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, [insert contact information]. 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 **www.benefits.hshs.org** or by calling **1-800-345-9474** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	HSHS Preferred Facility/PCP: Individual (Ind) **$0**/Family (Fam) **$0**. HSHS Preferred Specialist: Ind **$1,800**/Fam **$3,600.** Other Aetna: Ind **$3,600**/Fam **$7,200**. Out–of–Network: Ind **$7,000**/Fam **$14,000.**	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). 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	Wellness and preventive care is covered at 100%, not subject to the deductible.
Are there other deductibles for specific services?	Yes. **$400** per person for prescription drug expenses.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	HSHS Preferred: Ind **$3,800**/Fam **$7,600**. Other Aetna: Ind **$5,400**/Fam **$10,800**. Out–of–Network: Ind **$14,000**/Fam **$28,000**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not 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	
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.

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	Your Cost If You Use A HSHS Preferred Provider	Your Cost If You Use an Other Aetna Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness (Internist, General Physician, Family Practitioner or Pediatrician)	HSHS: No charge; Other - 10% coinsurance, deductible waived	25% coinsurance	50% coinsurance	HSHS includes HSHS Medical Group, Prairie Cardiovascular Consultants, and Prevea
	Specialist visit	HSHS: No charge; Other - 20% coinsurance, deductible waived	25% coinsurance	50% coinsurance	Deductible applies for most non-office visit charges
	Other practitioner office visit	20% coinsurance	25% coinsurance	50% coinsurance	Coverage is limited to 10 visits per calendar year for Spinal Manipulations
	Preventive care/ screening/ immunization	No charge	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance, deductible waived	PCP/Specialist - 25% coinsurance, deductible waived; Facility - 45% coinsurance	50% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	25% coinsurance, deductible waived	PCP/Specialist - 25% coinsurance, deductible waived; Facility - 45% coinsurance	50% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Pharmacy	Your Cost If You Use a Non-Network Pharmacy	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.express-scripts.com	Generic drugs	20% coinsurance	Not covered	A separate prescription drug out-of-pocket limit of $1,600 per person/ $3,200 Family Limit applies. Retail - 30 day supply Mail - 90 day supply If you choose to receive a brand name medication when a direct generic equivalent is available, you must pay the difference in price between the brand drug and its generic equivalent in addition to the applicable copay and coinsurance. Mail order required for coverage of maintenance medications after the second fill at a retail pharmacy. After the initial fill, specialty medications must be filled through Express Scripts to be covered. Prior authorization may be required.
	Preferred brand drugs	30% coinsurance	Not covered	
	Non-preferred brand drugs	Retail - $15 copay then 30% coinsurance Mail Order - $45 copay then 30% coinsurance	Not covered	
	Specialty drugs	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use A HSHS Preferred Provider	Your Cost If You Use an Other Aetna Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance, deductible waived	45% coinsurance	50% coinsurance	————none————
	Physician/surgeon fees	PCP - 10% coinsurance, deductible waived; Specialist - 20% coinsurance	25% coinsurance	50% coinsurance	————none————
If you need immediate medical attention	Emergency room services	Facility - 25% coinsurance after $100 copay/visit, deductible waived; Professional - 25% coinsurance	Facility - 25% coinsurance after $100 copay/visit, deductible waived; Professional - 25% coinsurance	Facility - 25% coinsurance after $100 copay/visit, deductible waived; Professional - 25% coinsurance	Non-emergency care for HSHS Preferred – Facility $300 copay then 30%, Professional 30%, Other Aetna Facility - 45% coinsurance, Professional – 30% coinsurance; 50% coinsurance for out–of-network.
	Emergency medical transportation	25% coinsurance, deductible waived	25% coinsurance, deductible waived	25% coinsurance, deductible waived	————none————
	Urgent care	Professional –20% coinsurance; Facility - 20% coinsurance, deductible waived	Professional – 25% coinsurance; Facility - 25% coinsurance, deductible waived	50% coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance, deductible waived	45% coinsurance	50% coinsurance	Pre-authorization required for out-of-network (OON) care.
	Physician/surgeon fee	PCP - 10% coinsurance, deductible waived; Specialist - 20% coinsurance	25% coinsurance	50% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost If You Use A HSHS Preferred Provider	Your Cost If You Use an Other Aetna Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health and substance use disorder outpatient services	PCP - 10% coinsurance Specialist - 20% coinsurance Facility- 25% coinsurance	25% coinsurance	50% coinsurance	Deductible waived for all except OON providers. No charge for HSHS Medical Group or Prevea provider office visit.
	Mental/Behavioral health and substance use disorder inpatient services	PCP - 10% coinsurance Specialist - 20% coinsurance Facility- 25% coinsurance	25% coinsurance	50% coinsurance	Deductible waived for all except OON providers. Pre-authorization required for OON care.
If you are pregnant	Prenatal and postnatal care	PCP - 10% coinsurance, deductible waived; Specialist – 20% coinsurance, deductible waived	25% coinsurance	50% coinsurance	Routine prenatal care mandated by ACA is covered at no charge.
	Delivery and all inpatient services	PCP-10% coinsurance, deductible waived; Specialist - 20% coinsurance; Facility - 25% coinsurance, deductible waived	Facility - 45% coinsurance; Professional - 25% coinsurance	50% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for OON care.

Common Medical Event	Services You May Need	Your Cost If You Use A HSHS Preferred Provider	Your Cost If You Use an Other Aetna Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	25% coinsurance	25% coinsurance	50% coinsurance	Coverage limited to 120 visits per calendar year. Pre-authorization required for OON care. Deductible waived for all except OON providers.
	Rehabilitation services	25% coinsurance	25% coinsurance	50% coinsurance	Deductible waived for all except OON providers.
	Habilitation services	25% coinsurance	25% coinsurance	50% coinsurance	Deductible waived for all except OON providers.
	Skilled nursing care	25% coinsurance	25% coinsurance	50% coinsurance	Coverage is limited to 180 days per calendar year. Pre-authorization required for OON care. Deductible waived for all except OON providers.
	Durable medical equipment	25% coinsurance	25% coinsurance	50% coinsurance	Deductible waived for all except OON providers.
	Hospice service	25% coinsurance	25% coinsurance	50% coinsurance	Pre-authorization required for OON care. Deductible waived for all except OON providers
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered.	————none————
	Glasses	Not covered	Not covered	Not covered.	————none————
	Dental check-up	Not covered	Not covered	Not covered.	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs – Except for required preventive services

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery – Coverage limited to HSHS contracted facility only
- Spinal manipulations – Coverage is limited to 10 visits per calendar year
- Infertility treatment – Coverage is limited to the diagnosis and treatment of underlying medical condition
- 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. 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 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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform.

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 the 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-982-3862.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-888-982-3862.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

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	$1,800
Specialist Coinsurance	20%
Hospital Facility Coinsurance	25%
Other Coinsurance	25%

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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,820
Copayments	$0
Coinsurance	$1,350
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$3,320**

Example assumes all services received from HSHS Preferred providers.

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,800
Specialist Coinsurance	20%
Hospital Facility Coinsurance	25%
Other Coinsurance	25%

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)*

Total Example Cost	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$960
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$1,440**

Example assumes all services received from HSHS Preferred providers.

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,800
Specialist Coinsurance	20%
Hospital Facility Coinsurance	25%
Other Coinsurance	25%

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	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$100
Coinsurance	$350
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

Example assumes all services received from HSHS Preferred providers.

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