




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.sfpi.com or by calling (419)368-8231]. 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/ebsa/healthreform.com

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	PPO \$150/Individual or \$325/family. Non-PPO: \$500/Individual or \$1,000/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 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 ?	No	See the Common Medical Events Chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network providers \$950 individual / \$1,500 family; for out-of-network providers \$2,000 individual / \$4,000 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 ?	Deductibles , prescription drug charges, 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 or call (888)632-3862 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
		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% coinsurance for other outpatient services	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Other practitioner office visit	20% coinsurance	40% coinsurance	Chiro limited to 15 visits (PPO) and 8 visits (non-PPO)
	Preventive care/screening/immunization	20% coinsurance	Not covered	PPO is 10% coinsurance for paps and mammograms. Limits described in SPD
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.CVSCaremark.com	Generic drugs (Tier 1)	20% coinsurance deductible waived		For all drugs, when \$1,800 has been paid by a person in a cal yr, plan pays balance at 100%
	Preferred brand drugs (Tier 2)	20% coinsurance deductible waived		
	Non-preferred brand drugs (Tier 3)	20% coinsurance deductible waived		
	Specialty drugs (Tier 4)	20% coinsurance deductible waived		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention**	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.sfpi.com

**For additional information concerning coverage of emergency medical treatment with non-network providers please see the plan or plan document at www.sfpi.com or contact SFPI directly at 800-722-7374

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 need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits/year (PPO) 60 visits (non-PPO)
	Rehabilitation services	20% coinsurance	40% coinsurance	60 days SNF (PPO) 30 days (non-PPO)
	Habilitation services	20% coinsurance	40% coinsurance	PT max 30 visits (PPO) 15 visits (non-PPO)
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	40% coinsurance	Max 100 days
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](#).)

- | | | |
|--------------------------------|--|----------------------------|
| • Cosmetic Surgery | • Long Term Care | • Routine eye care (Adult) |
| • Dental Care | • Non-emergency care when traveling outside the U.S. | • Routine Foot Care |
| • Hearing Aids | | • Weight loss programs |
| • Infertility Treatment (some) | | |

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

- | | | |
|---|--------------------------------|------------------------|
| • Acupuncture (if prescribed for rehabilitation purposes) | • Chiropractic Care | • Private Duty Nursing |
| • Bariatric Surgery | • Infertility treatment (some) | |

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

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agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: www.sfpi.com

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 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](#).

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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](#) \$150
- [Specialist \[cost sharing\]](#) 20%
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

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:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	0
Coinsurance	\$950
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$1,100

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$150
- [Specialist \[cost sharing\]](#) 20%
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

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:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$0
Coinsurance	\$950
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,100

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$150
- [Specialist \[cost sharing\]](#) 20%
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

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:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$0
Coinsurance	\$530
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$680

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.