



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.HealthReformPlanSBC.com or by calling 1-800-370-4526. 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 1-800-370-4526 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible? | In- <u>Network</u> : EE Only \$1,600; EE+ Family \$3,200. Out-of- <u>Network</u> : EE Only \$1,600; EE+ Family \$3,200. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your deductible? | Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | In- <u>Network</u> : EE Only \$5,000; EE+ Family: Individual \$6,750/ Family \$10,000. Out-of- <u>Network</u> : EE Only \$10,000; EE+ Family: Individual \$13,500/ Family \$20,000. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> , balance-billing charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in- <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | In-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 | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | <u>Preventive care /screening /immunization</u> | No charge | 30% <u>coinsurance</u> , <u>deductible</u> doesn't apply | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetna.com/pharmacy-insurance/individuals-families | Generic drugs | 30% coinsurance retail and mail order | Not covered | Up to 90-day supply |
| | Preferred brand drugs | 30% coinsurance retail and mail order | Not covered | |
| | Non-preferred brand drugs | 30% coinsurance retail and mail order | Not covered | |
| | <u>Specialty drugs</u> | Follows retail | Not covered | Up to 30-day supply. Must be obtained through Accredo specialty pharmacy |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | No coverage for non-emergency use. |
| | <u>Emergency medical transportation</u> | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | Non-emergency transport: not covered, except if pre-authorized. |
| | <u>Urgent care</u> | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care. |

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| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office & other outpatient services: 0% <u>coinsurance</u> | Office & other outpatient services: 30% <u>coinsurance</u> | None |
| | Inpatient services | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| If you are pregnant | Office visits | No charge | 30% <u>coinsurance</u> | Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |
| | Childbirth/delivery professional services | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| | <u>Rehabilitation services</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | <u>Habilitation services</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | <u>Skilled nursing care</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| | <u>Durable medical equipment</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| | <u>Hospice services</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| If your child needs dental or eye care | Children's eye exam | \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 30% <u>coinsurance</u> | 1 routine eye exam/calendar year. |
| | 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
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Routine foot care
- Weight loss programs - Except for required preventive services.

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 - 30 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/24 months for children up to age 16.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/calendar 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:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA

(3272) or <http://www.dol.gov/ebsa/healthreform>

- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

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 Minimum Value Standards? No.

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.

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 \$1,500
- Specialist coinsurance 0%
- 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 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$1,500 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$1,570 |

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

- The plan's overall deductible \$1,500
- Specialist coinsurance 0%
- 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 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$1,100 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$4,300 |
| The total Joe would pay is | \$5,400 |

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

- The plan's overall deductible \$1,500
- Specialist coinsurance 0%
- 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 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$1,500 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$1,510 |

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

- Hindi - **हन्दिी में भाषा सहायता के लएि, 1-800-370-4526 पर मुफ्त कॉल करें।**
- Hmong - **Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.**
- Ibo - **Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwughị ugwo ọ bụla**
- Ilocano - **Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.**
- Italian - **Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.**
- Japanese - **日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。**
- Karen - **လၢတၢ်မၤစၢၤတၢ်ကတိၤကိၤအီၣ်အီၣ် ၈၀၀-၃၇၀-၄၅၂၆ လၢတၢ်အိၣ်ဒီးတၢ်လၢတၢ်ခၢၣ်တၢ်စ့တၢ်**
- Korean - **한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.**
- Kru-Bassa - **Be'm'ké gbo-kpá-kpá dyé pídyi dé Bāsóò'-wuḍuùñ wěě, dǎ 1-800-370-4526**
- Kurdish - **برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خورایی یه یومندی بکن.**
- Laotian - **ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.**
- Marathi - **कोणत्याही शुल्काशवाय भाषा सहा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.**
- Marshallese - **Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.**
- Micronesian - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.**
- Pohnpeyan - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.**
- Mon-Khmer, Cambodian - **សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។**
- Navajo - **T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526**
- Nepali - **(नम्राली) मा ननिःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन िनुहोस् ।**
- Nilotic-Dinka - **Tën kuwoɲy ë thok ë Thuonjäŋ col 1-800-370-4526 kecïn ayöc.**
- Norwegian - **For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.**
- Panjabi - **ਪੰਜਾਬੀ ਵ ਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।**
- Pennsylvania Dutch - **Fer Hilfe in Deutsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.**
- Persian - **برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی**
- Polish - **Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.**
- Portuguese - **Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.**
- Romanian - **Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526**

