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). The copay applies per prescription. There is no charge for preventative drugs. Dispense as Written (DAW) provision applies. Specialty drugs must be obtained directly from the specialty pharmacy program after 3 refills at a retail pharmacy.
	Brand name drugs	$35 copay retail; $70 copay mail	$35 copay, then 40% coinsurance retail	
	Specialty drugs	Paid the same as generic and brand name drugs.		
If you have outpatient surgery	Facilty fee (e.g, ambulatory surgery center)	20% coinsurance	Not Covered	Preauthorization recommended for oral surgical procedures.
	Physician/surgeon fees	20% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	20% coinsurance (emergency services)/ Not Covered (non-emergency services)	20% coinsurance (emergency services)/ Not Covered (non-emergency services)	Non-participating providers paid at the participating provider level of benefits for emergency services.
	Emergency medical transportation	20% coinsurance (emergency services)/ Not	20% coinsurance (emergency services)/ Not Covered (non-emergency services)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Covered (non-emergency services)		
	Urgent care	20% coinsurance	Not Covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Preauthorization recommended.
	Physician/surgeon fees	20% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	Not Covered	None
	Inpatient services	No Charge	Not Covered	Preauthorization recommended.
If you are pregnant	Office visits	No Charge	Not Covered	Preauthorization recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). Cost sharing does not apply to preventative services from a participating provider. 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% coinsurance	Not Covered	
	Childbirth/delivery facility services	20% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Limited to 120 visits per year (3 visits per day maximum). Preauthorization recommended.
	Rehabilitation services	$25 copay/visit	Not Covered	Physical, speech & occupational therapy limited to a combined maximum of 60 visits per year. Cardiac rehab and pulmonary therapy limited to 36 sessions per each type of therapy in a 6-week period.
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 60 days per year. Preauthorization recommended.
	Durable medical equipment	20% coinsurance	Not Covered	None.
	Hospice services	20% coinsurance	Not Covered	Bereavement counseling is covered if received within 6 months of death. Preauthorization recommended. Inpatient services limited to 30 days per lifetime.
	Children's eye exam	$25 copay/visit	Not Covered	Limited to one exam every 24 months.
	Children's glasses	No charge	Not Covered	Limited to one pair every 12 months up to age 19.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's dental check-up	0% coinsurance	0% coinsurance of fee schedule	Covered under stand alone dental plan.

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.)

- Ambulance transportation for non-emergency services
- Cosmetic surgery
- Dental care (covered under stand alone dental plan)
- Emergency room services for non-emergency services
- Habilitation services
- Hearing aids
- Long-term care
- 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.)

- Acupuncture (if prescribed as a form of anesthesia)
- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Glasses (Adult & Child)
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult & Child)
- Weight loss programs (for the treatment of morbid obesity only)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/healthreform or Laborers Local No. 754 Welfare Fund at (845) 425-0210. 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/agencies/ebsa/healthreform or Laborers Local No. 754 Welfare Fund at (845) 425-0210.

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, kwiijigo 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** **$500**
- **Primary care physician copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office 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:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician 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:

Cost Sharing	
Deductibles	$500
Copayments	$900
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,500**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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