



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 <u>deductible</u>?	Loyola University In- <u>Network</u> : Individual \$500 / Family \$1,000. In- <u>Network</u> : Individual \$500 / Family \$1,000. Out-of- <u>Network</u> : Individual \$1,000 / Family \$2,000.	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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Emergency care; plus in- <u>network</u> <u>preventive care</u> are 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	Yes. On retail prescription Drugs: \$100 deductible per person/ \$200 family for preferred and non-preferred brand drugs.	You must satisfy this Prescription drug deductible for preferred and non-preferred drugs before coinsurance applies. Mail Order Prescriptions - Deductible does not apply. What you pay toward your plan's deductible, coinsurance and copays are all applied to your out-of-pocket max.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Loyola University In- <u>Network</u> : Individual \$3,000 / Family \$6,000. In- <u>Network</u> : Individual \$3,000 / Family \$6,000. Out-of- <u>Network</u> : Individual \$6,000 / Family \$12,000.	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.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services & 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> .
Will you pay less if you use a <u>network provider</u>?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of Loyola University in- <u>network</u> providers.	You pay the least if you use a <u>provider</u> in Loyola University In- <u>Network</u> Provider. You pay more if you use a <u>provider</u> in In- <u>Network</u> Provider. 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.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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
		Loyola University In-Network Provider (You will pay the least)	In-Network 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	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care /screening /immunization</u>	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <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 www.caremark.com	Generic drugs	Retail: you pay 15% to a maximum of \$200 per script. Mail Order: You pay 5% to a maximum of \$400 per script	Retail: you pay 15% to a maximum of \$200 per script. Mail Order: You pay 5% to a maximum of \$400 per script	Not covered	Not covered through the Aetna medical, prescription drug coverage is through CVS/Caremark. In Network: \$100 deductible per person / \$200 family. Mail order – deductible does not apply.
	Preferred brand drugs	Retail: you pay 30% to a maximum of \$200 per script. Mail Order: You pay 15% to a maximum of \$400 per script	Retail: you pay 30% to a maximum of \$200 per script. Mail Order: You pay 15% to a maximum of \$400 per script	Not covered	Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact CVS/Caremark.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Loyola University In-Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	Retail: you pay 45% to a maximum of \$400 per script. Mail Order: You pay 25% to a maximum of \$400 per script	Retail: you pay 45% to a maximum of \$400 per script. Mail Order: You pay 25% to a maximum of \$400 per script	Not covered	Retail: 1 copay per 30 day supply RX Out-of-Pocket Expense Limit: \$3,000 Person/\$6,000 Family.
	<u>Specialty drugs</u>	Retail: you pay 45% to a maximum of \$400 per script. Mail Order: You pay 25% to a maximum of \$400 per script	Retail: you pay 45% to a maximum of \$400 per script. Mail Order: You pay 25% to a maximum of \$400 per script	Not covered	Prior authorization and step therapy may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$150 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$150 <u>copay/visit</u> , <u>deductible</u> doesn't apply	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> after \$100 <u>copay/stay deductible</u> doesn't apply	20% <u>coinsurance</u> after \$250 <u>copay/stay</u>	50% <u>coinsurance</u> after \$500 <u>copay/stay</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	10% <u>coinsurance deductible</u> doesn't apply	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Loyola University In-Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 10% <u>coinsurance</u> 10% <u>coinsurance</u> after \$100	Office & other outpatient services: 20% <u>coinsurance</u> 20% <u>coinsurance</u> after \$250	Office & other outpatient services: 50% <u>coinsurance</u> 50% <u>coinsurance</u> after \$500	None Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Inpatient services	<u>copay/stay deductible doesn't apply</u>	<u>copay/stay</u>	<u>copay/stay</u>	
If you are pregnant	Office visits	No charge	No charge	50% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	10% <u>coinsurance</u> , <u>deductible doesn't apply</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u> after \$100 <u>copay/stay deductible doesn't apply</u>	20% <u>coinsurance</u> after \$250 <u>copay/stay</u>	50% <u>coinsurance</u> after \$500 <u>copay/stay</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	3 visits/ day. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Habilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> after \$100 <u>copay/stay deductible doesn't apply</u>	20% <u>coinsurance</u> after \$250 <u>copay/stay</u>	50% <u>coinsurance</u> after \$500 <u>copay/stay</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Loyola University In-Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Hospice services</u>	10% <u>coinsurance</u> after \$100 <u>copay</u> /stay for inpatient; <u>deductible doesn't apply</u> 10% <u>coinsurance</u> for outpatient	20% <u>coinsurance</u> after \$250 <u>copay</u> /stay for inpatient; 20% <u>coinsurance</u> for outpatient	50% <u>coinsurance</u> after \$500 <u>copay</u> /stay for inpatient; 50% <u>coinsurance</u> for outpatient	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	50% <u>coinsurance</u>	1 routine eye exam/12 months
	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 (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription Drugs
- 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 - 30 visits/calendar year.
- Bariatric surgery
- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. Artificial insemination & ovulation induction: 3 combined cycles/lifetime.
- Private-duty nursing – 45 – 8 hour shifts/calendar year.
- Routine eye care (Adult) - 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:

- 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number 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.
- 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 in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,660

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

- The plan's overall deductible \$500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$580

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

- The plan's overall deductible \$500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

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.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
- Syriac - ܟܠ ܥܘܪܟܐ ܟܠ ܗܝ ܡܫܝܚܐ ܟܠ ܥܘܪܟܐ ܟܠ ܗܝ ܡܫܝܚܐ ܟܠ ܗܝ ܡܫܝܚܐ ܟܠ ܗܝ ܡܫܝܚܐ ܟܠ ܗܝ ܡܫܝܚܐ 1-888-982-3862 ܟܠ ܗܝ ܡܫܝܚܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
- Telugu - భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-982-3862 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-888-982-3862.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פון אפצאל.
- Yoruba - Fún ìrànlowọ nípa èdè (Yorùbá) pe 1-888-982-3862 láí san owó kankan rárá.