



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 ?	\$1,650 /employee Only Contract or \$3,300 /employee + Dependent(s) Contract. Preferred, Participating and non-network providers.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , total amount of deductible expenses paid by all family members combined must meet the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care is 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.
What is the out-of-pocket limit for this plan ?	\$3,300 /employee Only Contract or \$6,600 /employee + Dependent(s) Contract. All Providers	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 , all family members combined must meet the overall family out-of-pocket limit .
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 network provider ?	Yes. www.mainehealthaetna.com or call 833-948-3540 for a list of network providers .	This plan uses a provider network . You will pay less if you use a Preferred provider in the network . You will pay the most if you use a non- 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 a non- network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	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
		Preferred Network (You will pay the least)	Participating and Non-Network Providers (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	10% coinsurance	30% coinsurance	-----none-----
	Specialist visit	10% coinsurance	30% coinsurance	-----none-----
	Preventive care / screening / immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mainehealthaetna.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)	This plan covers certain Preventive Medications subject to the Prescription Drug copayment and not subject to the plan's deductible. Prescription Drugs are subject to the deductible, and then copays apply. Retail covers up to a 30-day supply. Members can request a 90-day supply at a retail pharmacy or through 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. Step Therapy and Prior Authorization may apply to some drugs. Specialty drugs may have separate cost structures, limitations and means of delivery. 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 Drugs	RETAIL: \$40/MH pharmacy \$50/other pharmacy 90DAYSUPPLY: \$80/MH pharmacy \$100/other (see comments)	RETAIL: \$40/MH pharmacy \$50/other pharmacy 90DAYSUPPLY: \$80/MH pharmacy \$100/other (see comments)	
	Tier 4 - Specialty Drugs	\$60/prescription (MaineHealth pharmacy)	Not Applicable	

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.mainehealthaetna.com>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network (You will pay the least)	Participating and Non-Network Providers (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	-----none-----
	Physician/surgeon fees	10% coinsurance	30% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	-----none-----
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care/Walk-In Center	10% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	For all scheduled inpatient admissions (except maternity admissions), you must call 1-888-632-3862 for pre-admission review.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	For maternity admissions, you or someone you designate must call Aetna at 1-888-632-3852 if the hospital stay is longer than 72 hours for a normal vaginal delivery or longer than 120 hours for a cesarean section.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	-----none-----
	Rehabilitation services	10% coinsurance	10% coinsurance	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	10% coinsurance	10% coinsurance	
	Skilled nursing care	0% coinsurance	0% coinsurance	150 days limit/calendar year.
	Durable medical equipment	10% coinsurance	10% coinsurance	-----none-----
	Hospice services	0% coinsurance	30% coinsurance	-----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network (You will pay the least)	Participating and Non-Network Providers (You will pay the most)	
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 .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Long- term care • Routine foot care 	<ul style="list-style-type: none"> • Dental care • Private-duty nursing • Weight loss programs 	<ul style="list-style-type: none"> • Infertility treatment • Routine eye care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture • Hearing aids (\$3000 per ear/36 mos) 	<ul style="list-style-type: none"> • Bariatric surgery 	<ul style="list-style-type: none"> • 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-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	\$5,315
Patient pays	\$2,225

Sample care costs:

Hospital Charges	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory Tests	\$500
Prescriptions (1 Tier 1 - <u>30 day supply</u>)	\$200
Radiology	\$200
Vaccines, <u>other</u> preventive	\$40
Total	\$7,540

Patient Pays:

Deductibles	\$1,650
Copays	\$10
Coinsurance	\$565
Limits or Exclusions (what isn't covered)	\$0
Total	\$2,225

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	\$3,635
Patient pays	\$1,765

Sample care costs:

Prescriptions (<u>30 day supply</u> 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	\$1,650
Copays on Prescriptions	\$40
Coinsurance	\$75
Limits or Exclusions (what isn't covered)	\$0
Total	\$1,765

Mia's Simple Fracture

(Emergency room visit and follow up care)

Amount owed to provider	\$2,010
Plan pays	\$304
Patient pays	\$1,706

Sample care costs:

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

Patient Pays:

Deductibles	\$1,650
Copays	\$0
Coinsurance	\$56
Limits or Exclusions (what isn't covered)	\$0
Total	\$1,706

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - **हन्दि में भाषा सहायता के लिए, 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 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 - လာဝတ်မစာတတ်ကလေးတို့အပိုက် ကျင့် လို: 1-888-982-3862 လာဝတ်အိတ်ဒီးတတ်လာဝတ်သူတို့လားဝတ်
- Korean - **한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.**
- Kru-Bassa - **Be´m`ké gbo-kpá-kpá dyé pidyi dé Bāsóó`wuḍuñ wěé, dá 1-888-982-3862**
- Kurdish - **برای راهنمایی به زبان فارسی، با شماره 1-888-982-3862 به خورایی یه یومندی بکن.**
- Laotian - **ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.**
- Marathi - **कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.**
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
- Micronesian - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.**
- Pohnpeyan - **សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។**
- Mon-Khmer, Cambodian - **T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862**
- Navajo - **(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।**
- Nepali - **Tën kuwoony ë thok ë Thuonjäŋ col 1-888-982-3862 kecin ayöc.**
- Nilotic-Dinka - **For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.**
- Norwegian - **ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।**
- Panjabi - **Fer Hilfe in Deutsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.**
- Pennsylvania Dutch - **برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی**
- Persian -

