



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 1 st). 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. (Referrals are waived for emergency room, chiropractic care, massage therapy, acupuncture; physical, speech and occupational therapy; routine gynecological exams, and screening mammograms)

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: \$7.50/MH pharmacy \$10/other pharmacy 90 DAY SUPPLY: \$15 MH pharmacy \$20/other (see comments)	RETAIL: \$7.50/MH pharmacy \$10/other pharmacy 90 DAY SUPPLY: \$15 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 through home delivery.
	Tier 2 - Typically Preferred / Brand	RETAIL: \$26.25/MH pharmacy \$35/other pharmacy 90 DAY SUPPLY: \$52.50/MH pharmacy \$70/other (see comments)	RETAIL: \$26.25/MH pharmacy \$35/other pharmacy 90 DAY SUPPLY: \$52.50/MH pharmacy \$70/other (see comments)	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.
	Tier 3 - Typically Non- Preferred / Brand	RETAIL: \$37.50/MH pharmacy \$50/other pharmacy 90 DAYSUPPLY: \$75/MH pharmacy \$100/other	RETAIL: \$37.50/MH pharmacy \$50/other pharmacy 90 DAYSUPPLY: \$75/MH pharmacy \$100/other	Step Therapy and Prior Authorization may apply to some drugs.
	Tier 4 - Typically Specialty (brand and generic)	\$60/prescription (MaineHealth pharmacy)	Not Applicable	For more information, refer to “National Drug List” at: https://www.aetna.com/individualsfamilies/fi-nd-a-medication.html

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 ; no deductible	20% coinsurance ; no deductible	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 Behavioral 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
- Long- term care
- Routine foot care
- Dental care
- Private-duty nursing
- Weight loss programs
- Routine eye care

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

- Acupuncture
- Hearing aids (\$3000 per ear/36mos)
- Bariatric surgery
- Hearing Exams (\$40 preferred/\$60 participating) 1 exam/24 mos
- Chiropractic care

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-grievancesappeals/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, <u>other</u> 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, <u>other</u> 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.

- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwughị 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 - လာတၢ်မၤစၢၤတၢ်ကတိၢ်ကျိၢ်အီၣ် ကျိၢ် ကိး 1-888-982-3862 လၢတၢ်အိၣ်ဒီးတၢ်လၢတၢ်ဘျၣ်လၢတၢ်စ့ၤတၢ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
- Kru-Bassa - Bɛ́ m'ké gbo-kpá-kpá dyé pidyi dé Bāsów`wuḍuũn wɛ́ɛ, dá 1-888-982-3862
- Kurdish - برای راهنمایی به زبان فارسی یا شماره 1-888-982-3862 به خۆرایێ یه یۆهندی بکهن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - कोणॆाहॆ शुॆाशवाय भाषा सेवा प्राॆ करॆासाठॆ, 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 shík'a a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
- Nepali - (नेपाल) मा नः शु भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुोस्।
- Nilotic-Dinka - Tën kuony ë thok ë Thuonjän cöl 1-888-982-3862 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਿੱਚ ਬਾਮਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefle in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی یا 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 asistență lingvistică în românește telefonați 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.

