



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:
<b>What is the overall deductible?</b>	In-Network (INN): EE Only (EO) \$125; EE+ Family (FAM): Individual (IND) \$125/FAM \$375. Out-of-Network (OON): EO \$500; EE+ FAM: IND \$500/FAM \$1,500.	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.
<b>Are there services covered before you meet your deductible?</b>	Yes. Preventive care; plus INN office visits are 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>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	INN: EO 4% of Annual (ANN) Salary \$10,600 Max; EE+ FAM: IND 4% of ANN Salary \$10,600 Max / FAM 8% of ANN Salary \$21,200 Max. OON: EO 8% of ANN Salary; EE+ FAM: IND 8% of ANN Salary/FAM 12% of ANN Salary.	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.
<b>What is not included in the out-of-pocket limit?</b>	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.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of Dow Family Health Center providers.	You pay the least if you use a provider in Dow Family Health Center. You pay more if you use a provider in In-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.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the specialist you choose without a referral.



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 (You will pay the least)	In-Network (You will pay more)	Out-of-Network (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	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</u> / <u>screening</u> /immunization	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.
<b>If you have a test</b>	<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)	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	\$2 (bypasses deductible)	20% coinsurance	20% via paper claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center (You will pay the least)	In-Network (You will pay more)	Out-of-Network (You will pay the most)	
More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Preferred brand drugs	\$2 (bypasses deductible)	20% coinsurance	20% via paper claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims. Brand penalty applied when non-preferred brand filled over generic PLUS brand coinsurance Must fill through CVS Specialty Pharmacy
	Non-preferred brand drugs	\$2 (bypasses deductible)	30% coinsurance	30% via paper claims	
	<u>Specialty drugs</u>	Not covered	20% coinsurance Max \$200	20% via paper claims	
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	15% <u>coinsurance</u> after \$100 <u>copay/visit</u>	15% <u>coinsurance</u> after \$100 <u>copay/visit</u>	15% <u>coinsurance</u> after \$100 <u>copay/visit</u>	Out-of-network emergency use paid the same as in-network. 30% <u>coinsurance</u> after \$100 <u>copay/visit</u> for non-emergency use out-of-network.
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	Not applicable	\$20 <u>copay/visit</u>	30% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	30% <u>coinsurance</u>	Max <u>copay/calendar year</u> : \$500 in-network. 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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center (You will pay the least)	In-Network (You will pay more)	Out-of-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	Office: \$20 <u>copay/visit</u> , <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/stay</u>	30% <u>coinsurance</u>	Max <u>copay</u> /calendar year: \$500 in-network. 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 in-network. 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/stay</u> ; <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>	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/visit</u> , <u>deductible</u> doesn't apply; Speech Therapy not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$10 <u>copay/visit</u> , <u>deductible</u> doesn't apply; 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 (You will pay the least)	In-Network (You will pay more)	Out-of-Network (You will pay the most)	
	<u>Skilled nursing care</u>	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	30% <u>coinsurance</u>	180 days/calendar year for out-of-network care. Max <u>copay</u> /calendar year: \$500 in-network. 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/visit</u> , <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.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not applicable	No charge	No charge	1 routine eye exam/calendar year.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	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 (Child)
- 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.)**

- Bariatric surgery - Travel and Lodging limited to \$10,000 maximum for Institutes of Quality contracted in-network facility only.
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - \$3,000 maximum/36 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing - 120-8 hour shifts/calendar year.
- 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](#) 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 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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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	\$70
<b>The total Peg would pay is</b>	<b>\$1,690</b>

**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 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>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,400</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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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	\$10
<b>The total Mia would pay is</b>	<b>\$460</b>

### [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.

TTY: 711

- English -** To access language services at no cost to you, call 1-888-982-3862.
- Amharic -** የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ።.
- Arabic -** للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال 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 lengguâhi 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 બચવિના ભાષાની સે વિના ઓની પછોર માટે, કોલ કરો 1-888-982-3862.
- Hindi -** आपकेलिए बिना ककसी कीमत केभाषा 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 -** လာတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-888-982-3862 တက့ၢ်.
- Korean -** 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
- Laotian -** ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862.
- Mon-Khmer, Cambodian -** ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ។





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<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	INN: EE+ 1 DEP: IND 4% of Annual Salary (SAL) \$10,600 Max/ FAM 8% of (SAL) \$21,200 Max. OON: EE+ 1 DEP: IND 4% of SAL \$10,600 Max/ FAM 8% of SAL \$21,200 Max.	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.
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> 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. You pay more if you use a <u>provider</u> in In- <u>Network 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.
<b>Do you need a referral to see a specialist?</b>	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 (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 <u>provider's</u> 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</u> / <u>screening</u> /immunization	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)	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition	Generic drugs	\$2 (bypasses deductible)	20% coinsurance	20% via paper claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Preferred brand drugs	\$2 (bypasses deductible)	20% coinsurance	20% via paper claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims. Brand penalty applied when non-preferred brand filled over generic PLUS brand coinsurance Must fill through CVS Specialty Pharmacy
	Non-preferred brand drugs	\$2 (bypasses deductible)	30% coinsurance	30% via paper claims	
	<u>Specialty drugs</u>	Not covered	20% coinsurance Max \$200	20% via paper claims	
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	15% <u>coinsurance</u> after \$100 <u>copay</u> /visit	15% <u>coinsurance</u> after \$100 <u>copay</u> /visit	15% <u>coinsurance</u> after \$100 <u>copay</u> /visit	Out-of-network emergency use paid the same as in-network. 30% <u>coinsurance</u> after \$100 <u>copay</u> /visit for non-emergency use out-of-network.
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	Not applicable	\$20 <u>copay</u> /visit	30% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	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 in-network. 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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center (You will pay the least)	In-Network 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	Not applicable	Office: \$20 <u>copay/visit</u> , <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/stay</u>	30% <u>coinsurance</u>	Max <u>copay</u> /calendar year: \$500 in-network. 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 in-network. 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/stay</u> ; <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>	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/visit</u> , <u>deductible</u> doesn't apply; Speech Therapy not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$10 <u>copay/visit</u> , <u>deductible</u> doesn't apply; 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 (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<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 in-network. 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.
<b>If your child needs dental or eye care</b>	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
- 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 - Travel and Lodging limited to \$10,000 maximum for Institutes of Quality contracted in-network facility only.
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - \$3,000 maximum/36 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - 120-8 hour shifts/calendar year.
- 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](#) 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 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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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	\$70
<b>The total Peg would pay is</b>	<b>\$1,690</b>

**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 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>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,400</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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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	\$10
<b>The total Mia would pay is</b>	<b>\$460</b>

### [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.

TTY: 711

- English - **To access language services at no cost to you, call 1-888-982-3862.**
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ።.
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال 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, bilibili 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 બચવિના ભાષાની સે વિના ઓની પછોર માટે, કોલ કરો 1-888-982-3862.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा 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 - လာတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-888-982-3862 တက့ၢ်.
- Korean - 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
- Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862.
- Mon-Khmer, Cambodian - ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ។





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:
<b>What is the overall deductible?</b>	In- <u>Network</u> (INN): EE Only (EO) \$250; EE (E)+ Family (F): Individual (IND) \$250 / F \$750. Out-of- <u>Network</u> (OON): EO \$250; E+ F: IND \$250/ F \$750.	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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> & 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	INN: EO 4% of Annual Salary (SAL) \$10,600 Max; E+ F: IND 4% of SAL \$10,600 Max/F 8% of SAL \$21,200 Max. OON: EO 4% of SAL \$10,600 Max; E+ F: IND 4% of SAL/F 8% of SAL \$21,200 Max.	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.
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> 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 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.
<b>Do you need a referral to see a specialist?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	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	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory; 15% <u>coinsurance</u> for all other services	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	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory; 15% <u>coinsurance</u> for all other services	None
	<u>Preventive care</u> / <u>screening</u> /immunization	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.
<b>If you have a test</b>	<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	No charge for laboratory; 15% <u>coinsurance</u> for x-ray	None
	Imaging (CT/PET scans, MRIs)	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	\$2 (bypasses deductible)	20% coinsurance	20% via Paper Claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims
	Preferred brand drugs	\$2 (bypasses deductible)	20% coinsurance	20% via Paper Claims	

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 <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Non-preferred brand drugs	\$2 (bypasses deductible)	30% coinsurance	30% via Paper Claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims. Brand penalty applied when non-preferred brand filled over generic PLUS brand coinsurance
	<u>Specialty drugs</u>	Not covered	20% coinsurance Max \$200	20% via Paper Claims	Must fill through CVS Specialty Pharmacy
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
	Physician/surgeon fees	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<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>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Emergency medical transportation</u>	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	Not applicable	\$20 <u>copay/visit</u>	\$20 <u>copay/visit</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	Max family <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- <u>network</u> care.
	Physician/surgeon fees	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Not applicable	Office: \$20 <u>copay/visit</u> , deductible doesn't apply; other outpatient services: 15% <u>coinsurance</u>	Office: \$20 <u>copay/visit</u> , deductible doesn't apply; other outpatient services: 15% <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)	
	Inpatient services	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	Max family <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	<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). Max family <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>	15% <u>coinsurance</u>	
	Childbirth/delivery facility services	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u> ; <u>deductible</u> waived for newborn hospital expenses	15% <u>coinsurance</u> after \$250 <u>copay/stay</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>	15% <u>coinsurance</u>	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; Speech Therapy not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; Speech Therapy not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	Max family <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>	15% <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
		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>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
- 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.)

- Bariatric surgery - Travel and Lodging limited to \$10,000 maximum for Institutes of Quality contracted in-network facility only.
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - \$3,000 maximum/36 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing - 120-8 hour shifts/calendar year.
- 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 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 plan's overall deductible \$250
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$1,840</b>

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

- The plan's overall deductible \$250
- Specialist copayment \$10
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,400</b>

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

- The plan's overall deductible \$250
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$610</b>

### 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.

TTY: 711

- English -** To access language services at no cost to you, call 1-888-982-3862.
- Amharic -** የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ።.
- Arabic -** للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال 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 બચાવિના ભાષાની સે વિના ઓની પછોર માટે, કોલ કરો 1-888-982-3862.
- Hindi -** आपकेलिए बिना ककसी कीमत केभाषा 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 -** လာတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-888-982-3862 တက့ၢ်.
- Korean -** 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
- Laotian -** ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862.
- Mon-Khmer, Cambodian -** ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ។





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:
<b>What is the overall deductible?</b>	In- <u>Network</u> (INN): EE+ 1 Dependent (DEP): Individual (IND) \$250/ Family (FAM) \$500. Out-of- <u>Network</u> (OON): EE+ 1 DEP: IND \$250/ FAM \$500.	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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> & 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	INN: EE+ 1 DEP: IND 4% of Annual Salary (SAL) \$10,600 Max/ FAM 8% of (SAL) \$21,200 Max. OON: EE+ 1 DEP: IND 4% of SAL \$10,600 Max/ FAM 8% of SAL \$21,200 Max.	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.
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> 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. You pay more if you use a <u>provider</u> in In- <u>Network 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.
<b>Do you need a referral to see a specialist?</b>	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 (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	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	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory; 15% <u>coinsurance</u> for all other services	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	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory; 15% <u>coinsurance</u> for all other services	None
	<u>Preventive care</u> / <u>screening</u> /immunization	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.
<b>If you have a test</b>	<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	No charge for laboratory; 15% <u>coinsurance</u> for x-ray	None
	Imaging (CT/PET scans, MRIs)	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	\$2 (bypasses deductible)	20% coinsurance	20% via paper claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Preferred brand drugs	\$2 (bypasses deductible)	20% coinsurance	20% via paper claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims
	Non-preferred brand drugs	\$2 (bypasses deductible)	30% coinsurance	30% via paper claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200, Family \$300 (Not combined with Medical) Excludes Mail Claims. Brand penalty applied when non-preferred brand filled over generic PLUS brand coinsurance
	<u>Specialty drugs</u>	Not covered	20% coinsurance Max \$200	20% via paper claims	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
	Physician/surgeon fees	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<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>	Out-of-network emergency use paid the same as in-network.
	<u>Emergency medical transportation</u>	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	Not applicable	\$20 <u>copay/visit</u>	\$20 <u>copay/visit</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	15% <u>coinsurance</u> after \$250 <u>copay/stay</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>	15% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center (You will pay the least)	In-Network 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	Not applicable	Office: \$20 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: 15% <u>coinsurance</u>	Office: \$20 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: 15% <u>coinsurance</u>	None
	Inpatient services	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	15% <u>coinsurance</u> after \$250 <u>copay/stay</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	<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). 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>	15% <u>coinsurance</u>	
Childbirth/delivery facility services	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u> ; <u>deductible</u> waived for newborn hospital expenses	15% <u>coinsurance</u> after \$250 <u>copay/stay</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>	15% <u>coinsurance</u>	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/visit</u> , <u>deductible</u> doesn't apply; Speech Therapy not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$10 <u>copay/visit</u> , <u>deductible</u> doesn't apply; Speech Therapy not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay</u> /stay	15% <u>coinsurance</u> after \$250 <u>copay</u> /stay	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. Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. 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>	15% <u>coinsurance</u>	
	<u>Hospice services</u>	Not applicable	No charge	No charge	
<b>If your child needs dental or eye care</b>	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
- 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.)

- Bariatric surgery - Travel and Lodging limited to \$10,000 maximum for Institutes of Quality contracted in-network facility only.
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - \$3,000 maximum/36 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing - 120-8 hour shifts/calendar year
- 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 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 plan's overall deductible \$250
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$1,840</b>

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

- The plan's overall deductible \$250
- Specialist copayment \$10
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,400</b>

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

- The plan's overall deductible \$250
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$610</b>

### [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.

TTY: 711

- English -** To access language services at no cost to you, call 1-888-982-3862.
- Amharic -** የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ።.
- Arabic -** للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال 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 lengguâhi 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 બર્ચવિના ભાષાની સે વિના ઓની પછોર માટે, કોલ કરો 1-888-982-3862.
- Hindi -** आपकेलिए बिना ककसी कीमत केभाषा 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 -** လာတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-888-982-3862 တက့ၢ်.
- Korean -** 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
- Laotian -** ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862.
- Mon-Khmer, Cambodian -** ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ។

