Aetna: Hospira, a Pfizer company HSA Premier Medical Plan

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Coverage Tiers | **Plan Type:** HSA

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.aetnahospira.com or by calling **1-877-771-7722.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$1,750** Employee Only/ **$3,500** Family For out-of-network providers **$1,750** Employee Only / **$3,500** Family	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over on January 1st of each plan year. See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible.** Deductible amounts shown above are offset by company-provided HSA dollars & any earned incentives. Employees have the opportunity to offset the deductible by **$760**. Employees covering families have the opportunity to offset the deductible by **$1,520**.
Are there other deductibles for specific services?	There are no other specific **deductibles**	
Is there an out–of–pocket limit on my expenses?	Yes. For in-network providers **$5,000** Employee Only / **$10,000** Family For out-of-network providers **$10,000** Employee Only / **$20,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period 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, services deemed not medically necessary by Aetna's Medical Management, penalties for non-compliance, charges over the allowed amount and health care claims this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services. Check your policy or plan document for details.
Does this plan use a network of providers?	Yes. See www.Aetna.com or call 1-800-833-0220 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	All covered services must be medically necessary, and coverage or certification of services that are not medically necessary may be denied. Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	40% co-insurance	
	Specialist visit	20% co-insurance	40% co-insurance	
	Other practitioner office visit	20% co-insurance	40% co-insurance	
	Preventive care/screening/immunization	No Charge	40% co-insurance	Age and Frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnanavigator .com	Generic drugs	20% co-insurance	60% co-insurance	Co-insurance applies once plan deductible has been met.
	Brand drugs	20% co-insurance	60% co-insurance	Co-insurance applies once plan deductible has been met.
	Specialty drugs	20% co-insurance	60% co-insurance	Co-insurance applies once plan deductible has been met.
	Qualified Preventive Medications Generic drugs	No Charge	Not Covered	Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please visit www.aetnanavigator .com.
	Qualified Preventive Medications Preferred Brand drugs	$25 retail $62 mail order	Not Covered	
	Qualified Preventive Medications Non-Preferred Brand drugs	50% coinsurance retail $125 mail order	Not Covered	There is a minimum member payment of $50 and a maximum payment of $150 at retail
	Diabetic Supplies	No Charge	Not Covered	Requires prior-authorization approval to receive 0% coinsurance benefit

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	
	Physician/surgeon fees	20% co-insurance	40% co-insurance	
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	Non-emergency use- 50% after deductible.
	Emergency medical transportation	20% co-insurance	20% co-insurance	Benefits are subject to medical necessity.
	Urgent care	20% co-insurance	20% co-insurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Precertification for inpatient hospital care is required
	Physician/surgeon fee	20% co-insurance	40% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Precertification for inpatient hospital care is required
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Precertification for inpatient hospital care is required
If you are pregnant	Prenatal and postnatal care	No Charge	40% co-insurance	
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	Includes outpatient postnatal care
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Precertification for home health care is required. 40 visit maximum per calendar year
	Rehabilitation services	20% co-insurance	40% co-insurance	60 visits combined OT, PT & ST per calendar year. Combined In and Out-of-Network. Precertification for inpatient hospital care is required
	Habilitation services	Not Covered	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs (continued)	Skilled nursing care	20% co-insurance	40% co-insurance	120 days per calendar year. Combined In and Out-of-Network. Precertification for inpatient hospital care is required
	Durable medical equipment	20% co-insurance	40% co-insurance	Some limitations apply. Check your policy or plan document for details
	Hospice service	20% co-insurance	40% co-insurance	Precertification for inpatient hospital care is required
If your child needs dental or eye care	Eye exam	No Charge	40% co-insurance	Exams performed by the in-network Primary Care Physician are covered at 100% and are limited to one exam per calendar year. Exams performed by a specialist are subject to the deductible and plan co-insurance.
	Glasses	Not Covered	Not Covered	Coverage available in the Voluntary Vision plan (if elected)
	Dental check-up	Not Covered	Not Covered	Coverage available in the Voluntary Dental plan (if elected)

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acts of war/military duty
- Certain foot care
- Cosmetic medication
- Cosmetic surgery
- Custodial/convalescent care
- Dental Care
- Habilitation Services
- Hearing aids & hearing devices
- Long Term Care
- Non-accidental injury dental care
- Routine Foot Care
- Weight reduction programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for details, other covered services and your costs for these services.)

- Acupuncture (if rendered by a licensed provider & are in lieu of traditional anesthesia)
- Allergy Testing & Treatment
- Bariatric surgery (network is limited to Centers of Excellence)
- Chiropractic care (60 visit maximum; subject to medical review)
- Emergency coverage provided outside the United States.
- Infertility (lifetime maximum of $20,000 PAR & non-PAR combined)
- Private Duty Nursing (up to 70 8 hour shifts)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-877-771-7722. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:
Aetna
Attn: National Account CRT
PO Box 14463
Lexington, KY 40512
Phone: 1-888-833-0220

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-833-0220

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-833-0220

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This medical & prescription drug plan is a health savings account (HSA)-based plan. You can use this HSA account to help you pay for eligible medical expenses.

The examples provided on this page assume:

- You are enrolled in Employee Only coverage
- You have earned the maximum in HSA incentives for the year
- You have not yet used any of your HSA funds for other claims
- You have not set aside additional pre-tax contributions to your HSA

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,140
- **Patient pays** $2,400

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$990
Copays	$0
Coinsurance	$1,260
Limits and Exclusions	$150
Total	**$2,400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,470
- **Patient pays** $1,400

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$990
Copays	$0
Coinsurance	$860
Limits and Exclusions	$80
Total	**$1,930**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.