



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 <u>deductible</u>?</b>	Preferred Tier: EE Only \$2,000; EE+ Family \$4,000. Participating Tier: EE Only \$2,000; EE+ Family \$4,000. Out-of-Network: EE Only \$5,000; EE+ Family \$10,000.	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> is 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 <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Preferred Tier: EE Only \$4,000; EE+ Family \$8,000. Participating Tier: EE Only \$6,000; EE+ Family \$12,000. Out-of-Network: EE Only \$8,000; EE+ Family \$16,000.	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> , the overall family <u>out-of-pocket limit</u> must be met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.	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 <u>network provider</u>?</b>	Yes. See <a href="http://www.mainehealthaetna.com">www.mainehealthaetna.com</a> or call 1-833-948-3540 for a list of Preferred Tier and participating <u>providers</u> .	There are three <u>network provider</u> levels, Preferred, Participating, and Out-of-Network. You will pay the most if you use an out-of-network <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> may use an out-of-network <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you receive services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</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
		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>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care /screening</u> /immunization	No charge	No charge	50% <u>coinsurance</u>	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. Out-of-Network preventive care is covered at 50% after deductible is met.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.mainehealthatna.com">www.mainehealthatna.com</a>	Generic drugs	MaineHealth Pharmacy: Up to 30 Day SUPPLY: \$7.50 <u>copay</u>	Retail Pharmacy: Up to 30 DAY SUPPLY: \$10 <u>copay</u>	Not covered	This plan covers certain Preventive Medications subject to the Prescription Drug copayment and not subject to the plan's deductible. All other covered Prescription Drugs are subject to the deductible, and then <u>copays</u> apply.
		UP TO 90 DAY SUPPLY: \$15 <u>copay</u> (see comments)	UP TO 90 DAY SUPPLY: \$20 <u>copay</u> (see comments)		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	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)	
	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 comments)	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 copayment, if a generic drug is available but a brand name is dispensed.  Step Therapy and Prior Authorization may apply to some drugs.
	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	All GLP-1 medications must be filled at a MaineHealth Pharmacy. Up to 30-day supply only.  For more information, refer to "National Drug List" at <a href="http://www.aetna.com">www.aetna.com</a>
	<u>Specialty drugs</u>	MaineHealth: \$75 <u>copay</u>	Not covered	Not covered	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)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.

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
	<u>Emergency medical transportation</u>	20% coinsurance	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	20% coinsurance	30% coinsurance	50% coinsurance	No coverage for non-urgent use.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office & other outpatient services: 20% coinsurance	Office & other outpatient services: 30% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	30% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
<b>If you are pregnant</b>	Office visits Childbirth/delivery professional services	No charge 20% coinsurance	No charge 30% coinsurance	50% coinsurance 50% coinsurance	<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). <u>Pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	50% coinsurance	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% coinsurance	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	<u>Rehabilitation services</u>	20% coinsurance	30% coinsurance	50% coinsurance	60 visits/calender year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	20% coinsurance	30% coinsurance	50% coinsurance	None
	<u>Skilled nursing care</u>	20% coinsurance	20% coinsurance	50% coinsurance	150 days/calender year. Pre-authorization required for out-of-network care.
	<u>Durable medical equipment</u>	20% coinsurance	30% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% coinsurance	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.

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 your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered.
	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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & 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](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? 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>	\$2,000
■ <u>Specialist coinsurance</u>	20%
■ <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*)

<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>	\$2,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,970</b>

### 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>	\$2,000
■ <u>Specialist coinsurance</u>	20%
■ <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*)

<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>	\$2,000
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,620</b>

### Mia's Simple Fracture

(preferred network emergency room visit and follow up care)

■ The <u>plan's</u> <u>overall deductible</u>	\$2,000
■ <u>Specialist coinsurance</u>	20%
■ <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*)

<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>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,200</b>

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 -	လာတ်ကမ္မန်ကိုယ်အတ်မာစာအတ်ပံးတ်မာတ္ထာဖ်လာတအိုးအပ္ေဒသကာ်ဟူးအိုးကုန် ကို 1-888-982-3862 ေကာ်。
Korean -	무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
Laotian -	ເຜົ່າຂົ້ນໃຈ້ການບໍລິການພາກາໄດ້ລັບໜ່າຍຄ່າກັບທ່ານ, ໃຫ້ໃຫ້ທາງເປີ 1-888-982-3862.

Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសវន្ទភាសាដែលតាតិតាចំណុះសម្រាប់លោកអ្នក សូមហោច្បាស់ត្រឡប់តាន់លេខ 1-888-982-3862 ។
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bágh ílínígóó koji' hólne' 1-888-982-3862.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.
Persian-Farsi -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید.
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.
Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਅਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਛੋਨ 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-Croatian -	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 -	جَلْ بِلْجِيَّةَ حَلَقَنْتَهُ، ۱-۸۸۸-۹۸۲-۳۸۶۲. <b>حَلَقَنْتَهُ، ۱-۸۸۸-۹۸۲-۳۸۶۲.</b>
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.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862.