aetna™ Emory University Plan: MHS **Coverage for:** Individual + Family | **Plan Type:** POS

**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, visit www.hr.emory.edu or by calling 404-727-7613. 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 404-727-7613 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Tier 1: Individual $850 / Family $2,550<br>Tier 2: Individual $1000 / Family $3,000<br>Tier 3: Individual $2,000 / Family $6,000 | 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, when **Tier 1** or **Tier 2**, routine preventive care, prescription drugs, durable medical equipment and hospice services do not require you to meet a 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.<br>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 must meet the deductible for some specific services. Please refer to the summary for detailed information. |
| **What is the out-of-pocket limit for this plan?** | Tier 1: Individual $3,000 / Family $6,000<br>Tier 2: Individual $4,500 / Family $9,000<br>Tier 3: Individual $11,250 / Family $22,500 | 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, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services. | 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/custom/emory or call 1-800-847-9026 for a list of Network providers. | You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. You will pay the most if you use a Tier 3 provider, and you might receive a bill from a provider for the difference. |
| **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.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Tier 1 (You will pay the least) | Tier 2 (You will pay more) | Tier 3 (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 copay | $35 copay, $25 copay for pediatrician or Behavioral Health | 50% coinsurance | None |
| **If you visit a health care provider's office or clinic** | Specialist visit | $35 copay | $50 copay | 50% coinsurance | None |
| **If you visit a health care provider's office or clinic** | Preventive care/Screening /Immunization | No charge | No charge | 50% coinsurance | 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** | Non-preventive independent or outpatient labs: Diagnostic test (blood work) | 15% coinsurance | 25% coinsurance | 50% coinsurance | Not subject to deductible |
| **If you have a test** | Imaging (X-rays, CT/PET scans, MRIs)<br>Outpatient or free-standing facility | 15% coinsurance | 25% coinsurance | 50% coinsurance | You have to meet the deductible first. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.caremark.com | Generic drugs | 10% coinsurance. 30-Day Retail min. $10, max. $25. Mail-order min. $25, max. $62.50 | | **Tier 3** reimbursement is based on the discounted, in-network cost of the medication minus the applicable coinsurance. | You have to meet the deductible first. Certain items identified by your plan as preventive care are covered in full and not subject to the coinsurance amounts indicated. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Tier 1 (You will pay the least) | Tier 2 (You will pay more) | Tier 3 (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.caremark.com | Preferred brand drugs | 20% coinsurance. 30-Day Retail min. $30, max. $75. Mail-order min. $75, max $187.50 | | **Tier 3** reimbursement is based on the discounted, in-network cost of the medication minus the applicable coinsurance. | You have to meet the deductible first. Certain items identified by your plan as preventive care are covered in full and not subject to the coinsurance amounts indicated. |
| | Non-preferred brand drugs | 30% coinsurance. 30-Day Retail min. $60, max. $120. Mail-order min. $150, max. $300 | | **Tier 3** reimbursement is based on the discounted, in-network cost of the medication minus the applicable coinsurance. | You have to meet the deductible first. Certain items identified by your plan as preventive care are covered in full and not subject to the coinsurance amounts indicated. |
| | Specialty drugs | 40% coinsurance. 30-Day Retail min. $90, max. $150. Mail-order min. $212.50, max. $375 | | **Tier 3** reimbursement is based on the discounted, in-network cost of the medication minus the applicable coinsurance. | You have to meet the deductible first. Certain items identified by your plan as preventive care are covered in full and not subject to the coinsurance amounts indicated. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 25% coinsurance | 50% coinsurance | None |
| **If you have outpatient surgery** | Physician/surgeon fees | 15% coinsurance | 25% coinsurance | 50% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $250 copay | $250 copay | $250 copay | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Tier 1 (You will pay the least) | Tier 2 (You will pay more) | Tier 3 (You will pay the most) | |
| **If you need immediate medical attention** | Emergency medical transportation | $75 copay | $75 copay | $75 copay | None |
| **If you need immediate medical attention** | Urgent care | $25 copay | $35 copay | $50 copay | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance | 25% coinsurance | 50% coinsurance | Precertification required for **Tier 3** or $750 penalty applies. |
| **If you have a hospital stay** | Physician/surgeon fees | 15% coinsurance | 25% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay | $25 copay | $25 copay | Behavorial Mental Health (includes psychiatry, psychology and other licensed behavorial health providers; out-of-network is covered at the in-network level) |
| **If you need mental health, behavioral health, or substance abuse services** | Inpatient services | 15% coinsurance | 25% coinsurance | 50% coinsurance | Precertification required for **Tier 3** or $750 penalty applies. |
| **If you are pregnant** | Office visits | $35 copay | $50 copay | 50% coinsurance | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $750 for failure to obtain pre-authorization for out-of-network care may apply. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Tier 1 (You will pay the least) | Tier 2 (You will pay more) | Tier 3 (You will pay the most) | |
| **If you are pregnant** | Childbirth/delivery professional services | 15% coinsurance | 25% coinsurance | 50% coinsurance | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $750 for failure to obtain pre-authorization for out-of-network care may apply. |
| **If you are pregnant** | Childbirth/delivery facility services | 15% coinsurance | 25% coinsurance | 50% coinsurance | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $750 for failure to obtain pre-authorization for out-of-network care may apply. |
| **If you need help recovering or have other special health needs** | Home health care | 15% coinsurance | 25% coinsurance | 50% coinsurance | 120 visits/calendar year. Penalty of $750 for failure to obtain pre-authorization for **Tier 3.** |
| **If you need help recovering or have other special health needs** | Rehabilitation services | $25 copay/visit | $35 copay/visit | 50% coinsurance | Coverage is limited to 90 visits combined for Speech, Physical and Occupational therapies, including Outpatient Hospital Facility Services. See SPD at www.hr.emory.edu. |
| **If you need help recovering or have other special health needs** | Habilitation services | $25 copay/visit | $35 copay/visit | 50% coinsurance | Unlimited |
| **If you need help recovering or have other special health needs** | Skilled nursing care | 15% coinsurance | 25% coinsurance | 50% coinsurance | 120 days/calendar year. Penalty of $750 for failure to obtain pre-authorization for **Tier 3**. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Tier 1 (You will pay the least) | Tier 2 (You will pay more) | Tier 3 (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Durable medical equipment | 15% coinsurance, deductible doesn't apply | 25% coinsurance, deductible doesn't apply | 50% coinsurance | Excludes repairs for misuse/abuse. |
| **If you need help recovering or have other special health needs** | Hospice services | No charge | No charge | 50% coinsurance | Penalty of $750 for failure to obtain pre-authorization for out-of-network care. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | No charge | 1 routine eye exam every 12 months. |
| **If your child needs dental or eye care** | Children's glasses | Not covered | Not covered | Not covered | |
| **If your child needs dental or eye care** | Children's dental check-up | Not covered | Not covered | Not covered | |

*For more information about limitations and exceptions, see the plan or policy document at www.hr.emory.edu.

## 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.)**

- Adult hearing aids
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

**Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)**

- Acupuncture
- Bariatric surgery covered the same as hosptalization
- Behavorial Mental Health (includes psychiatry, psychology and other licensed behavorial health providers; out-of-network is covered at the in-network level)
- Chiropractic care - 20 visits/calendar year.
- Gene Based, Cellular and other Innovative Therapies (GCIT)
- Hearing aids - 1 hearing aid per ear/24 months up to age 26.
- Infertility treatment – Expenses, therapy and treatment have a $25,000 combined medical and pharmacy lifetime maximum.
- Routine eye care (Adult & Child) - 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 1-800-231-7729.
- 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:

- Emory Benefits at 404-727-7613
- 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.

## Language Access Services:

(Español): Para obtener asistencia en Español, llame al 1-800-231-7729 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-231-7729 (TTY: 711)

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-231-7729 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-231-7729 (TTY: 711)

*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** | **$850** |
| **Specialist copayment** | **$35** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**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 | $850 |
| Copayments | $0 |
| Coinsurance | $1,800 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,710** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$850** |
| **Specialist copayment** | **$35** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**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 | $850 |
| Copayments | $300 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,570** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$850** |
| **Specialist copayment** | **$35** |
| **Hospital (facility) coinsurance** | **15%** |
| **Other coinsurance** | **15%** |

**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 | $200 |
| Copayments | $900 |
| Coinsurance | $40 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,410** |

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

## 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).

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