




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 (800) 252-9653. 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](http://www.healthcare.gov/sbc-glossary) com or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>Care Navigation Services:</b> \$1,700/Individual; \$3,400/Family  <b>All Other Services:</b> \$6,900/Individual; \$13,800/Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of the <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . Care Navigation Services <a href="#">deductible</a> amounts apply to the overall plan <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, <a href="#">preventive care</a> is covered before the <a href="#">deductible</a> is met.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Medical Benefits:</b> \$6,900/Individual; \$13,800/Family  <b>Prescription Drug Benefits:</b> \$1,350/Individual; \$2,700/Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties, prescription drug expenses ( <a href="#">out-of-pocket limits</a> , <a href="#">copays</a> , discounts, coupons, etc.), excess charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses. They don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, See <a href="http://www.aetna.com/asa">www.aetna.com/asa</a> or call 1-800-252-9653 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some

Important Questions	Answers	Why This Matters:
		services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		Your plan includes telemedicine services with a \$0 consultation fee. Contact Teladoc at 1-800 Teladoc (835-2362).
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		None.
	<a href="#">Preventive care/screening/immunization</a>	No charge.		You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		None.
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		None.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mysmithrx.com">www.mysmithrx.com</a> or call (844) 454-5201.	Generic drugs	1-30 Day Supply (retail or mail order): \$10 <a href="#">copay</a> /drug.	1-30 Day Supply: 50% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .	<a href="#">Copays</a> apply after the medical <a href="#">deductible</a> is met.  Prescriptions filled at non-participating pharmacies are limited to 30 days.
		31-90 Day Supply (retail or mail order): \$20 <a href="#">copay</a> /drug.		

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)	
	Preferred brand drugs	<b>1-30 Day Supply (retail or mail order):</b> \$25 <a href="#">copay</a> /drug.  <b>31-90 Day Supply (retail or mail order):</b> \$50 <a href="#">copay</a> /drug.	<b>1-30 Day Supply:</b> 50% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .	Dispense as written penalty: If a brand name drug is requested by the covered person instead of a generic drug (and a generic is available), the covered person will be responsible for the difference in cost (between generic and applicable brand name drug) in addition to the applicable brand name drug copayment.  Prescriptions filled at non-participating pharmacies are limited to 30 days.
	Non-preferred brand drugs	<b>1-30 Day Supply (retail or mail order):</b> \$50 <a href="#">copay</a> /drug.  <b>31-90 Day Supply (retail or mail order):</b> \$100 <a href="#">copay</a> /drug.	<b>1-30 Day Supply:</b> 50% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .	
	<a href="#">Specialty drugs</a>	\$100 <a href="#">copay</a> /drug.	Not covered.	Limited to a 30-day supply & requires purchase through the specialty pharmacy program. Only first fill will be eligible through a retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		<a href="#">Pre-certification</a> is required prior to service.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		Pre-certification is required within two days of an inpatient admission from the Emergency Room.
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		None.
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		None.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		<a href="#">Pre-certification</a> is required prior to service.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		None.
If you need mental health, behavioral	Outpatient services	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		Your plan includes telemedicine services with a \$0 consultation fee. Contact Teladoc at 1-800 Teladoc (835-2362).

\*For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.mcn.coop/members/health-benefit-trust/>.

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)	
<b>health, or substance abuse services</b>	Inpatient services	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		<a href="#">Pre-certification</a> is required prior to service.
<b>If you are pregnant</b>	Office visits	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		<a href="#">Cost sharing</a> does not apply to <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		None.
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		<a href="#">Pre-certification</a> of a routine maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		<a href="#">Pre-certification</a> is required prior to service. Limited to 180 visits per calendar year.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		Inpatient rehabilitation therapy is limited to 30 days per calendar year. Alternative care includes acupuncture, acupressure, massage therapy and spinal manipulation/chiropractic services are covered up to \$750 per calendar year combined.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		None.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		<a href="#">Pre-certification</a> is required prior to service. Limited to 60 days per calendar year.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		<a href="#">Pre-certification</a> is required for DME over \$2,000.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a> , after <a href="#">deductible</a> .		<a href="#">Pre-certification</a> is required prior to service. Limited to 6 months per 3 calendar years.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered.		Vision may be available as a separate election.
	Children's glasses	Not covered.		Vision may be available as a separate election.
	Children's dental check-up	No charge.		Limited to 2 exams and cleanings per

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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)	
				calendar year for covered persons up to age 19.

#### 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](#).)**

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul> |
|--|---|--|

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture (Limited to \$750 per calendar year combined with acupressure, massage therapy &amp; spinal manipulation/chiropractic care)</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care (Limited to \$750 per calendar year combined with acupuncture, acupressure, &amp; massage therapy)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care (Limited to 1 pair custom foot orthotics per calendar year. This includes impression casting for orthotic appliances, padding, strapping &amp; fabrication)</li> </ul> |
|---|--|---|

**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: Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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: (888) 653-3508 or the Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 (800) 252-9653.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 252-9653.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 252-9653.

\*For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.mccun.coop/members/health-benefit-trust/>.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,900
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$6,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,960</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,900
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,420</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,900
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.