



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 1-888-982-3862. 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 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	In-Network: Individual \$1,000 / Family \$2,000. Out-of-Network: Individual \$3,000 / Family \$6,000.	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.
<u>Are there services covered before you meet your deductible?</u>	Yes. In-network preventive care is 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet deductibles for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	In-Network: Individual \$8,700 / Family \$17,400. Out-of-Network: Individual \$9,500 / Family \$19,000.	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.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<u>Will you pay less if you use a network provider?</u>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of in-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.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart starting here and continuing on the next pages 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 provider's office or clinic	Primary care visit to treat an injury or illness <u>Specialist</u> visit	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	None None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <u>coinsurance</u>	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 plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work) Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	None None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>  Visit <a href="https://specialty.optumrx.com/">https://specialty.optumrx.com/</a> for information about specialty drugs	Generic drugs	10% coinsurance Retail and Mail subject to: Retail: \$7.50/Minimum, \$30/Maximum; Mail and Retail 90: \$15/Minimum, \$60/Maximum	Not covered
	Preferred brand drugs	20% coinsurance Retail and Mail subject to: Retail: \$20/Minimum, \$100/Maximum; Mail and Retail 90: \$40/Minimum, \$200/Maximum	30-day supply retail and 31-90 day supply for mail order. 90-day retail ("Retail 90") at Walgreens/Duane Reade only. Certain medications are subject to step therapy and/or require preauthorization. If Brand drug is purchased when Generic is available, participant pays the applicable cost sharing plus the difference between the Brand and Generic price. No charge for FDA-approved Generic contraceptives (or Brand contraceptives if Generic is medically inappropriate).
	Non-preferred brand drugs	30% coinsurance Retail and Mail subject to: Retail: \$40/Minimum, \$200/Maximum; Mail and Retail 90: \$80/Minimum, \$400/Maximum	Not covered

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
<p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.optumrx.com">www.optumrx.com</a></p> <p>Visit <a href="https://specialty.optumrx.com/">https://specialty.optumrx.com/</a> for information about specialty drugs</p>	<u>Specialty drugs</u>	Optum Specialty only 30-day supply Generic: 10% coinsurance with \$15/Minimum, \$60/Maximum Preferred Brand Drug: 20% coinsurance with \$40/Minimum, \$200/Maximum Non-Preferred Brand Drug: 30% coinsurance with \$80/Minimum; \$400/Maximum; For more than 30-day supply, Generic: 10% coinsurance with \$30/minimum \$120/maximum Preferred Brand Drug: 20% coinsurance with \$80/minimum \$400/maximum Non-Preferred Brand drug: 30% coinsurance with \$160/minimum \$800/maximum	Not covered  Preauthorization Required. Optum Specialty drug Smart Fill or Split Fill program can provide specialty drugs for 30-day supply or less than or more than 30-day supply. For a Split Fill (one half month's supply) for certain conditions minimums and maximum may be reduced.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>
	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency transport.
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay/day</u> first 5 days per stay; 0% <u>coinsurance</u> thereafter	\$500 <u>copay/day</u> first 5 days per stay; 40% <u>coinsurance</u> thereafter	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care. Max <u>copay</u> /calendar year: \$2,500 out-of-network.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	\$250 <u>copay/day</u> first 5 days per stay; 0% <u>coinsurance</u> thereafter	\$500 <u>copay/day</u> first 5 days per stay; 40% <u>coinsurance</u> thereafter	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care. Max <u>copay</u> /calendar year: \$2,500 out-of-network.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u> services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Max <u>copay</u> /calendar year: \$2,500 out-of-network. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250 <u>copay/day</u> first 5 days per stay; 0% <u>coinsurance</u> thereafter	\$500 <u>copay/day</u> first 5 days per stay; 40% <u>coinsurance</u> thereafter	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	\$250 <u>copay/day</u> first 5 days per stay; 0% <u>coinsurance</u> thereafter	\$500 <u>copay/day</u> first 5 days per stay; 40% <u>coinsurance</u> thereafter	120 days/calendar year. Max <u>copay</u> /calendar year: \$2,500 out-of-network. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	<u>Hospice services</u>	\$250 <u>copay</u> /day first 5 days per stay, 0% <u>coinsurance</u> thereafter for inpatient; 20% <u>coinsurance</u> for outpatient	\$500 <u>copay</u> /day first 5 days per stay; 40% <u>coinsurance</u> thereafter for inpatient; 40% <u>coinsurance</u> for outpatient
If your child needs dental or eye care	Children's eye exam	No charge	40% <u>coinsurance</u>
	Children's glasses	Not covered	Not covered
	Children's dental check-up	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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Acupuncture - 10 visits/calender year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing - 70- 8 hour shifts/calender year.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

**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 at 1-888-982-3862.
- 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 1-888-982-3862. 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? No.**

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 <u>plan's overall deductible</u>	\$1,000
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) copayment</u>	\$250
■ <u>Other coinsurance</u>	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:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$630
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,190</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$1,000
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) copayment</u>	\$250
■ <u>Other coinsurance</u>	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*)

**Total Example Cost** **\$5,600**

**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$930
<i>What isn't covered</i>	
Limits or exclusions	\$230
<b>The total Joe would pay is</b>	<b>2,160</b>

### Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$1,000
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) copayment</u>	\$250
■ <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**

**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$360
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,360</b>

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

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## Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

## 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.

English -	To access language services at no cost to you, call 1-888-982-3862.
Amharic -	የችንች አገልግሎቶችን የለከፍም ለማግኘት፡ በ 1-888-982-3862 ይደውሉ፡፡
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء التصال على الرقم 1-888-982-3862.
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-982-3862.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-888-982-3862.
Cushitic-Oromo	Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.
French Creole (Haitian)-	Pou jwenn sèvis lang gratis, rele 1-888-982-3862.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પહોર માટે, કોણ કરોર 1-888-982-3862.
Hindi -	आपकेलिए बिना ककसी कीमत के भाषा सेवाओंका उपयोग करनेकेलिए, 1-888-982-3862 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.
Japanese -	言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。
Karen -	လာတ်ကမ္မန်ကိုယ်အတ်မာစာအတ်ပံးတ်မာတ်ဖုံးလာတ်အိုးအပူလာကဘုံဟုံအိုးဘုံန် ကို 1-888-982-3862 ဗော်။
Korean -	무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
Laotian -	ເຜົ່າຂົ້ນໃຈ້ກ້ານບໍລິການພາກາໄດ້ລັບໜ່າຍຄ່າກໍາທ່ານ, ໃຫ້ໃຫ້ທາງເປີ 1-888-982-3862.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាគម្មភាសាដែលត្រួតពិនិត្យសម្រាប់លោកអ្នក ស្មោះក្នុងសំណើនាគាន់លើ 1-888-982-3862 ។

Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo báqh ílínígóó koji' hólne' 1-888-982-3862.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.
Persian-Farsi -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید.
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.
Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫੋਨ ਕਰੋ।
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-888-982-3862.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.
Syriac-Assyrian -	جَلْ بِلْجِيَّةَ حَلَقَنْتَهُ، ۱-۸۸۸-۹۸۲-۳۸۶۲، مُبَحَّثَةَ:
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862.