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, go to **www.mainehealthaetna.com**. 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 www.healthcare.gov/sbc-glossary/ or call (888) 982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** individual/ **$1,000** family for Preferred Network and Participating Network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Check your policy or plan documents to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care and specialist 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$2,500**/indiv or **$5,000**/family for MaineHealth Preferred Network Providers. **$4,900**/indiv or **$9,800**/family for MaineHealth Participating Network Providers. **Prescription Drug Copay Maximum $2,250**/indiv or **$4,500**/family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year)for covered services. This limit helps you plan for health care expenses. Your out-of-pocket (deductible + coinsurance) will cross-accumulate between the Preferred and Participating Networks. The prescription drug copayment maximum applies to prescription drug copayments. This maximum is separate from the out-of-pocket limit described above.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care and prescription drugs that this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a Preferred network provider?	Yes. www.mainehealthaetna.com for a list of network providers.	There are two network provider levels, Preferred and Participating. Out of network services are not covered unless authorized and unavailable in network. You will pay the most if you use an out-of-network provider, and you will receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).

Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral from your Primary Care Physician before you see the specialist.

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
		MaineHealth Preferred Tier Provider (You will pay the least)	MaineHealth Participating Tier Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay/visit	$30 Copay/visit	--------none--------
	Specialist visit	$40 Copay/visit	$60 Copay/visit	--------none--------
	Preventive care/screening/ immunization	No charge	No charge	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	35% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.aetna.com	Tier 1 - Typically Generic	**RETAIL**: $8/MH pharmacy $10/other pharmacy **90 DAY SUPPLY**: $16 MH pharmacy $20/other (see comments)	**RETAIL**: $8/MH pharmacy $10/other pharmacy **90 DAY SUPPLY**: $16 MH pharmacy $20/other (see comments)	Prescription drugs are not subject to the overall deductible. Prescription drug copayments apply to the annual prescription drug copayment maximum described on page 1. **Retail covers up to a 30-day supply. Members can request a 90-day supply at a retail pharmacy or though home delivery.** When a generic drug is available but the member or physician requests the brand drug be dispensed, the member will pay the difference in cost between the brand and generic drug, in addition to their copayment, if a generic drug is available but a brand name is dispensed. Step Therapy and Prior Authorization may apply to some drugs. For more information, refer to "National Drug List" at: https://www.aetna.com/individualsfamilies/find-a-medication.html
	Tier 2 - Typically Preferred / Brand	**RETAIL**: $28/MH pharmacy $35/other pharmacy **90 DAY SUPPLY**: $56/MH pharmacy $70/other (see comments)	**RETAIL**: $28/MH pharmacy $35/other pharmacy **90 DAY SUPPLY**: $56/MH pharmacy $70/other (see comments)	
	Tier 3 - Typically Non-Preferred / Brand	**RETAIL**: $40/MH pharmacy $50/other pharmacy **90 DAY SUPPLY**: $80/MH pharmacy $100/other (see comments)	**RETAIL**: $40/MH pharmacy $50/other pharmacy **90 DAY SUPPLY**: $80/MH pharmacy $100/other (see comments)	
	Tier 4 - Typically Specialty (brand and generic)	$60/prescription (MaineHealth pharmacy)	Not Applicable	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		MaineHealth Preferred Tier Provider (You will pay the least)	MaineHealth Participating Tier Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	35% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$200 Copay/visit deductible does not apply then 20% coinsurance	$200 Copay/visit deductible does not apply then 20% coinsurance	All other services, including Lab/X-ray are covered at 80% after deductible. In an emergency, seek care immediately. If you are admitted to the hospital from the emergency room, the copayment is waived and the deductible and applicable coinsurance will be applied.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to Preferred out of pocket limit.
	Urgent care/Walk-In Clinic	$40 Copay/visit; deductible does not apply	$60 Copay/visit; deductible does not apply	----------none-------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	For all scheduled inpatient admissions (except maternity admissions), pre-admission authorization and approval must be received by the PCP.
	Physician/surgeon fees	20% coinsurance	35% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $15 Copay/visit Other Outpatient 20% coinsurance	Office Visit $15 Copay/visit Other Outpatient 20% coinsurance	All Inpatient/Residential, Partial Hospitalization programs, TMS services and Applied Behavioral Analysis services requires pre-certification through Behavorial Health Care Program (BHCP). Office visits with your PCP or a BHCP network provider do not need to be pre-certified.
	Inpatient services	20% coinsurance		
If you are pregnant	Office visits	$15 Copay/visit when performed by Preferred PCP.	$30 Copay/visit when performed by Participating PCP.	Copay applies for first prenatal visit. There may be other levels of cost share that are contingent on how services are provided, please see your

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		MaineHealth Preferred Tier Provider (You will pay the least)	MaineHealth Participating Tier Provider (You will pay the most)	
		$40 Copay/visit when performed by a Preferred Specialist. 20% coinsurance for subsequent care.	$60 Copay/visit when performed by a Participating Specialist. 35% coinsurance for subsequent care.	benefit overviews or SPD for a complete explanation.
	Childbirth/delivery professional services	20% coinsurance	35% coinsurance	For maternity admissions, you or someone you designate must call if the hospital stay is longer than 72 hours for a normal vaginal delivery or longer than 120 hours for a caesarean section.
	Childbirth/delivery facility services	20% coinsurance	35% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	35% coinsurance	--------none--------
	Rehabilitation services	$40 Copay/visit When performed by an occupational, physical or speech therapist. 20% coinsurance after deductible when billed by a network occupational, physical, or speech therapist separately from office visit.		Costs may vary by site of service. Coverage is limited to 60 visits per member per calendar year combined Physical, Occupational and Speech therapy.
	Habilitation services			
	Skilled nursing care	0% coinsurance	0% coinsurance	Coverage is limited to 150 days in a calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Subject to Participating out of pocket limit.
	Hospice services	0% coinsurance	35% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	--------none--------
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care
- Infertility treatment
- Long- term care
- Private-duty nursing
- Routine eye 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids ($3000 per ear/36mos)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- 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.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of Preferred Network pre-natal care and a hospital delivery)

Amount owed to provider	**$7,540**
Plan pays	**$5,658**
Patient pays	**$1,882**

Sample care costs:

Hospital Charges	$2,700
Routine Obstetric Care (1 Copay @ $15)	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory Tests	$500
Prescriptions (1 Tier 1 - 30 day supply)	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$500
Copays	$25
Coinsurance	$1,357
Limits or Exclusions (what isn't covered)	$0
Total	**$1,882**

Managing Joe's type 2 Diabetes
(a year of routine Preferred Network care of a well-controlled condition)

Amount owed to provider	**$5,400**
Plan pays	**$4,444**
Patient pays	**$956**

Sample care costs:

Prescriptions (30 day supply Tier 1 x 4)	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory Tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$500
Copays on Prescriptions	$40
Copays on Office Visits	$45
Coinsurance	$371
Limits or Exclusions (what isn't covered)	$0
Total	**$956**

Mia's Simple Fracture
(Emergency room visit and follow up care)

Amount owed to provider	**$2,010**
Plan pays	**$1,018**
Patient pays	**$992**

Sample care costs:

ER Visit	$1,000
X Rays	$660
Medical Equipment and Supplies	$100
Rehabilitative Therapy	$250
Total	**$2,010**

Patient Pays:

Deductibles	$500
Copays	$280
Coinsurance	$212
Limits or Exclusions (what isn't covered)	$0
Total	**$992**

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

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জনয্ িবনামুেলয্ 1-888-982-3862-েত কল করন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ဌေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᎧhᏯᏍᏗ ᏗhᏍᎦᏚᎩ ᎾᏑᎢ (ᏣᎳᎩ) ᎤᏲᎳᎮᏊᎦ 1-888-982-3862 ᎧᎾᎢ Ꮷ ᎪᎵᏍᏗ ᏧEᏩᏚᏗ hᏱᎡᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	?જરાતીમાં ભાષામાં સહાય માટ? કોઈ પણ ખચર્ વગર 1-888-982-3862 પર કોલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हन्दिी में भाषा सहायता के लएि, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.

Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese -	日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Karen -	လာတၫ်မၤစၢၤတၫ်ကတိၤကျိာ်အဂီၤ် ကျိာ် ကိး 1-888-982-3862 လာတအိာ်ဒီးတၫ်လာ်ဘျုာ်လာ်စုၤဘာ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dɛ́ Ɓaǎsɔ́-wudùǔn wɛ̃ɛ, dá 1-888-982-3862
Kurdish -	بۆ یارمەتی بە زمانی کوردی بە خۆڕایی پەیوەندی بکەن. 1-888-982-3862 برای راهنمایی به زبان فارسی با شماره
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याह‌ शुल्का‌शवाय भाषा सेवा प्राप्त करण्यासाठ‌, 1-888-982-3862 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
Nepali -	(नेपाल‌) मा ‌नःशुल्क भाषा सहायता पाउनका ला‌ग 1-888-982-3862 मा फोन ग ोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਿਵੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 ‘ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
Portuguese -	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-982-3862
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.

Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syriac -	ܐ ܕܒܪ ܐ ܒ ܦܬܓ ܘܒܪ ܕܠܐ ܐ ܘܓ ܡܐ ܠ ܒܦܪ ܒ 1-888-982-3862 ܘ .
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	ఉ ం ఎ ట ఖ ర ల 1-888-982-3862 ష ల
Thai -	สำหรับความชวยเหลอทางดานภาษาเป น ภาษาไทย โทร 1-888-982-3862 ฟร ม ค าใชจ าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 . پر بات کریں۔
Vietnamese -	Đê ̉ đươ ̣c hô ̃ trơ ̣ ngôn ngư ̃ bă ̀ng (ngôn ngư ̃), hă ́y goi miễn phi ́ đê ́n sô ́ 1-888-982-3862.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.