



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 1-800-645-5677. 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 1-800-645-5677 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	In- <u>Network</u> : Individual \$2,500. Out-of- <u>Network</u> : Individual \$5,000.	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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> & generic prescription drugs; plus in- <u>network</u> 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>
<b>Are there other deductibles for specific services?</b>	Yes. \$275 for covered brand-name <u>prescription drugs</u> , including <u>specialty drugs</u> . There are no other specific deductibles.	You must pay all the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	In- <u>Network</u> : Individual \$6,500. Out-of- <u>Network</u> : Individual \$13,000. <u>Prescription drugs</u> : Individual \$4,000 (non-Medicare)/\$2,000 (Medicare).	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> .
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-800-645-5677 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.
<b>Do you need a referral to see a specialist?</b>	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)	
<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	50% <u>coinsurance</u>	You may pay the applicable primary care physician office visit copay for certain mental health providers.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care /screening /immunization</u>	No charge	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>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b>  <b><u>Prescription drug coverage is administered by CVS Caremark.</u></b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic prescription drugs	<u>Copay</u> /prescription: \$10 (retail); low cost generic \$9, other generic \$25 (mail order)	<u>Copay</u> /prescription: \$10 (retail); low cost generic \$9, other generic \$25 (mail order)	Copayment applies to prescription drugs on the CVS formulary.  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 <u>in-network</u> .
	Preferred brand drugs	<u>Copay</u> /prescription: \$30 (retail), \$75 (mail order)	<u>Copay</u> /prescription: \$30 (retail), \$75 (mail order)	Copayment/coinsurance applies to prescription drugs on the CVS formulary.  Members that do not have Medicare must use a CVS Specialty pharmacy.
	Non-preferred drugs	<u>Copay</u> /prescription: \$75 (retail), \$187.50 (mail order)	<u>Copay</u> /prescription: \$75 (retail), \$187.50 (mail order)	
	<u>Specialty drugs</u>	Lesser of 8% of the cost or \$450 for a supply 1-31 days; \$900 for a supply of 32-60 days; \$1,350 for a supply of 61-90 days (after deductible)	Lesser of 8% of the cost or \$450 for a supply 1-31 days; \$900 for a supply of 32-60 days; \$1,350 for a supply of 61-90 days (after deductible)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <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 immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$150 <u>copay/visit</u>	20% <u>coinsurance</u> after \$150 <u>copay/visit</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . 50% <u>coinsurance</u> for out-of- <u>network</u> non-emergency transport.
	<u>Urgent care</u>	20% <u>coinsurance</u> after \$40 <u>copay/visit</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>	50% <u>coinsurance</u>	Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of- <u>network</u> care.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <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>	Office & other outpatient services: 50% <u>coinsurance</u>	Certain mental health providers are considered primary care. The applicable primary care physician office visit copayment would be charged for those specific providers.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of- <u>network</u> care.
If you are pregnant	Office visits	No charge	50% <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). Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of- <u>network</u> care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of- <u>network</u> care.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	90 days/benefit period. Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of- <u>network</u> care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.

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>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$200 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.)

- 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, including artificial insemination.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

### 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 1-800-645-5677.
  - 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, 1-800-645-5677. 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 \$2,500
- 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>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,370</b>

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

- The plan's overall deductible \$2,500
- 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>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,020</b>

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

- The plan's overall deductible \$2,500
- 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>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,570</b>

### Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-645-5677.

### 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).

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).**





- Hawaiian - No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-800-645-5677. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-800-645-5677 पर कॉल करें।
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-645-5677.
- Igbo - Iji nwetaòhèrè na orụ gasị asụsụ n'efu, kpọọ 1-800-645-5677
- Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-645-5677.
- Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-645-5677.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-645-5677.
- Japanese - 言語サービスを無料でご利用いただくには、1-800-645-5677 までお電話ください。
- Karen - လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖဲးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-645-5677 တက့ၢ်.
- Korean - 무료 언어 서비스를 이용하려면 1-800-645-5677 번으로 전화해 주십시오.
- Kru-Bassa - M̄ dyi wuḍu-dù kà kò dò bě dyi m̄oú n̄ ní Pídyi ní, níí, dá nòbà nià ke: 1-800-645-5677
- Kurdish - 1-800-645-5677 بۆ دەسپێرێتگه‌شتن به خزمه‌تگوزاری زمان به‌ی تێچوون بۆ تو، په‌یوه‌ندی بکه به ژماره‌ی
- Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໃບຫາເບີ 1-800-645-5677
- Marathi - कोणत्याही शक्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-800-645-5677 वर फोन करा.
- Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-645-5677.
- Micronesian- Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-645-5677.
- Pohnpeyan -
- Mon-Khmer, Cambodian - ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-645-5677 ។
- Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo báqáh ílínígóó kojí' hólne' 1-800-645-5677.
- Nepali - निःशुल्क भाषा सेवा प्राप्त गर्न 1-800-645-5677 मा टेलिफोन गर्नुहोस् ।
- Nilotic-Dinka - Të koor yin wëër de thokic ke ciin wëu kor keek tënɔŋ yin. Ke cɔl koc ye koc kuony ne nɔmba 1-800-645-5677.
- Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-800-645-5677.
- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-645-5677.
- Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-645-5677 تماس بگیرید .
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-645-5677.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-645-5677.

