



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 <u>deductible</u> ?	In Network: Individual \$0 / Family \$0. Out-of-Network: Individual \$750 / 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 <u>deductible</u> ?	Yes. Emergency care, <u>preventive care</u> , inpatient hospital services, outpatient hospital services & <u>prescription drugs</u> ; plus in-network office visits 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 <u>deductibles</u> 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> ?	<u>Network</u> : Individual \$3,000 / Family \$5,000. Out-of-Network: Individual \$4,000 / Family \$6,000. <u>Prescription drugs</u> : Individual \$800 / Family \$1,600.	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> , <u>balance-billing</u> 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 <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</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 <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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	20% <u>coinsurance</u>	Includes Internist, General Physician, Family Practitioner or Pediatrician None 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. Age and frequency schedules may apply.
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit	20% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	No charge	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$35 <u>copay</u> /visit for hospital; \$25 <u>copay</u> /visit for free standing facility	10% <u>coinsurance</u> after \$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply for hospital; 20% <u>coinsurance</u> for free standing facility	None
	Imaging (CT/PET scans, MRIs)	\$50 <u>copay</u> /visit for hospital; \$25 <u>copay</u> /visit for free standing facility	10% <u>coinsurance</u> after \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply for hospital; 20% <u>coinsurance</u> for free standing facility	None

<p>If you need drugs to treat your illness or condition</p> <p>Prescription drug coverage is administered by Navitus 1-866-333-2757</p> <p>More information about prescription drug coverage is available at www.navitus.com</p>	<p>Drug Tier 1 - includes preferred generics and some lower-cost brand products</p>	<p>31 Day Retail: \$5</p> <p>90 day mail order: \$5</p>	Not covered	<p>Covers 31 day supply (retail), 90 day supply (mail order - Navitus).</p> <ul style="list-style-type: none"> • Includes contraceptive drugs & devices obtainable from a pharmacy, and oral fertility drugs. • No charge for formulary generic FDA-approved women's contraceptives in-network. • Precertification may be required. Step therapy may be required. • Mandatory generic when available.
	<p>Drug Tier 2 - includes preferred brand products and some higher-cost non-preferred generics</p>	<p>31 Day Retail: \$35</p> <p>90 day mail order: \$70</p>	Not covered	
	<p>Drug Tier 3 - includes non-preferred products; may include some high-cost non-preferred generics</p>	<p>31 Day Retail: \$50</p> <p>90 day mail order: \$100</p>	Not covered	
	<p>Drug Tier 4 - includes specialty products available at specialty pharmacies</p>	<p>31 Day Retail: \$100</p> <p>90 day mail order: \$200</p>	Not covered	
<p>If you have outpatient surgery</p>	<p>Facility fee (e.g., ambulatory surgery center)</p>	\$100 <u>copay</u> /visit	10% <u>coinsurance</u> after \$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply	None
	<p>Physician/surgeon fees</p>	\$35 <u>copay</u> /visit	20% <u>coinsurance</u>	None
<p>If you need immediate medical attention</p>	<p><u>Emergency room care</u></p>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u> for non-emergency use.
	<p><u>Emergency medical transportation</u></p>	No charge	No charge	20% <u>coinsurance</u> for non-emergency transport.
	<p><u>Urgent care</u></p>	\$35 <u>copay</u> /visit	\$35 <u>copay</u> /visit, after <u>deductible</u>	No coverage for non-urgent use.
<p>If you have a hospital stay</p>	<p>Facility fee (e.g., hospital room)</p>	\$250 <u>copay</u> /stay	10% <u>coinsurance</u> after \$250 <u>copay</u> /stay, <u>deductible</u> doesn't apply	Penalty of 50% of <u>allowed amount</u> , not to exceed \$250, for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<p>Physician/surgeon fees</p>	\$35 <u>copay</u> /visit	20% <u>coinsurance</u>	None

If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office \$35 <u>copay</u> /visit Other outpatient services: \$25 <u>copay</u> /visit	Office: 20% <u>coinsurance</u>	None
	Inpatient services	\$250 <u>copay</u> /stay	10% <u>coinsurance</u> after \$250 <u>copay</u> /stay, <u>deductible</u> doesn't apply	None
If you are pregnant	Office visits	No charge	20% <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%, not to exceed \$250, of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	\$35 <u>copay</u> /pregnancy	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250 <u>copay</u> /stay	10% <u>coinsurance</u> after \$250 <u>copay</u> /stay, <u>deductible</u> doesn't apply	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	10% <u>coinsurance</u>	200 visits/calendar year. Penalty of 50%, not to exceed \$250, of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit	20% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit	20% <u>coinsurance</u>	Limited to treatment of Autism.
	<u>Skilled nursing care</u>	\$250 <u>copay</u> /stay	10% <u>coinsurance</u> after \$250 <u>copay</u> /stay, <u>deductible</u> doesn't apply	100 days/calendar year. Penalty of 50%, not to exceed \$250, of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	No charge	20% <u>coinsurance</u>	None
	<u>Hospice services</u>	\$250 <u>copay</u> /stay, for inpatient; no charge for outpatient	\$250 <u>copay</u> /stay, <u>deductible</u> doesn't apply for inpatient; no charge for outpatient	Penalty of 50%, not to exceed \$250, 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	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids - Limited to \$4,000 maximum every 3 years.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination, ovulation induction & oral & injectable fertility drugs.
- Private-duty nursing - Limited to \$400/day.

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 \$0
- Specialist copayment \$35
- Hospital (facility) copayment \$250
- Other copayment \$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	\$12,800
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$560

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

- The plan's overall deductible \$0
- Specialist copayment \$35
- Hospital (facility) copayment \$250
- Other copayment \$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	\$7,400
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

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

- The plan's overall deductible \$0
- Specialist copayment \$35
- Hospital (facility) copayment \$250
- Other copayment \$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	\$1,900
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$300

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).

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 (Aetna).

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - **हनिदी में भाषा सहायता के लिए, 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 akwụghị ụgwọ 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 - လာဘ်တရားတရားကတိကုန်အင်္ဂါ ကျိန် ကိး 1-800-370-4526 လာဘ်အိန်ဒီးတရားလာဘ်ကျိန်လာဘ်ကျိန်
- Korean - **한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.**
- Kru-Bassa - **Ḃe m'ké gbo-kpá-kpá dyé pídyi dé Ḃašwó-wuḂuñ 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 - **तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.**
- Marshallese - Ñān bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.**
- Mon-Khmer, Cambodian - **សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។**
- Navajo - T'áá shi shizaad k'ehjí bee shík'a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
- Nepali - **(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 800-370-4526 मा फोन गर्नुहोस् ।**
- Nilotic-Dinka - **Tën kuwoony ë thok ë Thuonjäng col 1-800-370-4526 kec'in ayöc.**
- Norwegian - **For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.**
- Panjabi - **ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।**
- Pennsylvania Dutch - **Fer Hefte in Deitsch, 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.**

