

Summary of Benefits and Coverage: *What this Plan Covers & What You Pay for Covered Services*

Coverage for: Individual + Family | Plan Type: EPO



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 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services
Are there other deductibles 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> ?	Maximum Savings/Jackson Health System: Individual \$3,000 / Family \$6,000. Standard Savings/Aetna National: Individual \$3,000 / Family \$6,000.	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, prescription drug brand additional charges, and services this plan does not cover.</u>	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 Aetna HMO Advantage or call 1-833-704-0009 for a list of Maximum Savings/Jackson Health System <u>Providers</u> .	You pay the least if you use a <u>provider</u> in Maximum Savings/Jackson Health System <u>Provider</u> . You pay more if you use a <u>provider</u> in Standard Savings/Aetna National <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 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
		Maximum Savings/Jackson Health System Provider (You will pay the least)	Standard Savings/Aetna National 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	\$15 <u>copay/visit</u>	\$15 <u>copay/visit</u>	Not covered	<p>Additional charges may apply for non-preventive services performed in the Physician's office.</p> <p>Virtual Visits via Participating Primary Care Providers</p> <p>Telehealth/Telemedicine 'service' provided through CVS Virtual Primary Care/ CVS Virtual Care.</p>
	CVS Virtual Primary Care CVS Virtual Care	\$0 copay \$0 copay	\$0 copay \$0 copay	Not covered	
If you visit a health care provider's office or clinic	<u>Specialist visit</u>	\$40 <u>copay/visit</u>	\$40 <u>copay/visit</u>	Not covered	<p>Additional charges may apply for non-preventive services performed in the Physician's office.</p> <p>Virtual Visits via Participating Specialist Providers.</p> <p>Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments not covered.</p>
If you visit a health care provider's office or clinic	<u>Preventive care /screening /immunization</u>	No charge	No charge	Not covered	<p>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.</p>

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		Maximum Savings/Jackson Health System Provider (You will pay the least)	Standard Savings/Aetna National Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have a test	<i>Diagnostic test (x-ray, blood work)</i>	No charge	No charge for laboratory; \$100 copay/visit for x-ray	Not covered	Non-preventive ultrasound and mammograms are included in this category.
If you have a test	<i>Imaging (CT/PET scans, MRIs)</i>	No charge	Complex Imaging Facility \$100 copay/visit \$750 copay; other hospital based	Not covered	None
If you need drugs to treat your illness or condition <i>More information about prescription drug coverage is available at www.aetnapharmacy.com/standard</i>	<i>Generic drugs</i>	Not applicable	<i>Copay/prescription: \$15 (30 day supply), \$45 (90 day supply)</i>	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail at Extended Day Supply Network Pharmacy & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your <u>formulary</u> for prescriptions requiring precertification for coverage. Your cost will be higher for choosing Brand over Generics. Review your Aetna Extended Day Supply Network provider directory for a list of <u>network providers</u> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Maximum Savings/Jackson Health System Provider (You will pay the least)	Standard Savings/Aetna National Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.aetnapharmacy.com/standard</p>	Preferred brand drugs	Not applicable	Copay/prescription: \$40 (30 day supply), \$120 (90 day supply)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail at Extended Day Supply Network Pharmacy & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your <u>formulary</u> for prescriptions requiring precertification for coverage. Your cost will be higher for choosing Brand over Generics. Review your Aetna Extended Day Supply Network provider directory for a list of <u>network providers</u> .
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.aetnapharmacy.com/standard</p>	Non-preferred brand drugs	Not applicable	Copay/prescription: \$55 (30 day supply), \$165 (90 day supply)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail at Extended Day Supply Network Pharmacy & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your <u>formulary</u> for prescriptions requiring precertification for coverage. Your cost will be higher for choosing Brand over Generics. Review your Aetna Extended Day Supply Network provider directory for a list of <u>network providers</u> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Maximum Savings/Jackson Health System Provider (You will pay the least)	Standard Savings/Aetna National Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p><i>More information about prescription drug coverage is available at www.aetnapharmacy.com/standard</i></p>	<u>Specialty drugs</u>	<i>Not applicable</i>	<i>Copay/prescription: \$150 (30 day supply)</i>	<i>Not covered</i>	<i>All prescriptions must be filled through the Aetna Specialty Pharmacy <u>Network</u>.</i>
If you have outpatient surgery	<i>Facility fee (e.g., ambulatory surgery center)</i>	<i>No charge</i>	<i>\$0 at Ambulatory Surgery Center; \$100 <u>copay/visit</u> at other Hospital</i>	<i>Not covered</i>	<i>Prior Authorization May Apply</i>
If you have outpatient surgery	<i>Physician/surgeon fees</i>	<i>No charge</i>	<i>No charge</i>	<i>Not covered</i>	
If you need immediate medical attention	<u>Emergency room care</u>	<i>\$150 <u>copay/visit</u> (waived if admitted)</i>	<i>\$150 <u>copay/visit</u> (waived if admitted)</i>	<i>\$150 <u>copay/visit</u> (waived if admitted)</i>	<i>Out-of-<u>network</u> emergency use paid the same as in-<u>network</u>. No coverage for non-emergency use.</i>
If you need immediate medical attention	<u>Emergency medical transportation</u>	<i>No charge</i>	<i>No charge</i>	<i>No charge</i>	<i>Out-of-<u>network</u> emergency use paid the same as in-<u>network</u>. Non-emergency transport: not covered, except if pre-authorized.</i>
If you need immediate medical attention	<u>Urgent care</u>	<i>\$15 <u>copay/visit</u> at JHS Urgent Care</i>	<i>\$25 <u>copay/visit</u></i>	<i>\$25 <u>copay/visit</u></i>	<i>No coverage for non-urgent use. CVS Minute Clinic \$0 copay/visit, all other Walk-In Clinics - \$15 copay applies to in-network/out-of-network</i>
If you have a hospital stay	<i>Facility fee (e.g., hospital room)</i>	<i>No charge</i>	<i>\$200 <u>copay/stay</u></i>	<i>Not covered</i>	<i>Prior Authorization May Apply.</i>

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		Maximum Savings/Jackson Health System Provider (You will pay the least)	Standard Savings/Aetna National Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	<i>Physician/surgeon fees</i>	<i>No charge</i>	<i>No charge</i>	<i>Not covered</i>	
If you need mental health, behavioral health, or substance abuse services	<i>Outpatient services</i>	<i>Physician Office visit & other outpatient services: \$15 <u>copay</u>/visit</i>	<i>Physician Office visit & other outpatient services: \$15 <u>copay</u>/visit</i>	<i>Not covered</i>	<i>None</i>
If you need mental health, behavioral health, or substance abuse services	<i>Inpatient services</i>	<i>No charge</i>	<i>\$200 <u>copay</u>/stay</i>	<i>Not covered</i>	<i>Prior Authorization May Apply</i>
If you are pregnant	<i>Office visits</i>	<i>No charge</i>	<i>No charge</i>	<i>Not covered</i>	<i><u>Cost sharing</u> does not apply for <u>preventive services</u>. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Prior Authorization May Apply</i>
If you are pregnant	<i>Childbirth/delivery professional services</i>	<i>No charge</i>	<i>No charge</i>	<i>Not covered</i>	<i><u>Cost sharing</u> does not apply for <u>preventive services</u>. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).</i>
If you are pregnant	<i>Childbirth/delivery facility services</i>	<i>No charge at JHS/UM Facilities</i>	<i>\$200 <u>copay</u>/stay</i>	<i>Not covered</i>	<i><u>Cost sharing</u> does not apply for <u>preventive services</u>. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).</i>
If you need help recovering or have other special health needs	<i><u>Home health care</u></i>	<i>No charge</i>	<i>No charge</i>	<i>Not covered</i>	<i>Approved treatment plan required.</i>

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		Maximum Savings/Jackson Health System Provider (You will pay the least)	Standard Savings/Aetna National Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	\$30 <u>copay/visit</u>	\$30 <u>copay/visit</u>	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
If you need help recovering or have other special health needs	<u>Habilitation services</u>	\$15 <u>copay/visit</u>	\$15 <u>copay/visit</u>	Not covered	None
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	No charge	No charge	Not covered	60 days/calendar year. Prior Authorization May Apply.
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	\$5 <u>copay/visit</u>	\$5 <u>copay/visit</u>	Not covered	
If you need help recovering or have other special health needs	<u>Hospice services</u>	No charge	No charge	Not covered	Prior Authorization May Apply
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay/exam</u>	\$15 <u>copay/exam</u>	Not covered	1 routine eye exam/12 months.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's dental check-up	Not covered	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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care. except diabetics and medical guidelines applied.
- Weight loss programs
- Artificial Insemination, In-vitro fertilizations, Comprehensive Infertility GIFT, ZIFT, and other infertility treatments are not covered.

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

- Bariatric surgery - Limited to Jackson Health System providers.
- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Acupuncture

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 1-877-267-2323 x61565 or www.cciio.cms.gov. 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:

- You may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. 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 \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$200
- Other copayment \$0

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>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
<u>Limits or exclusions</u>	\$60
The total Peg would pay is	\$560

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$200
- Other copayment \$0

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>	\$0
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
<u>Limits or exclusions</u>	\$20
The total Joe would pay is	\$1,220

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$200
- Other copayment \$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
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
<u>Limits or exclusions</u>	\$0
The total Mia would pay is	\$700

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

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 1-800-370-4526.
- Amharic -** የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።.
- Arabic -** للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526.
- Armenian -** Անվճար լեզվական ծառայությունները օգտվելու համար գանգահարեք 1-800-370-4526 հեռախոսահամարով:
- Carolinian (Kapasal Falawasch) -** ngere aukke ghut allillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.
- Chamorro -** Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
- Chinese Traditional -** 如欲使用免費語言服務，請致電 1-800-370-4526.
- Cushitic-Oromo** Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
- French -** Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
- French Creole (Haitian)-** Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
- German -** Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
- Greek -** Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
- Gujarati -** તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પછોર માટે, કોલ કરો 1-800-370-4526.
- Hindi -** आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।.
- Hmong -** Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
- Italian -** Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
- Japanese -** 言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
- Karen -** လာတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လာတအိၣ်ဒီးအပူၤလာကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-370-4526
- Korean -** 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
- Laotian -** ເພື່ອຂ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໃບຫາເບີ 1-800-370-4526.
- Mon-Khmer, Cambodian -** ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។

