



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 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:
What is the overall deductible?	In- <u>Network</u> (INN): EE+ 1 Dependent (DEP): Individual (IND) \$125/ Family (FAM) \$250. Out-of- <u>Network</u> (OON): EE+ 1 DEP: IND \$500/ FAM \$1,000.	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>Preventive care</u> & <u>prescription drugs</u> ; plus INN office visits 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. For <u>prescription drugs</u> - IND \$100 / FAM \$200. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	INN: EE+ 1 DEP: IND 4% of Annual (ANN) Salary \$8,550 Max/ FAM 8% of ANN Salary \$17,100 Max. OON: EE+ 1 DEP: IND 8% of ANN Salary/ FAM 12% of ANN Salary.	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 & penalties for failure to obtain <u>pre-authorization</u> for services.	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 www.aetna.com/docfind or call 1-888-982-3862 for a list of Dow Family Health Center <u>providers</u> .	You pay the least if you use a <u>provider</u> in Dow Family Health Center <u>Provider</u> . You pay more if you use a <u>provider</u> in In- <u>Network</u> <u>Provider</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</u> 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 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
		Dow Family Health Center Provider (You will pay the least)	In-Network Provider (You will pay more)	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	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory; 15% <u>coinsurance</u> for all other services	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory; 15% <u>coinsurance</u> for all other services	30% <u>coinsurance</u>	None
	<u>Preventive care /screening /immunization</u>	No charge	No charge	No charge	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)	No charge for laboratory; \$10 <u>copay</u> /visit for x-ray, <u>deductible</u> doesn't apply	No charge for laboratory; 15% <u>coinsurance</u> for x-ray	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$2 (retail)	20% <u>copay</u> /prescription, after specific <u>deductible</u> (retail & mail order)	20% <u>copay</u> /prescription, after specific <u>deductible</u> (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral &

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
More information about prescription drug coverage is available at www.aetnapharmacy.com/advancedcontrol	Preferred brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$2 (retail)	20% <u>copay/prescription</u> , after specific <u>deductible</u> (retail & mail order)	20% <u>copay/prescription</u> , after specific <u>deductible</u> (retail)	injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics. Maintenance drugs-after three retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy, otherwise, higher costs may apply. <u>Deductible</u> waived for mail order drugs. All prescriptions must be filled through the Aetna Specialty Performance Pharmacy <u>Network</u> . \$200 maximum <u>copay</u> for each 30 day supply.
	Non-preferred brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$2 (retail)	30% <u>copay/prescription</u> , after specific <u>deductible</u> (retail & mail order)	30% <u>copay/prescription</u> , after specific <u>deductible</u> (retail)	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	20% <u>copay/prescription</u> , after specific <u>deductible</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	Not applicable	15% <u>coinsurance</u> after \$100 <u>copay/visit</u>	15% <u>coinsurance</u> after \$100 <u>copay/visit</u>	30% <u>coinsurance</u> after \$100 <u>copay/visit</u> for non-emergency use out-of-network.
	<u>Emergency medical transportation</u>	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Non-emergency transport: not covered, except 30% <u>coinsurance</u> if pre-authorized.
	<u>Urgent care</u>	Not applicable	\$20 <u>copay/visit</u> , after <u>deductible</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay</u> /stay	30% <u>coinsurance</u>	Max <u>copay</u> /calendar year: \$500. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	Office: \$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 15% <u>coinsurance</u>	Office & other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay</u> /stay	30% <u>coinsurance</u>	Max <u>copay</u> /calendar year: \$500. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	Not applicable	No charge	No charge	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Max <u>copay</u> /calendar year: \$500. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay</u> /stay; <u>deductible</u> waived for newborn hospital expenses	30% <u>coinsurance</u> ; <u>deductible</u> waived for newborn hospital expenses	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	90 visits/calendar year. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; Occupational & Speech Therapy not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; Occupational & Speech Therapy not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay</u> /stay	30% <u>coinsurance</u>	180 days/calendar year for out-of-network care. Max <u>copay</u> /calendar year: \$500. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	15% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	Not applicable	No charge	No charge	Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not applicable	No charge	No charge	1 routine eye exam/calendar year.
	Children's glasses	Not applicable	Not covered	Not covered	Not covered.
	Children's dental check-up	Not applicable	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
- Weight loss programs - Except for required preventive services.

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

- Bariatric surgery - Travel and Lodging limited to \$10,000 maximum for Institutes of Quality contracted facility.
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - \$3000 maximum/36 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - \$15,000 maximum/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/calendar year.
- Routine foot care - If deemed medically necessary.

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.
- 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 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number 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.
- 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 \$125
- Specialist copayment \$10
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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>	\$100
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,680

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

- The plan's overall deductible \$125
- Specialist copayment \$10
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$220

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

- The plan's overall deductible \$125
- Specialist copayment \$10
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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>	\$100
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$450

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

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.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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