



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](http://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 \$350 / Family \$700.	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 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
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 \$500 / Family \$1,000. Out-of-Network: Individual \$2,000 / Family \$5,000. Prescription Drugs separate out-of-pocket limit is \$1,600 Individual/ \$3,200 Family	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.	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 <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> 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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$10 <b>copay</b> /visit, <b>deductible</b> doesn't apply	30% <b>coinsurance</b>	None
	<b>Specialist</b> visit	\$15 <b>copay</b> /visit, <b>deductible</b> doesn't apply	30% <b>coinsurance</b>	None
	<b>Preventive care</b> / <b>screening</b> /immunization	No charge	Not covered, except 30% <b>coinsurance</b> for immunizations up to 12 months, mammograms & gynecological exams	You may have to pay for services that aren't preventive. Ask your <b>provider</b> if the services needed are preventive. Then check what your <b>plan</b> will pay for.
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	No charge	30% <b>coinsurance</b>	None
	Imaging (CT/PET scans, MRIs)	No charge	30% <b>coinsurance</b>	None
If you need drugs to treat your illness or condition  More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	\$5 copay/1-30 day supply \$10 / 31-60 day supply \$15 / 61-90 day supply at a retail pharmacy \$10 copay/90 day supply	Not covered	Up to 30-day supply at retail; 90-day mail order.  Step Therapy with NO Grandfathering applies.
	Preferred brand drugs	\$10 copay/1-30 day supply \$20 / 31-60 day supply \$30 / 61-90 day supply at a retail pharmacy \$20 copay/90 day supply	Not covered	For Brand drugs with a Generic Equivalent available, member pays the difference in cost between generic & brand, plus brand copay.

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)	
	Non-preferred brand drugs	You pay the applicable brand copayment as listed above, plus the cost difference between the brand drug and the generic drug.	Not covered	
	<u>Specialty drugs</u>	Brand or generic copayments apply	Not covered	Up to 30-day supply – must be filled through Accredo Specialty Pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$125 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$125 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> , <u>deductible</u> doesn't apply	10% <u>coinsurance</u> , <u>deductible</u> doesn't apply	Non-emergency transport: not covered, except 30% <u>coinsurance</u> if pre-authorized.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office & other outpatient services: \$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Office & other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	No charge	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.

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 are pregnant	Office visits	\$10 Copayment per visit for Office. \$15 Copayment per visit for office; Specialist	30% <u>coinsurance</u>	<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.) <u>Pre-authorization</u> may be required for out-of-network care.
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	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>	<u>Pre-authorization</u> required for out-of-network care.
	<u>Rehabilitation services</u>	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	\$52 maximum/visit for Physical Therapy for out-of-network.
	<u>Habilitation services</u>	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	\$52 maximum/visit for Physical Therapy for out-of-network.
	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	120 days/calendar year for in-network, 60 days/calendar year for out-of-network. <u>Pre-authorization</u> required for out-of-network care.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> , <u>deductible</u> doesn't apply	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>	No charge	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered.	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 - Up to \$60 or 75% of in-network payments, whichever is lower for out-of-network.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year. \$35 maximum/visit for out-of-network.
- Hearing aids - 1 hearing aid to \$1,000 maximum per ear/24 months up to age 16.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/calendar year for in-network only.

## 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](http://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](http://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](http://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 \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$0
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$70</b>

**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 \$15
- Hospital (facility) copayment \$0
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,400</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$0
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$300</b>

### 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](mailto: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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- 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 - **လၢတၢ်မၤစၢၤတၢ်ကတိၤတၢ်အီၣ်အီၣ်အီၣ် ၈၀၀-၃၇၀-၄၅၂၆ လၢတၢ်အီၣ်အီၣ်အီၣ်လၢတၢ်တၢ်တၢ်တၢ်**
- Korean - **한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.**
- Kru-Bassa - **Be'm'ké gbo-kpá-kpá dyé pidyi dé Bāsóó'-wuḍuūñ wěε, dá 1-800-370-4526**
- Kurdish - **برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرای یه یومندی بکهن.**
- Laotian - **ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.**
- Marathi - **कोणत्याही शुल्काशिवाय भाषा सेवा 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-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 - **(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।**
- Nilotic-Dinka - **Tën kuwoony ë thok ë Thuonjäŋ col 1-800-370-4526 kec'in ayöc.**
- Norwegian - **For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.**
- Panjabi - **ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਹਾਦਿਤਾ 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**
- Russian - **Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.**

