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 call 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 $1,450 / Family $2,900 **Tier 2***: Individual $1,650 / Family $3,300 **Tier 3**: Individual $2,750 / Family $5,500 *Does not apply to routine preventive care.	Aside from ACA covered preventive care, you must pay all the costs up to the deductible amount for medical and prescription, before this plan begins to pay for covered services you use. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, when in **Tier 1** or **Tier 2**, routine preventive care does not require you to meet a deductible.	This plan covers some items and services even if you have not met the deductible amount. 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://healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Tier 1**: Individual $3,750 / Family $7,500 **Tier 2**: Individual $5,500 / Family $11,000 **Tier 3**: Individual $11,500 / Family $23,000	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services, and health care that the plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com 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	15% coinsurance	25% coinsurance	50% coinsurance	
	Specialist visit	15% coinsurance	25% coinsurance	50% coinsurance	
	Routine preventive care/Screening/ Immunization	No charge	No charge	50% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	25% coinsurance	50% coinsurance	
	Imaging (CT/PET scans, MRIs)	15% coinsurance	25% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	10% coinsurance. 30-Day Retail max. $25. Mail-order max. $62.50.		**Tier 3** reimbursement is based on the discounted, in-network cost of the medication minus the applicable coinsurance.	You do 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.
	Preferred brand drugs	20% coinsurance. 30-Day Retail max. $75. Mail-order max. $187.50.			
	Non-preferred brand drugs	30% coinsurance. 30-Day Retail max. $120. Mail-order max. $300.			
	Specialty drugs	40% coinsurance. 30-Day Retail max. $150. Mail-order max. $375.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	15% coinsurance	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	15% coinsurance	25% coinsurance	50% coinsurance	None
	Emergency medical transportation	15% coinsurance	25% coinsurance	50% coinsurance	None
	Urgent care	15% coinsurance	25% coinsurance	50% coinsurance	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.
	Physician/surgeon fees	15% coinsurance	25% coinsurance	50% coinsurance	None

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

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 mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	25% coinsurance	50% coinsurance	None
	Inpatient services	15% coinsurance	25% coinsurance	50% coinsurance	Precertification required for **Tier 3** or $750 penalty applies.
If you are pregnant	Office visits	15% coinsurance	25% coinsurance	50% coinsurance	None
	Childbirth/delivery professional services	15% coinsurance	25% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	15% coinsurance	25% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	15% coinsurance	25% coinsurance	50% coinsurance	120 visits per calendar year
	Rehabilitation services	15% coinsurance	25% coinsurance	50% coinsurance	90 visits combined for Speech, Physical and Occupational Therapies. See SPD at www.hr.emory.edu.
	Habilitation services	15% coinsurance	25% coinsurance	50% coinsurance	
	Skilled nursing care	15% coinsurance	25% coinsurance	50% coinsurance	120 day maximum
	Durable medical equipment	15% coinsurance	25% coinsurance	50% coinsurance	No Deductible
	Hospice services	No charge, after deductible	No charge, after deductible	50% coinsurance	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	50% coinsurance	1 routine exam every 12 months
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	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.)

- Adult hearing aids
- Cosmetic surgery
- Dental care – Adult/Child
- Glasses
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)		
• Acupuncture, applicable copays and coinsurance apply • Bariatric surgery covered the same as hospitalization • Chiropractic care	• Infertility expenses, therapy, and treatment (includes both Comprehensive [up to 6 ovulation inductions and insemination cycles] and ART services. Combined medical and pharmacy maximum up to $25,000 per lifetime.	• Hearing aids for children up to age 26, when medically necessary; one per year, per 24 mo. max. • Routine eye care (1 exam every year)

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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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: Emory Benefits at 404-727-7613. Department of Labor's Employee Benefits Security Administration may be contacted at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 404-727-7613.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 404-727-7613.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 404-727-7613.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 404-727-7613.]

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 www.hr.emory.edu.]

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 **Tier 1** pre-natal care and a hospital delivery)

The plan's overall deductible	$1,450
Specialist *coinsurance*	15%
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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,450
Copayments	$0
Coinsurance	$1,893
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,403**

Managing Joe's type 2 Diabetes
(a year of routine **Tier 1** care of a well-controlled condition)

The plan's overall deductible	$1,450
Specialist *coinsurance*	15%
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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,450
Copayments	$0
Coinsurance	$507
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,012**

Mia's Simple Fracture
(**Tier 1** emergency room visit and follow up care)

The plan's overall deductible	$1,450
Specialist *coinsurance*	15%
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,450
Copayments	$0
Coinsurance	$289
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,739**

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