



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> ?	\$0. Out-of-Network: Individual \$300 / Family \$600.	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> 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> ?	In- <u>Network</u> : Individual \$3,500 / Family \$7,000. Out-of-Network: Individual \$4,000 / Family \$8,000.	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 pre-authorization 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</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
		In-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	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for all other services	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for all other services	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	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)	No charge for laboratory; \$20 <u>copay</u> /visit for x-ray, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
If you need drugs to treat your	Generic drugs	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	Not covered.
	Non-preferred brand drugs	Not covered	Not covered	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)	
illness or condition More information about <u>prescription drug coverage</u> is available at www.aetna.com/pharmacy-insurance/individuals-families	<u>Specialty drugs</u>	Not covered	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	None
	<u>Emergency medical transportation</u>	No charge	No charge	30% <u>coinsurance</u> for non-emergency transport out-of-network.
	<u>Urgent care</u>	\$28 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$75 <u>copay</u> /day first 5 days per stay, <u>deductible</u> doesn't apply; no charge thereafter	30% <u>coinsurance</u>	Penalty of \$1,000 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	\$75 <u>copay</u> /day first 5 days per stay, <u>deductible</u> doesn't apply; no charge thereafter	30% <u>coinsurance</u>	Penalty of \$1,000 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u> , <u>deductible</u> doesn't apply	<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.) Penalty of \$1,000 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$75 <u>copay</u> /day first 5 days per stay, <u>deductible</u> doesn't apply; no charge thereafter	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	Penalty of \$1,000 for failure to obtain pre-authorization for out-of-network care.
	<u>Rehabilitation services</u>	\$15 <u>copay</u> /visit first 30 visits, \$25 <u>copay</u> /visit thereafter, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including <u>habilitation services</u> . Includes treatment of Autism up to age 21.

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>	\$15 <u>copay</u> /visit first 30 visits, \$25 <u>copay</u> /visit thereafter, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	120 days/calendar year. Penalty of \$1,000 for failure to obtain pre-authorization for out-of-network care. Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. Penalty of \$1,000 for failure to obtain pre-authorization for out-of-network care.
	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	
	<u>Durable medical equipment</u>	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	
	<u>Hospice services</u>	No charge	30% <u>coinsurance</u>	
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.)

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) • Glasses (Child) | <ul style="list-style-type: none"> • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. • Prescription drugs | <ul style="list-style-type: none"> • 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 - 1 surgery/lifetime.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing - 45- 8 hour shifts/calendar year.
- Chiropractic care - 30 visits/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 : <https://www.dol.gov/agencies/ebsa>
- 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 <https://www.dol.gov/agencies/ebsa>
- 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 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 \$0
- Specialist copayment \$20
- Hospital (facility) copayment \$75
- 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	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Peg would pay is	\$300

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 \$20
- Hospital (facility) copayment \$75
- 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	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,000
The total Joe would pay is	\$6,100

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

- The plan's overall deductible \$0
- Specialist copayment \$20
- Hospital (facility) copayment \$75
- 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	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$100

[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).

- Hindi - हन्दिी 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 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 - လာဝာ်မစာလာ်ကလာ်ကျိၣ်အဂီၢ် ကျိၣ် ကိး 1-800-370-4526 လာတအိၣ်ဒီးတၢ်လာ်ဘူၣ်လာ်စ့ဘၣ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
- Kru-Bassa - Ɖe´m`ké gbo-kpá-kpá dyé pidiyi dé Ɖaśwó`wuḍuūñ wéɛ, dá 1-800-370-4526
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرای یه یهوندی بکهن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ: 800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- 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 - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទួលកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។
- Mon-Khmer, Cambodian - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
- Navajo - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony ë thok ë Thuonjän cöl 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 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

