



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-network: Individual \$750 / Family \$1,500; Out-of-network: Individual \$1,000 / Family \$2,000.	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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In- <u>network</u> <u>prescription drugs</u> , office visits & <u>preventive care</u> are 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 out-of-pocket limit for this plan?	In-network: Individual \$5,000 / Family \$10,000; Out-of-network: There is no out-of-pocket limit.	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 out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.	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 network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in- <u>network</u> <u>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</u> charge 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 referral to see a specialist?	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	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/standard <u>Aetna Standard Formulary</u>	Generic drugs	<u>Copay</u> /Prescription \$0 (retail), \$9 (90 day supply), \$0 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Your cost will be higher for choosing Brand over Generics. Pharmacy out-of-pocket maximum: \$1,450 individual/\$2,900 family First prescription fill must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
	Preferred brand drugs	<u>Copay</u> /prescription, \$35 (retail), \$70 (mail order)	Not covered	
	Non-preferred brand drugs	<u>Copay</u> /prescription, \$50 (retail), \$100 (mail order)	Not covered	
	<u>Specialty</u> drugs	<u>Copay</u> /prescription, \$150 copay	Not covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	None
	Physician/surgeon fees	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$50 <u>copay</u> / deductible waived	20% <u>coinsurance</u> after \$50 <u>copay</u> / deductible waived	40% coinsurance after \$50 copay and deductible for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No coverage for non-emergency transport.
	<u>Urgent care</u>	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	None.
	Physician/surgeon fees	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u> after deductible	None
	Inpatient services	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	None
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	None
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	None

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)	
	<u>Habilitation services</u>	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	None
	<u>Skilled nursing care</u>	15% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	None
	<u>Durable medical equipment</u>	15% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	15% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	None
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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child) 	<ul style="list-style-type: none"> • Glasses (Child) • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • 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 <u>plan</u> document.)		
<ul style="list-style-type: none"> • Chiropractic care 	<ul style="list-style-type: none"> • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. 	<ul style="list-style-type: none"> • 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 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 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 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.

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 Minimum Value Standard? 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.-----

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** \$750
- **Specialist copayment** \$50
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 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 \$12,800

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$80
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Peg would pay is	\$3,200

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

- The **plan's** overall **deductible** \$750
- **Specialist copayment** \$50
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 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 \$7,400

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$1,500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

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

- The **plan's** overall **deductible** \$750
- **Specialist copayment** \$50
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 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 \$860

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$100
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$860

Note: These numbers assume the patient does not participate in the **plan's** wellness program. If you participate in the **plan's** wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: 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).

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TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-370-4526 ku busa
- Bengali-Bangala - বাংলায় ভাষা সহায়তার জনস্বিভিনামুেল্ 1-800-370-4526-তে কল ক ন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
- Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
- Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
- Cherokee - Ⴀႃႃႃ Ⴀႃႃႃႃ Ⴀႃႃႃႃႃ Ⴀႃႃႃႃႃ Ⴀႃႃႃႃႃ Ⴀႃႃႃႃႃႃ 1-800-370-4526 Ⴀႃႃႃ Ⴀႃႃႃႃ Ⴀႃႃႃႃႃ Ⴀႃႃႃႃႃႃ
- Chinese - 欲取得繁體中文語言協助，請撥打1-800-370-4526，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-370-4526.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
- French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
- Gujarati - ગજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કોલ કરો.

