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 deductible?	For Augusta Network: $0 person/$0 family For Aetna Network: $1,000 person/$2,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. For Augusta Network and Aetna Network: Preventive care, emergency room care, prenatal and postnatal care, routine eye exam, routine hearing exam, urgent care office visit charge, and office visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
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?	For Augusta Network: $3,500 person/$7,000 family For Aetna Network: $5,000 person/$10,000 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.MyAugustaBenefits.com or call: (866) 989-3044 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 most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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.

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	No Charge/visit (office visit)/ $30 copay (office surgery)	$45 copay/visit/ $30 copay/visit (OBGYN PCP)	Not Covered	Copay applies per visit regardless of what services are rendered. Includes telemedicine.
	Specialist visit	$50 copay/visit/ No Charge/visit (OBGYN)	$65 copay/visit/ $50 copay/visit (OBGYN)	Not Covered	
	Preventive care/ screening/ immunization	No Charge (preventive care, routine eye exam and routine hearing exam)/Paid based on place of service (all other routine care)	No Charge (preventive care, routine eye exam and routine hearing exam)/Paid based on place of service (all other routine care)	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan 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	Diagnostic test (x-ray, blood work)	20% coinsurance	35% coinsurance	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	Not Covered	Preauthorization required for MRI/MRA and PET scans.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com	Generic drugs	**Augusta Pharmacy** $7 copay (31-day supply)/$14 copay (60-day supply)/ $21 copay (90-day supply)/Not Covered (mail order)	**Non-Augusta Pharmacy** $10 copay (31-day supply)/$20 copay (60-day retail & mail order)/$30 copay (90-day retail & mail order)	Not Covered	Deductible does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (specialty drugs). The copay 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. Step Therapy provision applies.
	Preferred brand drugs	**Augusta Pharmacy** $30 copay (31-day supply)/$60 copay (60-day supply)/ $90 copay (90-day	**Non-Augusta Pharmacy** $40 copay (31-day supply)/$80 copay (60-day retail & mail	Not Covered	

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)		
		supply)/Not Covered (mail order)	order)/$120 copay (90-day retail & mail order)		
	Non-preferred brand drugs	**Augusta Pharmacy** Greater of: $40 copay or 40% (31-day supply)/$80 copay or 40% (60-day supply)/$120 copay or 40% (90-day supply)/Not Covered (mail order)	**Non-Augusta Pharmacy** Greater of: $50 copay or 50% (31-day supply)/$100 copay or 50% (60-day retail & mail order)/ $150 copay or 50% (90-day retail or mail order)	Not Covered	
	Specialty drugs	**Augusta Pharmacy** 35% up to $350 copay (30-day supply)	**Non-Augusta Pharmacy** 35% up to $350 copay (30-day retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	Not Covered	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	35% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance	Aetna Network and out-of-network providers are paid at the Augusta Network level of benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	Aetna Network and out-of-network providers are paid at the Augusta Network level of benefits.
	Urgent care	$75 copay/visit (office visit)/20% coinsurance (all other services)	$75 copay/visit (office visit)/20% coinsurance (all other services)	Not Covered	Copay applies to the physician office visit only. Aetna Network is paid at the Augusta Network level of benefits.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	Not Covered	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	35% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	$30 copay/visit	Not Covered	Copay applies per visit regardless of what services are rendered. Aetna Network is paid at the Augusta Network level of benefits. Includes telemedicine. Preauthorization required for inpatient admissions and partial hospitalization and intensive outpatient care.
	Inpatient services	20% coinsurance	20% coinsurance	Not Covered	
If you are pregnant	Office visits	No Charge*	No Charge	Not Covered	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section). Cost sharing does not apply to preventive services from the 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 deductible amount may apply. *If a service is not available at an Augusta Health Facility/Provider, the benefit will be covered at Tier 1 as long as it is an in-network Aetna provider. Baby does not count toward the mother's expense; therefore the family deductible amount may apply.
	Childbirth/delivery professional services	20% coinsurance*	25% coinsurance	Not Covered	
	Childbirth/delivery facility services	20% coinsurance*	25% coinsurance	Not Covered	

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 need help recovering or have other special health needs	Home health care	20% coinsurance	35% coinsurance	Not Covered	Limited to 90 visits per year. Preauthorization required.
	Rehabilitation services	20% coinsurance	35% coinsurance	Not Covered	Physical, speech & occupational therapy limited to a combined maximum of 30 visits per year. A medical necessity review will need to be completed after the 31st visit per year for physical, speech & occupational therapy and Preauthorization required. 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.
	Habilitation services	20% coinsurance	35% coinsurance	Not Covered	Includes telemedicine.
	Skilled nursing care	20% coinsurance	35% coinsurance	Not Covered	Limited to 100 days per year. Preauthorization required.
	Durable medical equipment	20% coinsurance	35% coinsurance	Not Covered	Preauthorization required for rentals or purchase over $1,500.
	Hospice services	20% coinsurance	35% coinsurance	Not Covered	Bereavement counseling is covered. Preauthorization 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Adult & Child)	• Infertility treatment (except diagnosis or treatment of underlying medical condition)	• 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 plan document.)		
• Bariatric surgery (for morbid obesity only - 1 surgical procedure per lifetime) • Chiropractic care (10 visits per year) • Hearing aids (when medically necessary- $2,000 every 48 months)	• Private-duty nursing (70 visits (up to 8 hours per visit) per year) • Routine eye care (Adult & Child – 1 exam per year)	• Weight loss programs

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, kwiijigo 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 plan's overall deductible** **$0**
- **Primary care physician copayment** **$0**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,570

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$720

Mia's Simple Fracture
(Augusta Network emergency room visit and follow-up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$510

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