



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. 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:
What is the overall deductible?	Preferred Tier: Individual \$650 / Family \$1,300. Participating Tier: Individual \$900 / Family \$1,800.	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.
Are there services covered before you meet your deductible?	Yes. Certain preventive services are covered without cost sharing. Many services are covered by copayment before deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment 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?	Preferred Tier: Individual \$3,000 / Family \$6,000. Participating Tier: Individual \$5,000 / Family \$10,000.	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care 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. See www.mainehealthaetna.com or call 1-833-948-3540 for a list of preferred tier and participating providers.	There are two network provider levels, Preferred and Participating. You will pay the least if you use a provider in the preferred network. You will pay the most if you use the participating network. Out of network services are not covered unless its Emergency 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 Tier Provider (You will pay the least)	Participating Tier Provider (You will pay more)	Out-of-Network 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	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Preventive care /screening</u> /immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$80 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$120 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.mainehealthattna.com	Generic drugs	MaineHealth Pharmacy: Up to 30 Day SUPPLY: \$7.50 <u>copay</u> UP TO 90 DAY SUPPLY: \$15 <u>copay</u> (see comments)	Retail Pharmacy: Up to 30 DAY SUPPLY: \$10 <u>copay</u> UP TO 90 DAY SUPPLY: \$20 <u>copay</u> (see comments)	Not covered	Prescription drugs are not subject to the overall deductible. Prescription drug <u>copayments</u> apply to the annual 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.

Common Medical Event	Services You May Need	Preferred Tier Provider (You will pay the least)	Participating Tier Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Preferred brand drugs	MaineHealth Pharmacy: UP TO 30 DAY SUPPLY: \$26.25 <u>copay</u> UP TO 90 DAY SUPPLY: \$52.50 <u>copay</u> (see comments)	Retail Pharmacy: UP TO 30 DAY SUPPLY: \$35 <u>copay</u> UP TO 90 DAY SUPPLY: \$70 <u>copay</u> (see comment)	Not covered	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 <u>copayment</u> , if a generic drug is available but a brand name is dispensed.
	Non-preferred brand drugs	MaineHealth Pharmacy: UP TO 30 DAY SUPPLY: \$45 <u>copay</u> UP TO 90 DAY SUPPLY: \$90 <u>copay</u> (see comments)	Retail Pharmacy: UP TO 30 DAY SUPPLY: \$60 <u>copay</u> UP TO 90 DAY SUPPLY: \$120 <u>copay</u> (see comments)	Not covered	Step Therapy and Prior Authorization may apply to some drugs. All GLP-1 medications must be filled at a MaineHealth Pharmacy. Up to 30-day supply only.
	<u>Specialty drugs</u>	MaineHealth: \$75 <u>copay</u>	Not applicable	Not covered	For more information, refer to "National Drug List" at www.aetna.com All prescriptions must be filled through the MaineHealth Specialty Pharmacy <u>Network</u> . Up to 30-day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$300 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$300 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$300 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Tier Provider (You will pay the least)	Participating Tier Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Emergency medical transportation</u>	\$200 <u>copay/trip</u> , <u>deductible</u> doesn't apply	\$200 <u>copay/trip</u> , <u>deductible</u> doesn't apply	\$200 <u>copay/trip</u> , <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$60 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fees	20% <u>coinsurance</u> 20% <u>coinsurance</u>	30% <u>coinsurance</u> 30% <u>coinsurance</u>	Not covered Not covered	None None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$20 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: \$40 <u>copay</u> , <u>deductible</u> doesn't apply	Office: \$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: \$60 <u>copay</u> , <u>deductible</u> doesn't apply	Not covered	None
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits Childbirth/delivery professional services Childbirth/delivery facility services	No charge 20% <u>coinsurance</u> 20% <u>coinsurance</u>	No charge 30% <u>coinsurance</u> 30% <u>coinsurance</u>	Not covered Not covered Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	<u>Home health care</u> <u>Rehabilitation services</u> <u>Habilitation services</u> <u>Skilled nursing care</u>	20% <u>coinsurance</u> \$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply \$40 <u>copay/visit</u> , <u>deductible</u> doesn't apply 20% <u>coinsurance</u>	20% <u>coinsurance</u> \$60 <u>copay/visit</u> , <u>deductible</u> doesn't apply \$60 <u>copay/visit</u> , <u>deductible</u> doesn't apply 20% <u>coinsurance</u>	Not covered Not covered Not covered Not covered	None 60 visits/calender year for Physical, Occupational & Speech Therapy combined. None 150 days/calender year.

Common Medical Event	Services You May Need	Preferred Tier Provider (You will pay the least)	Participating Tier Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	<u>Durable medical equipment</u>	20% coinsurance	30% coinsurance	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% coinsurance	20% coinsurance	Not covered	None
	<u>Children's eye exam</u>	Not covered	Not covered	Not covered	Not covered.
	<u>Children's glasses</u>	Not covered	Not covered	Not covered	Not covered.
	<u>Children's dental check-up</u>	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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult and Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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 - 12 visits per calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care - 24 visits per calendar year.
- Hearing aids - 1 hearing aid to up to \$3,000 maximum per ear every 36 months.
- Private-duty nursing

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)

■ The <u>plan's</u> <u>overall deductible</u>	\$650
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$650
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,810

Managing Joe's Type 2 Diabetes

(a year of routine preferred network care of a well-controlled condition)

■ The <u>plan's</u> <u>overall deductible</u>	\$650
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care provider office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

(preferred network emergency room visit and follow up care)

■ The <u>plan's</u> <u>overall deductible</u>	\$650
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$650

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

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.

English -	To access language services at no cost to you, call 1-888-982-3862.
Amharic -	የችንች አገልግሎቶችን የለከፍም ለማግኘት፡ በ 1-888-982-3862 ይደውሉ፡፡
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء التصال 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 ખર્ચવિના ભાષાની સે વિના ઓની પહોર માટે, કોણ કરોર 1-888-982-3862.
Hindi -	आपकेलिए बिना ककसी कीमत के भाषा 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 -	လာတ်ကမ္မန်ကြို့အတ်မာစာအတ်ပံးတ်မာတ္ထာဖ်လာတ်အို့ဒီးအပ္ဗာလာကဘာ့ဟူ့အို့အဂို့ဘာ့န် ကို 1-888-982-3862 ဗော်။
Korean -	무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
Laotian -	ເຜົ່າຂົ້ນໃຈ້ການບໍລິການພາກາໄດ້ລັບໜ່າຍຄ່າກັບທ່ານ, ໃຫ້ໃຫ້ທາງເປີ 1-888-982-3862.

Mon-Khmer,
Cambodian -

ເພີ່ມເປົ້າໂທນີ້ແລ້ວເອົາເປົ້າໂທນີ້ໃຫຍ່ເພື່ອສະໜັບສະໜູນເວັບໄຊຂອງເວັບໄຊນີ້

Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo báhí ílinígóó koji' hólne' 1-888-982-3862.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.

برای دسترسی به خدمات زبان به طور رایگان، با شماره 3862-982-888-1 تماس بگیرید.

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 1-888-982-3862.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.

ਪੁਨਜੀ - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫੋਨ ਕਰੋ।

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862.

Serbo-Cr

Za besplatne prevodilačke usluge pozovite 1-888-982-3862.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.

Syriac-Assyrian - www.18889823862.com : 1-888-982-3862.

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862.