



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, [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or by calling 1-866-851-0754. 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 1-866-851-0754 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> : Individual \$1,000 / Family \$2,000. Non Network: Individual \$1,000 / Family \$2,000.	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. <u>Prescription drugs</u> ; plus <u>Network</u> office visits & <u>preventive care</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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>Network</u> : Individual \$5,250 / Family \$10,500. Non Network: Individual \$5,250 / Family \$10,500.	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 out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges & 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 network provider?	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-866-851-0754 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>Non 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>Non Network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	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
		In-Network Provider (You will pay the least)	Out-of-Network 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	\$20 <u>copay</u> /office visit only, <u>deductible</u> doesn't apply; 20% <u>coinsurance</u> for all other services	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$60 <u>copay</u> /office visit only, <u>deductible</u> doesn't apply; 20% <u>coinsurance</u> for all other services	50% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	50% <u>coinsurance</u> , except no charge for immunizations up to age 6	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> ; except no charge for lab at Quest Lab & Stormont Vail Lab	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition  <u>Prescription drug coverage</u> is	Generic drugs	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply (retail & mail order)	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply (retail & mail order)	First fill is a 30 day supply at retail and mail order. A 90 day supply is allowed at retail and mail order for subsequent refills. Diabetic and Asthma medications that are considered Generic or Preferred brand with the following <u>copays</u> : Generic 10% <u>coinsurance</u> with a \$20 maximum per 30 day supply. Preferred brand: 20% <u>coinsurance</u> with a \$40 maximum
	Preferred brand drugs	35% <u>coinsurance</u> , <u>deductible</u> doesn't apply (retail & mail order)	35% <u>coinsurance</u> , <u>deductible</u> doesn't apply (retail & mail order)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>administered by Caremark</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Non-preferred brand drugs	60% <u>coinsurance</u> , <u>deductible</u> doesn't apply (retail & mail order)	60% <u>coinsurance</u> , <u>deductible</u> doesn't apply (retail & mail order)	per 30 day supply. Contraceptives: Covered with 0% member <u>coinsurance</u> . Non-preferred Contraceptives: Covered subject to 65% <u>coinsurance</u> . Compound Medications covered only at a <u>Network Pharmacy</u> .
	<u>Specialty drugs</u>	30% <u>coinsurance</u> with \$100 maximum/prescription, <u>deductible</u> doesn't apply	Not covered	All fills must be filled through CVS Caremark Specialty (1-800-237-2767)
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$100 copay/visit	20% <u>coinsurance</u> after \$100 copay/visit	<u>Non Network</u> emergency use paid the same as <u>Network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Non Network</u> emergency use paid the same as <u>Network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> required for <u>Non Network</u> care.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office: \$20 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> required for <u>Non Network</u> care.
<b>If you are pregnant</b>	Office visits	No charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	services described elsewhere in the SBC (i.e., ultrasound). <u>Pre-authorization</u> for Non Network care may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> required for <u>Non Network</u> care.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> required for <u>Non Network</u> care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	180 days/lifetime for inpatient. <u>Pre-authorization</u> required for <u>Non Network</u> care.
If your child needs dental or eye care	Children's eye exam	No charge	50% <u>coinsurance</u>	1 routine eye exam/calendar 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 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 (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Bariatric surgery - 1 surgery/lifetime for in-network only.
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - \$5,000 maximum per ear/3 years.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Routine eye care (Adult) - 1 routine eye exam/calendar year.

**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:

- For more information on your rights to continue coverage, contact the [plan](tel:1-866-851-0754) at 1-866-851-0754.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your coverage is a church [plan](#), church [plans](#) are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-866-851-0754. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- Additionally, a consumer assistance program can help you file your [appeal](#). Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

**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 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](#).

*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 \$1,000
- Specialist copayment \$60
- 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*)

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

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$3,370</b>

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

- The plan's overall deductible \$1,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Primary care provider office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Diabetic supplies (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$3500
<b>The total Joe would pay is</b>	<b>\$4,740</b>

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

- The plan's overall deductible \$1,000
- Specialist copayment \$60
- 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*)

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

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$1,410</b>

### Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-851-0754.

### Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

TTY: 711

- English - **To access language services at no cost to you, call 1-866-851-0754.**
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-866-851-0754 ይደውሉ።.
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-866-851-0754.
- Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-866-851-0754 հեռախոսահամարով:
- Carolinian (Kapasal Falawasch) - ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-851-0754.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-866-851-0754.
- Chinese Traditional - 如欲使用免費語言服務，請致電 1-866-851-0754.
- Cushitic-Oromo - Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilibili 1-866-851-0754.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-866-851-0754.
- French Creole (Haitian)- Pou jwenn sèvis lang gratis, rele 1-866-851-0754.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-866-851-0754 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-866-851-0754.
- Gujarati - તમારેકોઇ જાતના બચવિના ભાષાની સે વિના બોની વહોરૂ માટે, કોલ કરો 1-866-851-0754.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-866-851-0754 पर कॉल करें।.
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-866-851-0754.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-866-851-0754.
- Japanese - 言語サービスを無料でご利用いただくには、1-866-851-0754 までお電話ください。
- Karen - လာတဝ်ကမ္ဘာ့ကိပ်အတိတ်မစာအတိတ်ဖဲတိတ်မတဖုလတအိတ်ဒီးအပူလတကဘတ်ဟုတ်အိတ်အဂီတ်ဘတ်နုတ် ကိး 1-866-851-0754 တကုတ်.
- Korean - 무료 언어 서비스를 이용하려면 1-866-851-0754 번으로 전화해 주십시오.
- Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-866-851-0754.
- Mon-Khmer, Cambodian - ដើម្បីទទួលបានសេវាកម្មភាសាដៃលក់គតិកថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-866-851-0754 ។

