



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 <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> ?	Maximum Savings/Jackson Health System: Individual \$2,500 / Family \$5,000. Standard Savings/Aetna National: Individual \$2,500 / Family \$5,000.	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 Select Advantage HMO 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit	\$15 <u>copay</u> /visit	Not covered	Additional charges may apply for non-preventive services in the Physician's office.. Virtual Visits via Participating Primary Care Providers Telehealth/Telemedicine 'service' provided through CVS Virtual Primary Care/CVS Virtual Care.
	CVS Virtual Primary Care CVS Virtual Care	\$10 copay/visit \$10 copay/visit	\$10 copay/visit \$10 copay/visit	Not covered	
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	\$30 <u>copay</u> /visit	\$30 <u>copay</u> /visit	Not covered	Additional charges may apply for non-preventive services performed in the Physician's office. Virtual Visits via Participating Specialist Providers Artificial insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments not covered.
If you visit a health care <u>provider's</u> office or clinic	<u>Preventive care/screening</u> /immunization	No charge	No charge	Not covered	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.

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If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	\$50 <u>copay</u> /visit	Not covered	Non-preventive ultrasound and mammograms are included in this category.
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	Complex Imaging Facility: \$50 <u>copay</u> /visit \$750 copay at other hospitals	Not covered	Prior Authorization May Apply
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/standard	Generic drugs	Not applicable	<u>Copay</u> /prescription: \$15 (30 day supply), \$45 (90 day supply)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail at Extended Day Supply <u>Network</u> Pharmacy & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . 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 <u>Network provider</u> directory for a list of <u>network providers</u> .

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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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/standard</p>	Preferred brand drugs	Not applicable	Copay/prescription: \$25 (30 day supply), \$75 (90 day supply)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail at Extended Day Supply <u>Network</u> Pharmacy & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . 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 <u>Network provider</u> 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 <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/standard</p>	Non-preferred brand drugs	Not applicable	Copay/prescription: \$35 (30 day supply), \$105 (90 day supply)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail at Extended Day Supply <u>Network</u> Pharmacy & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . 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 <u>Network provider</u> directory for a list of <u>network providers</u> .

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<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>	<u>Specialty drugs</u>	Not applicable	<u>Copay</u> /prescription: \$50 (30 day supply)	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy <u>Network</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	\$0 Ambulatory Surgery Center; \$50 <u>copay</u> /visit at other Hospital	Not covered	Prior Authorization May Apply
If you have outpatient surgery	Physician/surgeon fees	No charge	No charge	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit (waived if admitted)	\$100 <u>copay</u> /visit (waived if admitted)	\$100 <u>copay</u> /visit (waived if admitted)	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
If you need immediate medical attention	<u>Emergency medical transportation</u>	No charge	No charge	No charge	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
If you need immediate medical attention	<u>Urgent care</u>	\$15 <u>copay</u> /visit at JHS urgent care	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	No coverage for non-urgent use. Walk-In Clinics \$15 copay/visit, applies to in-network/out-of-network
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$100 <u>copay</u> /stay	Not covered	Prior Authorization May Apply
If you have a hospital stay	Physician/surgeon fees	No charge	No charge	Not covered	

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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 mental health, behavioral health, or substance abuse services	Outpatient services	Physician Office visit & other outpatient services: \$15 <u>copay</u> /visit	Physician Office visit & other outpatient services: \$15 <u>copay</u> /visit	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	No charge	\$100 <u>copay</u> /stay	Not covered	Prior Authorization May Apply
If you are pregnant	Office visits	No charge	No charge	Not covered	<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.
If you are pregnant	Childbirth/delivery professional services	No charge	No charge	Not covered	<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).
If you are pregnant	Childbirth/delivery facility services	No charge at JHS/UM Facilities	\$100 <u>copay</u> /stay	Not covered	<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).
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	No charge	Not covered	Approved treatment plan required.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.

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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>Habilitation services</u>	\$15 <u>copay</u> /visit	\$15 <u>copay</u> /visit	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</u>	\$5 <u>copay</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</u> /exam	\$15 <u>copay</u> /exam	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.)

- Acupuncture
- 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 diabetes 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/Center of Excellence
- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

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](#).

[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.

