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, call 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 www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible.
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?	In-network: Medical: $1,100/individual; $2,200/family. Prescription Drug: $5,500/individual; $9,600/family.	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 and 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.aetna.com/docfind or call 1-800-370-4526 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the full cost if you use an out-of-network provider. Be aware your network provider might use an out-of-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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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.	$5 copay/visit.	Not covered.	None.
	Specialist visit.			
	Preventive care/screening/ Immunization.	No charge.	Not covered.	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).	No charge.	Not covered.	None.
	Imaging (CT/PET scans, MRIs).			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carefirst.com/rxgroup	Generic drugs.	Retail: $10 copay/ prescription. Mail order: $15 copay/ prescription.	Not covered.	Limit: Retail 31-day supply; Mail order: 90-day supply. No charge for ACA-required generic preventive drugs (e.g., FDA-approved generic contraceptives) or brand name preventive drugs if a generic is not medically appropriate. Preauthorization may be required for certain drugs or coverage may be denied.
	Preferred brand drugs.	Retail: $20 copay/ prescription. Mail order: $25 copay/ prescription.	Not covered.	
	Non-preferred brand drugs.	Retail: $30 copay/ prescription. Mail order: $35 copay/ prescription.	Not covered.	
	Specialty drugs.	See above copays.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center).	No charge.	Not covered.	None.
	Physician/surgeon fees.			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care.	$50 copay/visit.	$50 copay/visit.	Copay waived if admitted.
	Emergency medical transportation.	No charge.	No charge.	None.
	Urgent care.	$5 copay/visit.	Not covered.	None.
If you have a hospital stay	Facility fee (e.g., hospital room).	No charge.	Not covered.	None.
	Physician/surgeon fees.			
If you need mental health, behavioral health, or substance abuse services	Outpatient services.	Office visit: $5 copay/visit. Other outpatient services: no charge.	Not covered.	None.
	Inpatient services.	No charge.	Not covered.	None.
If you are pregnant	Office visits.	First visit: $5 copay. Thereafter no charge.	Not covered.	Cost sharing doesn't apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services.	No charge.	Not covered.	None.
	Childbirth/delivery facility services.			
If you need help recovering or have other special health needs	Home health care.	No charge.	Not covered.	Limit: 90 visits/calendar year.
	Rehabilitation services.	$5 copay/visit.	Not covered.	Combined physical, occupational and speech therapy: 90 visits/calendar year.
	Habilitation services.			
	Skilled nursing care.	No charge.	Not covered.	Limit: 90 days/calendar year.
	Durable medical equipment.	No charge.	Not covered.	Limit: 1 item of durable medical equipment for the same or similar purpose. Repairs for misuse/abuse not covered.
	Hospice services.	No charge.	Not covered.	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam.	$5 copay/visit.	Not covered.	Separately administered by National Vision Administrators. Limit: 1 routine eye exam/year.
	Children's glasses	$15 copay/pair lenses; no charge for frames up to $75 allowance.	You pay 100% and apply for reimbursement up to $41.50/pair lenses and $29.50/pair frames.	Separately administered by National Vision Administrators. Limit: 1 pair glasses/year.
	Children's dental check-up	PPO: no charge. HMO: $5 copay/exam.	PPO: no charge. HMO: not covered.	Separately administered by United Concordia. PPO: limit 2 exams/year.

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 (except for services related to mastectomy, cleft lip, or cleft palate).
- Long-term care.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing.
- Routine foot care.
- Weight loss programs (except as required by ACA).

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

- Acupuncture (limit: 90 visits/year).
- Bariatric surgery.
- Chiropractic care (limit: 90 visits/year).
- Dental care (Adult) (Separately administered by United Concordia) (limit: 1 exam/120 days).
- Hearing aids (limit: 1 hearing aid per ear every 36 months and $5,000 per ear every 36 months; no coverage for individuals 19 and older).
- Infertility treatment (in vitro fertilization: limit 3 attempts per live birth and $100,000/lifetime)
- Routine eye care (Adult) (limit: 1 routine eye exam/12 months).

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: 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. 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, call 1-800-370-4526.

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 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 1-800-370-4526.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-4526.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-370-4526.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-370-4526.

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	$0
Specialist copay	$5
Hospital (facility) cost sharing	$0
Other cost sharing	$0

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

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$90

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

The plan's overall deductible	$0
Specialist copay	$5
Hospital (facility) cost sharing	$0
Prescription drug copay	$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)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$570
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$600

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

The plan's overall deductible	$0
Specialist copay	$5
Emergency room copay	$50
Other cost sharing	$0

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

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$90

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