




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, go to www.MyAugustaBenefits.com or call (866) 989-3044. 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 Care Coordinators at (866) 989-3044 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For Augusta Network: \$1,500 person / \$3,000 family For Aetna Network: \$2,000 person / \$4,000 family	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.
Are there services covered before you meet your <u>deductible</u>?	Yes. For Augusta Network and Aetna Network: <u>Preventive care</u> , routine eye exams and routine hearing exams 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For Augusta Network: \$4,000 person / \$8,000 family For Aetna Network: \$7,000 person / \$14,000 family	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 and 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 www.MyAugustaBenefits.com or call: (866) 989-3044 for a list of <u>network providers</u> .	This <u>plan</u> 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.
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> .
Is a Health Savings Account (HSA) available under this <u>plan</u> option?	Yes.	An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS.

 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
		Augusta Network	Aetna Network	Non-Participating Providers	
		(You will pay the least)	(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>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	Includes telemedicine.
	<u>Specialist</u> visit	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge (<u>preventive care</u> , routine eye exam & routine hearing exam)/ 25% <u>coinsurance</u> (all other routine care)	No Charge (<u>preventive care</u> , routine eye exam & routine hearing exam)/ 35% <u>coinsurance</u> (all other routine care)	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Routine hearing exam limited to 1 exam per 12 month period. Routine eye exam limited to 1 exam per year.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required for MRI/MRA and PET scans.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.medimpact.Com	Generic drugs	Augusta Pharmacy 25% <u>coinsurance</u> (retail)/Not Covered (mail order)	Non-Augusta Pharmacy 35% <u>coinsurance</u> (retail or mail order)	Not Covered	Major medical <u>deductible</u> applies. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. There is no charge for preventive drugs. Dispense as Written (DAW) provision applies. <u>Specialty drugs</u> must be obtained directly from the specialty pharmacy. Step Therapy provision applies.
	Preferred brand drugs	Augusta Pharmacy 25% <u>coinsurance</u> (retail)/Not Covered (mail order)	Non-Augusta Pharmacy 35% <u>coinsurance</u> (retail or mail order)	Not Covered	
	Non-preferred brand drugs	Augusta Pharmacy 25% <u>coinsurance</u> (retail)/Not Covered (mail order)	Non-Augusta Pharmacy 35% <u>coinsurance</u> (retail or mail order)	Not Covered	

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	<u>Specialty drugs</u>	Augusta Pharmacy Not Covered	Non-Augusta Pharmacy 25% <u>coinsurance</u> (retail)/35% <u>coinsurance</u> (mail order)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required.
	Physician/surgeon fees	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Out-of-network providers</u> are paid at the Aetna Network level of benefits.
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Aetna Network and <u>out-of-network providers</u> are paid at the Augusta Network level of benefits.
	<u>Urgent care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Out-of-network providers</u> are paid at the Aetna Network level of benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required.
	Physician/surgeon fees	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% <u>coinsurance</u>	25% <u>coinsurance</u> (office visit)/ 35% <u>coinsurance</u> (all other outpatient)	Not Covered	Aetna Network is paid at the Augusta Network level of benefits for office visits. Includes telemedicine. <u>Preauthorization</u> required for inpatient admissions and partial hospitalization and intensive outpatient care.
	Inpatient services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	
If you are pregnant	Office visits	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> from the
	Childbirth/delivery professional services	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
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		(You will pay the least)	(You will pay the most)		
					Augusta Network or Aetna Network. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Aetna Network is paid at the Augusta Network level of benefits for professional services. Baby does not count toward the mother's expense; therefore the family <u>deductible</u> amount may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	Limited to 90 visits per year. <u>Preauthorization</u> required.
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	Physical, speech & occupational therapy limited to a combined maximum of 30 visits per year. Cardiac rehab limited to 36 visits per 12 week period or per occurrence. Respiratory/pulmonary therapy limited to 36 hours or a 6 week period per course of treatment. Includes telemedicine.
	<u>Habilitation services</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	Includes telemedicine.
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	Limited to 100 days per year. <u>Preauthorization</u> required.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required for rentals or purchase over \$1,500.
	<u>Hospice services</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Not Covered	Bereavement counseling is covered. <u>Preauthorization</u> required.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not Covered	Limited to 1 exam per year.
	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult & Child)• Glasses (Adult & Child)	<ul style="list-style-type: none">• Hearing aids (except for a cochlear implant)• Infertility treatment (except diagnosis or treatment of underlying medical condition)	<ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.• Routine foot care (except for metabolic or peripheral vascular disease)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none">• Chiropractic care (10 visits per year)• Private-duty nursing (70 visits (up to 8 hours per visit) per year)	<ul style="list-style-type: none">• Routine eye care (Adult & Child – 1 exam per year)	<ul style="list-style-type: none">• Weight loss programs (for morbid obesity only)

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 U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or Care Coordinators at (866) 989-3044. 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 the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or Care Coordinators at (866) 989-3044.

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 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwüijigo holne' 1-800-378-1179.

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 Augusta Network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Primary care physician coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

This EXAMPLE event includes services like:

Primary care physician 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

Managing Joe's Type 2 Diabetes

(a year of routine Augusta Network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

This EXAMPLE event includes services like:

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

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,520

Mia's Simple Fracture

(Augusta Network emergency room visit and follow-up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

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