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) 462-2357. 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: $250 individual / $500 employee plus spouse or employee plus child(ren) / $750 family For non-participating providers: $500 individual / $1,000 employee plus spouse or employee plus child(ren)/ $1,500 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 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?	Yes. For participating providers: $5,280 person /$10,560 family (deductible, coinsurance, medical copays and preauthorization penalties) For non-participating providers: Unlimited For prescription drug copays: $1,320 person / $2,640 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, 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.

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	$15 copay/visit, then 10% coinsurance	55% coinsurance	Copay applies per visit regardless of what services are rendered.
	Specialist visit	$15 copay/visit, then 10% coinsurance	55% coinsurance	
	Preventive care/screening/ immunization	No Charge (preventive care)/10% coinsurance (routine care)	55% coinsurance (routine and non-routine colonoscopies & mammograms)/Not Covered (all other services)	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Routine and non-routine colonoscopies and mammograms must be performed in a physician's office or independent facility. Colonoscopies or mammograms performed in a hospital will not be covered.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	55% coinsurance	Quest Diagnostics or LabCorp must be used for outpatient non-routine lab services that are available through Quest Diagnostics or LabCorp. If a covered person and/or a physician elect to use another lab, including the lab in the physician's office, no benefits will be paid, unless the services cannot be performed through Quest Diagnostics or LabCorp.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	55% coinsurance	Preauthorization required for PET scans and non-orthopedic CT/MRI's. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.gethisi.com	Generic drugs	$10 copay (30-day retail)/ $50 copay (90-day retail)/ $30 copay (mail order)	Not Covered	Deductible does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription). The copay applies per prescription. There is no charge for preventive drugs. Mandatory generic provision applies. Maintenance drugs must be filled through the 90-day retail or mail order pharmacies after 1 fill and 2 refills at a 30 day retail pharmacy. Preauthorization required for injectables costing over $2,000 per drug per month.
	Brand name drugs	$20 copay (30-day retail)/ $70 copay (90-day retail)/ $30 copay (mail order)	Not Covered	
	Specialty drugs	Paid the same as generic & brand name drugs	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	55% coinsurance	Preauthorization required for certain surgeries, including infusion therapy costing over $2,000 per drug per month. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service. See your plan document for a detailed listing.
	Physician/surgeon fees	10% coinsurance	55% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay/visit (emergency services)/ $100 copay/visit, then 10% coinsurance (non-emergency services)	$100 copay/visit (emergency services)/ $100 copay/visit, then 55% coinsurance (non-emergency services)	Non-participating providers paid at the participating provider level of benefits for emergency services. Copay is waived if admitted to the hospital.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-participating providers paid at the participating provider level of benefits.
	Urgent care	10% coinsurance	55% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	55% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Physician/surgeon fees	No Charge	55% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	55% coinsurance	----------none----------
	Inpatient services	No Charge	55% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.

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 are pregnant	Office visits	10% coinsurance	55% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service. Cost sharing does not apply to preventive services from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family deductible amount may apply.
	Childbirth/delivery professional services	10% coinsurance	55% coinsurance	
	Childbirth/delivery facility services	No Charge	55% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	55% coinsurance	Limited to 60 visits per year.
	Rehabilitation services	$15 copay/visit, then 10% coinsurance	$15 copay/visit, then 55% coinsurance	Physical, speech, respiratory & occupational therapy limited to 15 visits per each type of therapy per condition per year.
	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	10% coinsurance	55% coinsurance	Limited to 60 days per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Durable medical equipment	10% coinsurance	55% coinsurance	Preauthorization required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Hospice services	10% coinsurance (hospice services)/$15 copay/visit, then 10% coinsurance (bereavement)	55% coinsurance (hospice services)/$15 copay/visit, then 55% coinsurance (bereavement)	Bereavement counseling is only covered if received within 6 months of death; limited to 6 visits per lifetime.

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 your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Limited to 1 exam per year.
	Children's glasses	No Charge	No Charge	Limited to 1 pair of lenses per 12 month period and 1 set of frames per 24 month period.
	Children's dental check-up	Not Covered	Not Covered	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.)

- **Acupuncture**
- **Cosmetic surgery**
- **Dental care (covered under stand alone dental plan)**
- **Habilitation services**
- **Hearing aids**
- **Infertility treatment**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S. (If you become sick or injured while traveling, the plan may cover expenses incurred up to 120 consecutive days. This 120-day time limit does not apply if you are traveling for business or are a student.)**
- **Routine foot care**

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

- **Bariatric surgery (for the treatment of morbid obesity only)**
- **Chiropractic care**
- **Glasses (Adult & Child)**
- **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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/ebsa/healthreform or Standardbred Breeders and Owners Association at (732) 462-2357. 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 Standardbred Breeders and Owners Association at (732) 462-2357.

Additionally, a consumer assistance program can help you file your appeal. Contact the New Jersey Department of Banking and Insurance at (800) 446-7467 or (609) 292-7272.

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, 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** **$250**
- **Primary care physician coinsurance** **10%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$70
Coinsurance	$344
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$724

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

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$15**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$720
Coinsurance	$186
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,211

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

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$15**
- **Hospital (facility) copay** **$100**
- **Other coinsurance** **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)*

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$205
Coinsurance	$86
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$541

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