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 410-996-5415 or 410-996-5413. 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.dol.gov/ebsa/healthreform.com or call 410-996-5415 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers **$200** Individual / **$400** Family.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible starts over September 1. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Coinsurance and copayments do not count toward deductible. Does not apply to preventative care or prescription drugs.
Are there services covered before you meet your deductible?	Yes. Preventative Care is covered before you meet your deductible.	This plan covers certain preventative care 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 do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers
What is the out-of-pocket limit for this plan?	Medical: For in-network providers **$1,500** Individual / **$4,500** Family. Prescription: **$3,600** Individual / **$7,200** Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care services this plan does not 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 or call 1-800-589-2386 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 of you use an out-of-network provider, and you might receive a bill from a provider for the cost of your visit if you receive services from an out-of-network provider (a balance bill). 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
		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	$20 copay/visit after deductible	Not covered	----------None----------
	Specialist visit	$25 copay/visit after deductible	Not covered	----------None----------
	Preventive care/screening/ immunization	No charge for covered services	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Maximum tests per year may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay/visit after deductible	Not covered	----------None----------
	Imaging (CT/PET scans, MRIs)	$50 copay/visit after deductible	Not covered	----------None----------
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	$5 copay retail / $10 copay for 90 day maintenance drug mail order	N/A	----------None----------
	Preferred brand drugs	$25 copay retail / $50 copay for 90 day maintenance drug mail order	N/A	----------None----------
	Non-preferred brand drugs	$50 copay retail / $100 copay for 90 day maintenance drug mail order	N/A	----------None----------
	Specialty drugs	$5 copay retail for generic; $25 copay retail for preferred brand; $50 copay retail for non-preferred brand/$10 copay mail order for generic; $50 copay mail order for	N/A	----------None----------

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; $100 copay mail order for non-preferred brand		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay after deductible	Not covered	----------None----------
	Physician/surgeon fees	$0 copay after deductible	Not covered	----------None----------
If you need immediate medical attention	Emergency room care	$75 copay/visit after deductible	$75 copay/visit after deductible	Copay waived if admitted.
	Emergency medical transportation	$0 copay after deductible	$0 copay after deductible	----------None----------
	Urgent care	$35 copay/visit after deductible	Not covered	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copay after deductible	Not covered	----------None----------
	Physician/surgeon fees	$0 copay after deductible	Not covered	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/per visit after deductible	Not covered	----------None----------
	Inpatient services	$0 copay after deductible	Not covered	Pre-certification is required.
If you are pregnant	Office visits	No charge for covered services	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) that may be subject to the deductible and copay.
	Childbirth/delivery professional services	$0 copay after deductible	Not covered	----------None----------
	Childbirth/delivery facility services	$0 copay after deductible	Not covered	----------None----------
If you need help recovering or have	Home health care	$0 copay after deductible	Not covered	Prior authorization is required.

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)	
other special health needs	Rehabilitation services	$25 copay/visit after deductible	Not covered	60 visits per year for speech therapy, physical therapy, occupational therapy and spinal manipulation combined.
	Habilitation services	Treatment is covered based on the type of service performed and the place rendered	Not covered	----------None----------
	Skilled nursing care	$0 copay after deductible	Not covered	Limit of 100 days per calendar year.
	Durable medical equipment	$0 copay after deductible	Not covered	----------None----------
	Hospice services	$0 copay after deductible	Not covered	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------None----------
	Children's glasses	Not covered	Not covered	----------None----------
	Children's dental check-up	Not covered	Not covered	----------None----------

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	• Long-term care	• Routine dental care (adult)
• Private duty nursing	• Routine eye care (adult)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids	• Infertility treatment	
• Non-emergency care when traveling outside the U.S. for participating providers. Call the toll free number on the back of your card.	• Routine foot care	

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: benefitsinfo@ccps.org or (410) 996-5415. Other options to continue coverage are 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: benefitsinfo@ccps.org.

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.

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.ccps.org.

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	$200
Specialist copayment	$25
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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$220
Coinsurance	$0
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$570**

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

The plan's overall deductible	$200
Specialist copayment	$25
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	**$4,100**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$420
Coinsurance	$0
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$700**

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

The plan's overall deductible	$200
Specialist copayment	$25
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	**$9,850**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$590
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Mia would pay is	**$890**

Note: These examples assume single coverage.

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