

 **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 (732) 671-6400. 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 deductible?	For participating <u>providers</u> : \$1,500 person / \$3,000 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> .
Are there services covered before you meet your deductible?	Yes. For participating <u>providers</u> : <u>Preventive care</u> , office <u>diagnostic tests</u> , <u>emergency room care</u> (<u>emergency services</u> – all <u>providers</u>), prenatal/postnatal care, office <u>rehabilitation services/habilitation services</u> , <u>urgent care</u> , <u>primary care provider</u> and <u>specialist</u> 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes: \$50/person for prescription drug coverage.	
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For participating <u>providers</u> : \$5,000 person / \$10,000 family For prescription drugs: \$1,500/person, \$3,000/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.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>preauthorization</u> penalty amounts, balance billing 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</u> 's <u>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</u> 's 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.
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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit (office visit)/ No Charge (all other services)	Not Covered	<u>Copay</u> applies to the physician office visit only. Includes telemedicine.
	Specialist visit	\$40 <u>copay</u> /visit (office visit)/ No Charge (all other services)	Not Covered	
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No Charge	Not Covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge (office)/20% <u>coinsurance</u> (all other outpatient)	Not Covered	There is no charge for lab work received from a LabCard or LabCorp <u>provider</u> and the <u>deductible</u> does not apply.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</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 20% 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.mysmithrx.com	Generic drugs	Retail: \$20 copayment (per 30-day supply); Mail: \$40 copayment	<u>Prescription drugs</u> are covered under a stand alone <u>prescription drug plan</u> offered by your employer. Contact your employer for details regarding this program. <u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.	
	<u>Formulary</u> brand drugs	Retail: \$40 copayment (per 30-day supply); Mail: \$80 copayment		
	<u>Non-formulary</u> brand drugs	Retail: \$70 copayment (per 30-day supply); Mail: \$140 copayment		
	Specialty drugs	Same as retail copayments shown above		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u> ,

	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	benefits could be reduced by 20% of the total cost of the service. See your <u>plan</u> document for a detailed listing.
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit, then 20% <u>coinsurance</u> (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	\$100 <u>copay</u> /visit, then 20% <u>coinsurance</u> (<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>	20% <u>coinsurance</u>	20% <u>coinsurance</u> (<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>	\$40 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay</u> /visit (office visit) /20% <u>coinsurance</u> (all other outpatient)	Not Covered	Includes telemedicine.
	Inpatient services	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
If you are pregnant	Office visits	No Charge (\$40 <u>copay</u> for initial visit)	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 20% of the total cost of the
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	

	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not Covered	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.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	Limited to 100 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
	<u>Rehabilitation services</u>	\$10 <u>copay</u> /visit (office) / 20% <u>coinsurance</u> (all other locations)		Physical, speech/hearing & occupational therapy limited to 45 visits per each type of therapy per year. Inpatient limited to 60 days per year and <u>preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 20% of the total cost of the service.
	<u>Habilitation services</u>	\$10 <u>copay</u> /visit (office) / 20% <u>coinsurance</u> (all other locations)		-----none-----
	<u>Skilled nursing care</u>	20% <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 20% of the total cost of the service.
	<u>Durable medical equipment</u>	20% <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 20% of the total cost of the service.
	<u>Hospice services</u>	20% <u>coinsurance</u>		Bereavement counseling is 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.)

<ul style="list-style-type: none">• Acupuncture• Bereavement counseling• Cosmetic surgery• Dental care (Adult & Child)	<ul style="list-style-type: none">• Emergency room services for non-emergency services• Glasses (Adult & Child)• Long-term care	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing (inpatient)• Routine eye care (Adult & Child)• Routine foot care (except for metabolic or peripheral vascular disease)
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none">• Bariatric surgery (for morbid obesity only)• Chiropractic care (25 visits per year)	<ul style="list-style-type: none">• Hearing aids (1 hearing aid per ear per 24-month period)• Infertility treatment (\$30,000 per lifetime)	<ul style="list-style-type: none">• Private-duty nursing (outpatient – 240 hours per year)• Weight loss programs (for morbid obesity only)
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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 or T & M Associates, Inc. at (732) 671-6400. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://HealthCare.gov), 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 (866) 444-3272 or www.dol.gov/ebsa/healthreform or T & M Associates, Inc. at (732) 671-6400.

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, kwiijjigo 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>	\$1,500
■ <u>Primary care physician coinsurance</u>	0%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

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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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,200

What isn't covered

Limits or exclusions	\$70
The total Peg would pay is	\$3,770

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>	\$1,500
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

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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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$200
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$3,500
The total Joe would pay is	\$4,600

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$100
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$200
Coinsurance	\$100

What isn't covered

Limits or exclusions	\$10
The total Mia would pay is	\$1,810

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