



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> ?                             | Individual \$300.   | 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> .   |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> , generic drugs & primary care 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 <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> ?       | Individual \$1,100. <u>Prescription drugs</u> : Individual \$500.   | 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> ?            | Not applicable.   | This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> .  |
| 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   |
|--|---|--|--|
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness        | \$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply  | None   |
|  | <u>Specialist</u> visit                                 | 20% <u>coinsurance</u>   | None   |
|  | <u>Preventive care</u> / <u>screening</u> /immunization | No charge  | Age and frequency schedules may apply.   |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)              | 20% <u>coinsurance</u>   | None   |
|  | Imaging (CT/PET scans, MRIs)                            | 20% <u>coinsurance</u>   | None   |
| <b>If you need drugs to treat your illness or condition</b><br><br><b><u>Prescription drug coverage is administered by CVS Caremark.</u></b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.caremark.com">www.caremark.com</a> | Generic drugs   | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$5 (retail); \$10 (mail order)   | Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . |
|  | Preferred brand drugs                                   | <u>Copay</u> /prescription: \$20 (retail), \$40 (mail order)   |  |
|  | Non-preferred brand drugs                               | <u>Copay</u> /prescription: \$50 (retail), \$100 (mail order)  |  |
|  | <u>Specialty drugs</u>                                  | Copay/prescription, deductible doesn't apply: Generic - \$5 (retail), \$10 (mail order)<br><br>Copay/prescription: Preferred Brand - \$20 (retail), \$40 (mail order)<br><br>Copay/prescription: Non-preferred - \$50 (retail), \$100 (mail order) | Members that do not have Medicare must use a CVS Specialty pharmacy.   |

| Common Medical Event  | Services You May Need                          | What You Will Pay  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|---|
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                     | None  |
|   | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                     | None  |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | 20% <u>coinsurance</u> after \$150 <u>copay/visit</u>      | None  |
|   | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>                                     | None  |
|   | <u>Urgent care</u>                             | 20% <u>coinsurance</u> after \$40 <u>copay/visit</u>       | None  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>                                     | Penalty of \$200 for failure to obtain <u>pre-authorization</u> .   |
|   | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                     | None  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Office & other outpatient services: 20% <u>coinsurance</u> | None  |
|   | Inpatient services                             | 20% <u>coinsurance</u>                                     | Penalty of \$200 for failure to obtain <u>pre-authorization</u> .   |
| If you are pregnant   | Office visits                                  | No charge  | <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 \$200 for failure to obtain <u>pre-authorization</u> may apply. |
|   | Childbirth/delivery professional services      | 20% <u>coinsurance</u>                                     |   |
|   | Childbirth/delivery facility services          | 20% <u>coinsurance</u>                                     |   |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                        | 20% <u>coinsurance</u>                                     | Penalty of \$200 for failure to obtain <u>pre-authorization</u> .   |
|   | <u>Rehabilitation services</u>                 | 20% <u>coinsurance</u>                                     | None  |
|   | <u>Habilitation services</u>                   | 20% <u>coinsurance</u>                                     | None  |
|   | <u>Skilled nursing care</u>                    | 20% <u>coinsurance</u>                                     | 90 days/benefit period. Penalty of \$200 for failure to obtain <u>pre-authorization</u> .   |
|   | <u>Durable medical equipment</u>               | 20% <u>coinsurance</u>                                     | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.  |
|   | <u>Hospice services</u>                        | 20% <u>coinsurance</u>                                     | Penalty of \$200 for failure to obtain <u>pre-authorization</u> for care.   |
| If your child needs dental or eye care                                    | Children's eye exam                            | Not covered  | Not covered.  |
|   | Children's glasses                             | Not covered  | Not covered.  |
|   | Children's dental check-up                     | 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)
- Hearing aids
- Long-term care
- 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.)

- Acupuncture - Limited to adult postoperative & chemotherapy, nausea & vomiting, nausea of pregnancy, postoperative dental pain, fibromyalgia/myofascial pain & temporomandibular disorders (TMJ).
- Bariatric surgery
- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing – included as part of home health care

**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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. 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? 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 **\$300**
- Specialist coinsurance **20%**
- 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*)

|  |                 |
|--|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <u>Deductibles</u>                     | \$300           |
| <u>Copayments</u>                      | \$10            |
| <u>Coinsurance</u>                     | \$2,200         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$2,570</b>  |

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

- The plan's overall deductible **\$300**
- Specialist coinsurance **20%**
- 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  
Diabetic supplies (*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>                     | \$300          |
| <u>Copayments</u>                      | \$900          |
| <u>Coinsurance</u>                     | \$70           |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$1,290</b> |

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

- The plan's overall deductible **\$300**
- Specialist coinsurance **20%**
- 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*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | \$300          |
| <u>Copayments</u>                      | \$10           |
| <u>Coinsurance</u>                     | \$500          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$810</b>   |

### 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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

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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- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫੋਨ ਕਰੋ।
- Romanian - Pentru a accesa gratuit serviciile de limbă, apălați 1-800-370-4526.
- Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.
- Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se tologi, vala'au le 1-800-370-4526.
- Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-800-370-4526.
- Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.
- Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-370-4526.
- Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-800-370-4526.
- Syriac - ܟܝ ܫܒܩܗ ܥܘܢܐ ܟܠ ܝܠܟܬܝܗ ܟܠܝܢܝܗ ܟܠܝܢܝܗ ܟܠܝܢܝܗ، ܡܢ ܒܚܝܢܐ: 1-800-370-4526
- Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.
- Telugu - మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-800-370-4526 కు కాల్ చేయండి.
- Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.
- Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-370-4526.
- Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-370-4526.
- Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-370-4526 numarayı arayın.
- Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.
- Urdu - بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔
- Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.
- Yiddish - צו צוטריט שפראך באדינונגען אין קיין פרייז צו איר, רופן 1-800-370-4526
- Yoruba - Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-800-370-4526.