

 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 (973) 399-6800. 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>?	For participating <u>providers</u> : \$0 person / \$0 family For non-participating <u>providers</u> : \$350 person / \$700 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 <u>deductible</u>?	Yes. For participating <u>providers</u> : All services are covered before you meet a <u>deductible</u> . For non-participating <u>providers</u> : <u>Emergency medical transportation</u> and <u>emergency room care (emergency services only)</u> 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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For participating <u>providers</u> : \$500 person / \$1,000 family For non-participating <u>providers</u> : \$2,000 person / \$5,000 family (<u>deductible</u> , <u>coinsurance</u> and medical <u>copays</u>) / For <u>prescription drug copays</u> : \$1,470 person / \$2,940 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>balance billing</u> charges, <u>preauthorization</u> penalty amounts, 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> . 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 charge</u> 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 provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay /visit	30% coinsurance	<u>Copay</u> applies per visit regardless of what services are rendered. Includes telemedicine other than Teladoc (participating <u>providers</u> only), limited to 1 visit per day. There is no charge and the <u>deductible</u> does not apply if you receive consultation services through Teladoc.
	<u>Specialist</u> visit	\$15 copay /visit	30% coinsurance	
	<u>Preventive care/ screening/ immunization</u>	No Charge	Mammograms, ob/gyn exams & sterilizations & immunizations to 12 months in age: 30% coinsurance / All other preventive/routine care: Not Covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	30% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance	<u>Preauthorization</u> required for PET scans and non-orthopedic CT/MRI's. If you don't get <u>preauthorization</u> for non-participating <u>providers</u> , benefits could be reduced by the lesser of \$400 or 50% 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.caremark.com	Generic drugs	\$5 copay (30-day retail)/ \$18 copay (90-day retail & mail order)	\$5 copay (30-day retail)/ \$18 copay (90-day retail)	<u>Deductible</u> does not apply. Covers up to a 90-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 for preventive drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained directly from the specialty pharmacy. Certain <u>specialty drugs</u> are eligible for <u>copay</u> assistance programs through CVS True Accumulation Program.
	Preferred brand drugs	\$10 copay (30-day retail)/ \$40 copay (90-day retail & mail order)	\$10 copay (30-day retail)/ \$40 copay (90-day retail)	
	Non-preferred brand drugs	\$10 copay (30-day retail)/ \$88 copay (90-day retail & mail order)	\$10 copay (30-day retail)/ \$88 copay (90-day retail)	
	<u>Specialty drugs</u>	\$5 copay (generic) / \$10 copay (preferred) / \$10 copay (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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% <u>coinsurance</u>	<u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u> for non-participating <u>providers</u> , benefits could be reduced by the lesser of \$400 or 50% of the total cost of the service. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	No Charge	30% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$125 <u>copay</u> /visit (<u>emergency services</u>)/ Not Covered (non- <u>emergency services</u>)	\$125 <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>	\$15 <u>copay</u> /visit	30% <u>coinsurance</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)	No Charge	30% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> for non-participating <u>providers</u> , benefits could be reduced by the lesser of \$400 or 50% of the total cost of the service.
	Physician/surgeon fees	No Charge	30% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay</u> /visit (office visit) / No Charge (all other outpatient)	30% <u>coinsurance</u>	Includes telemedicine other than Teladoc.
	Inpatient services	No Charge	30% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> for non-participating <u>providers</u> , benefits could be reduced by the lesser of \$400 or 50% of the total cost of the service.
If you are pregnant	Office visits	\$10 <u>copay</u> /visit	30% <u>coinsurance</u>	<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> for non-participating <u>providers</u> , benefits could be reduced by the lesser of \$400 or 50% 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 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.
	Childbirth/delivery professional services	No Charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No Charge	30% <u>coinsurance</u>	

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	30% <u>coinsurance</u>	Limited to 3 visits per day. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> for non-participating <u>providers</u> , benefits could be reduced by the lesser of \$400 or 50% of the total cost of the service.
	<u>Rehabilitation services</u>	\$15 <u>copay</u> /visit	30% <u>coinsurance</u> (speech & occupational therapy) / 30% <u>coinsurance</u> , not to exceed the lesser of \$52/visit or 75% of the participating <u>provider</u> cost	Includes physical, speech & occupational therapy.
	<u>Habilitation services</u>	No Charge	30% <u>coinsurance</u>	-----none-----
	<u>Skilled nursing care</u>	No Charge	30% <u>coinsurance</u>	Limited to 120 days per year for participating <u>providers</u> ; 60 days per year for non-participating <u>providers</u> (participating and non-participating <u>provider</u> limits do reduce each other). <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> for non-participating <u>providers</u> , benefits could be reduced by the lesser of \$400 or 50% of the total cost of the service.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <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> for non-participating <u>providers</u> , benefits could be reduced by the lesser of \$400 or 50% of the total cost of the service.
	<u>Hospice services</u>	No Charge	30% <u>coinsurance</u>	Bereavement counseling is covered if received within 6 months of death.
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> /visit	30% <u>coinsurance</u>	Limited to 1 exam per year.
	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">• Cosmetic surgery• Dental care (Adult & Child)• Emergency room services for non-emergency services	<ul style="list-style-type: none">• Glasses (Adult & Child)• Long-term care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Private-duty nursing (inpatient only)• Routine foot care (except for metabolic or peripheral vascular disease)
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">• Acupuncture (limited to treatment of pain, nausea or as a form of anesthesia)• Bariatric surgery (for morbid obesity only)• Chiropractic care (limited to 30 visits per year)	<ul style="list-style-type: none">• Hearing aids (up to age 16 only, limited to 1 hearing aid, up to \$1,000 per aid, per hearing impaired ear, every 24 months)• Infertility treatment (limited to 4 completed egg retrievals per lifetime)	<ul style="list-style-type: none">• Private-duty nursing (outpatient only)• Routine eye care (Adult & Child – 1 exam per year)• Weight loss programs (for 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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at (877) 267-2323 x 61565 or www.cciio.cms.gov, or Irvington Board of Education at (973) 399-6800. 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 Irvington Board of Education at (973) 399-6800 or Meritain Health, Inc. at (800) 925-2272.

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

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>	\$0
■ <u>Primary care physician copayment</u>	\$10
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

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>	\$0
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$420

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>copayment</u>	\$125
■ Other <u>coinsurance</u>	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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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$300

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