



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.myLuminareHealth.com. 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 1-866-893-4472 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For preferred providers : \$2,000/individual or \$4,000/family; For nonpreferred providers : \$4,000/individual or \$8,000/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. The following services by a preferred provider : preventive care .	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. There are no other specific deductibles .	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For preferred providers : \$6,350/individual or \$12,700/family; For nonpreferred providers : \$6,350/individual or \$12,700/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 ?	Penalties for failure to obtain preauthorization for services, 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.aetna.com/ASA or call 1-866-893-4472 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
		Preferred Provider (You will pay the least)	Nonpreferred 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	\$25 copay /office visit after deductible	20% coinsurance after deductible	None.
	Specialist visit	\$35 copay /office visit after deductible Chiropractic Service : \$25 copay /office visit after deductible	20% coinsurance after deductible	None.
	Preventive care/screening/immunization	No charge	20% coinsurance after deductible ; deductible waived for child immunizations.	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)	0% coinsurance after deductible	20% coinsurance after deductible	None.
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	20% coinsurance after deductible	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com.	Generic drugs	\$20 copay /prescription after deductible for retail and \$40 copay /prescription after deductible for mail order (90-day supply)	\$20 copay for retail	Deductible does apply.
	Preferred brand drugs	\$45 copay /prescription after deductible for retail and \$90 copay /prescription after deductible for mail order (90-day supply)	\$45 copay for retail	Copay and deductible applies to a 30-day supply Retail and 90-day supply Mail Order.
	Non-preferred brand drugs	50% with \$100 copay /prescription after deductible maximum for retail and 50% with \$200 copay /prescription after deductible maximum for mail order (90-day supply)	50% with \$100 copay /prescription after deductible maximum for retail	Copay and deductible do not apply to preventive drugs required by the Affordable Care Act.
	Specialty drugs	\$125 copay after deductible	Not covered	If you use a non-participating pharmacy, you must also pay the difference in cost between a participating and the non-participating pharmacy. Specialty drugs must be filled through the Accredo Pharmacy after the 2 nd retail fill to avoid paying 100%. Covers up to a 30-day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	20% coinsurance after deductible	None.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	None.
If you need immediate medical attention	Emergency room care	\$150 copay /visit after deductible	Preferred provider benefit applies.	Copay waived if admitted. Non-emergency use of emergency room care is not covered.
	Emergency medical transportation	0% coinsurance after deductible	Preferred provider benefit applies.	No coverage for non-emergency transport.
	Urgent care	\$40 copay /visit after deductible	20% coinsurance after deductible	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay /office visit after deductible	20% coinsurance after deductible	None.
	Inpatient services	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	20% coinsurance after deductible	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance after deductible	20% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required.
	Rehabilitation services	0% coinsurance after deductible	20% coinsurance after deductible	Outpatient physical, occupational and speech therapy combined limited to 60 visits per calendar year.
	Habilitation services	Not covered	Not covered	Habilitation services are not covered.
	Skilled nursing care	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required. Limited to 60 days per calendar year.
	Durable medical equipment	0% coinsurance after deductible	20% coinsurance after deductible	None
	Hospice services	0% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	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](#).)

- | | | |
|-------------------------|--|------------------------|
| • Acupuncture | • Hearing aids | • Routine foot care |
| • Cosmetic surgery | • Infertility treatment | • Weight loss programs |
| • Dental care | • Long-term care | |
| • Habilitation services | • Non-emergency care when traveling outside the U.S. | |

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

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|---------------------|----------------------------|
| • Bariatric surgery | • Private-duty nursing |
| • Chiropractic care | • Routine eye care (Adult) |

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 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: 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

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 1-866-893-4472.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-893-4472.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-893-4472.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-866-893-4472uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-893-4472.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-893-4472.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-893-4472.

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 plan's overall deductible	\$2,000
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$60

The total Peg would pay is	\$2,070
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$1,200
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$20

The total Joe would pay is	\$3,220
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$100
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$0

The total Mia would pay is	\$2,100
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.