



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 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For each calendar year, <u>Network</u> : Individual \$800 / Family \$1,600. Out-of- <u>Network</u> : Individual \$1,600 / Family \$3,200.	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.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Preventive care is covered before you meet your deductible.	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>	There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>Network</u> : Individual \$5,500 / Family \$11,000. Out-of- <u>Network</u> : Individual \$11,000 / Family \$22,000.	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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	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.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-370-4526 for a list of network <u>providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of- network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a specialist?</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
		Designated Network Provider (You will pay the least)	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	\$25 <u>copay</u> /visit	40% <u>coinsurance</u>	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	40% <u>coinsurance</u>	Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge, except hearing exams not covered	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 plan will pay for
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Non-Designated Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p><b>Prescription drug coverage</b> is administered by Optum Rx</p> <p>More information about <a href="http://www.catalystrx.com">prescription drug coverage</a> is available at <a href="http://www.catalystrx.com">www.catalystrx.com</a></p>	Tier 1 drugs (most generics and potentially some cost-effective branded medications)	\$6 copay/30 days	\$6 copay/30 days; \$14 copay/90 days mail order	\$6 copay plus billed amount minus contracted rate/30 days	Covers up to 30-day supply; 90-day supply (mail order prescription) from OptumRx Home Delivery only. No Charge for formulary generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generic.
	Tier 2 drugs (most brand name drugs and most costly or less desirable generics)	After <a href="#">deductible</a> , 20% <a href="#">coinsurance</a> with \$150 max/30 days	After <a href="#">deductible</a> , 20% <a href="#">coinsurance</a> with \$34 min/\$150 max 30 days, 15% coinsurance with \$75 min/\$375 max 90 days mail order	After <a href="#">deductible</a> , 20% <a href="#">coinsurance</a> with \$34 min/\$150 max plus billed amount minus contracted rate/30 days	
	Tier 3 drugs (non-preferred brand drugs and more costly or less desirable generics)	After <a href="#">deductible</a> , 20% <a href="#">coinsurance</a> with \$225 maximum/RX 30 days	After <a href="#">deductible</a> , 20% <a href="#">coinsurance</a> with \$68 min/\$225 max 30 days, 15% coinsurance with \$150 min/\$475 max 90 days mail order	After <a href="#">deductible</a> , 20% <a href="#">coinsurance</a> with \$68 min/\$225 max plus billed amount minus contracted rate/30 days	
	<u>Specialty drugs</u> : Tier 1, Tier 2, Tier 3	1: 20% <a href="#">coinsurance</a> to \$100 max; 2: 20% <a href="#">coinsurance</a> with \$150 max; 3: 20% <a href="#">coinsurance</a> with \$200 max	Not covered	Not covered	Covers up to 30-day supply. <u>Specialty drugs</u> must be filled through UVA Specialty Pharmacy. Mandatory generics required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	No coverage for non-emergency use.
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-emergency transport.
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<a href="#">Pre-authorization</a> required for <a href="#">out-of-network</a> care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 <u>copay</u> /visit; Other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<a href="#">Pre-authorization</a> required for <a href="#">out-of-network</a> care.
If you are pregnant	Office visits	No charge for routine services	40% <u>coinsurance</u>	Cost sharing doesn't apply to certain <a href="#">preventive services</a> . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Pre-authorization</a> for <a href="#">out-of-network</a> care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	90 visits/calendar year. <a href="#">Pre-authorization</a> required for <a href="#">out-of-network</a> care.
	<a href="#">Rehabilitation services</a>	\$40 copay/visit	40% <u>coinsurance</u>	Limited to 40 visits/calendar year for Physical and Occupational Therapy combined, 40 visits/calendar year for Speech Therapy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Designated Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage limited to 180 days/calendar year. <a href="#">Pre-authorization</a> required for <a href="#">out-of-network</a> care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<a href="#">Pre-authorization</a> required for <a href="#">out-of-network</a> care.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not applicable	Not covered	Not covered
	Children's glasses	Not applicable	Not covered	Not covered
	Children's dental check-up	Not applicable	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)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs – Except for required preventive services.

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

- Acupuncture – 20 visits/calendar year
- Bariatric surgery
- Chiropractic care – 26 visits/calendar year
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.
- Artificial insemination, ovulation induction & advanced reproductive technology: \$15,000 maximum/lifetime.

## 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 1-800-370-4526.
- 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 [www.dol.gov/ebsa/healthreform](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 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- 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 [www.dol.gov/ebsa/healthreform](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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this plan Meet Minimum Value Standard? 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 in-network pre-natal care and a hospital delivery)

- The **plan's** overall **deductible** **\$800**
- **Specialist copayment** **\$50**
- **Hospital (facility)coinsurance** **20%**
- **Other coinsurance** **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>\$12,800</b>
<i>Cost Sharing</i>	
Deductibles*	\$800
Copayments	\$74
Coinsurance	\$2,001
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,935</b>

**Managing Joe's type 2 Diabetes**

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

- The **plan's** overall **deductible** **\$800**
- **Specialist copayment** **\$50**
- **Hospital (facility)coinsurance** **20%**
- **Other coinsurance** **20%**

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
<i>Cost Sharing</i>	
Deductibles*	\$900
Copayments	\$426
Coinsurance	\$1,089
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Peg would pay is</b>	<b>\$2,470</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The **plan's** overall **deductible** **\$800**
- **Specialist copayment** **\$50**
- **Hospital (facility)coinsurance** **20%**
- **Other coinsurance** **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>\$1,900</b>
<i>Cost Sharing</i>	
Deductibles*	\$800
Copayments	\$280
Coinsurance	\$311
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,391</b>

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

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