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 deductible?	Individual/Family: Home Host In-network: $0 / $0 Regional In-network: $2,000 / $4,000	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. Preventive care and primary care services 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 https://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?	Individual / Family: Home Host In-network: None Regional In-network: $5,000 / $10,000 Prescription Drugs: $1,500 / $3,750	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, copayments, balance-billing charges, penalties for failure to obtain preauthorization, 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 1-888-982-3862 for a list of Home Host network providers.	You pay the least if you use a provider in Home Host. You will pay more if you use an provider in In-Network Provider. 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. No **deductible** applies to **copay**.

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	$10 copay per visit	$20 copay per visit	Not covered	Teladoc® is also available 24/7 at a $5 copay per visit.
	Specialist visit	$10 copay per visit	$40 copay per visit	Not covered	———————— None ————————
	Preventive care/screening/ immunization	No charge	No charge	Not covered	Age and frequency schedules apply. 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	$40 copay per visit	Not covered	———————— None ————————
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance, deductible doesn't apply	Not covered	———————— None ————————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	Retail: $5 copay per script Mail Order: $10 copay per script via Aetna Rx Home Delivery or at a CVS pharmacy		Not covered	Retail scripts filled up to a 30 day supply; Mail Order or Maintenance Rx at a CVS pharmacy up to 90 days. If you request a brand-name when a generic is available, you pay the copay plus the price difference between generic and brand. After 3 fills of maintenance drugs at retail, you are required to fill a 90-day supply at CVS Rx Home Delivery or a CVS pharmacy or pay 50% coinsurance. This applies to women's contraceptives too.
	Preferred brand drugs	Retail: $35 copay per script Mail Order: $70 copay per script via Aetna Rx Home Delivery or at CVS		Not covered	
	Non-preferred brand drugs	Retail: $70 copay per script Mail Order: $140 copay per script via Aetna Rx Home Delivery or at CVS		Not covered	

[* For more information about limitations and exceptions, see the plan or policy document at https://healthalliance.cheiron.us/benefits.]

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)	
www.aetna.com/individuals-families/find-a-medication/2024-standard-opt-out-plan.html	Specialty drugs	15% coinsurance unless Prudent Rx applies; If Specialty drug is offered through Prudent Rx: $0 copay if you enroll and 30% coinsurance if you do not enroll, deductible doesn't apply.		Not covered	**Your Rx plan has an annual out-of-pocket maximum of $1,500 per person / $3,750 per family**.
	Contraceptives and Preventive Generics per USPSTF List	Retail and Mail Order: $0 copay		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 copay per visit	20% coinsurance	Not covered	———— None ————
	Physician/surgeon fees	No charge	20% coinsurance, deductible doesn't apply	Not covered	———— None ————
If you need immediate medical attention	Emergency room care	$75 copay per visit	$150 copay per visit	$150 copay per visit	Non-emergency use applies 20% coinsurance outside of Home Host.
	Emergency medical transportation	$100 copay per trip	$100 copay per trip	$100 copay per trip	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$35 copay per visit	$35 copay per visit	Not covered	———— None ————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Not covered	———— None ————
	Physician/surgeon fees	No charge	20% coinsurance, deductible doesn't apply	Not covered	———— None ————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$20 copay per visit, deductible doesn't apply	Not covered	———— None ————
	Inpatient services	No charge	20% coinsurance	Not covered	———— None ————
If you are pregnant	Office visits	$10 copay per visit	$20 copay per visit	Not covered	Cost sharing does not apply for preventive services if Home Host or in-network. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance, deductible doesn't apply	Not covered	
	Childbirth/delivery facility services	No charge	20% coinsurance	Not covered	

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 help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Not covered	Limited to 100 visits per calendar year.
	Rehabilitation services	No charge	$40 copay per visit	Not covered	Coverage is limited to 30 visits per calendar year for Physical and Occupational Therapy combined. 20 visits per calendar year for Speech Therapy. Combined with Habilitative.
	Habilitation services	No charge	$40 copay per visit	Not covered	Included in Rehabilitation services.
	Skilled nursing care	No charge	20% coinsurance	Not covered	Limited to 210 days per calendar year.
	Durable medical equipment	No charge	20% coinsurance, deductible doesn't apply	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	20% coinsurance	Not covered	———— None ————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered
	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) & glasses (Child)
- 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 - 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care
- Hearing aids - $1,000 maximum per ear per 36 months - Home Host only
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

[* For more information about limitations and exceptions, see the plan or policy document at https://healthalliance.cheiron.us/benefits.]

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 **1-866-444-3272** or www.dol.gov/ebsa or the U.S. Department of Health and Human Services 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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-888-982-3862.]

[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.

[* For more information about limitations and exceptions, see the plan or policy document at https://healthalliance.cheiron.us/benefits.]

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 at **Regional In-Network**)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other copayment** **$20**

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	$2,000
Copayments	$30
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,390**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition **within Home Host network**)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$10**
- **Hospital (facility) copayment** **$0**
- **Other copayment** **$35**

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	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

Mia's Simple Fracture

(in-network emergency room visit and follow up care **within Home Host network**)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$10**
- **Hospital (facility) copayment** **$75**
- **Other copayment** **$100**

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	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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