



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- <u>Network</u> : EE Only \$4,150; EE+ Family \$8,300. Out-of- <u>Network</u> : EE Only \$4,150; EE+ Family \$8,300.	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. In- <u>network</u> <u>preventive care</u> 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 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 \$5,150 / Family \$10,300. Out-of- <u>Network</u> : Individual \$6,150 / Family \$12,300.	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.	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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered; except 40% <u>coinsurance</u> for mammograms & gynecological exams	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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If you need drugs to treat your illness or condition <u>Prescription drug coverage</u> is administered by Optum Rx More information about <u>prescription drug coverage</u> is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Utilization management programs may apply.
	Preferred brand drugs	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Non-preferred brand drugs	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	40% <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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
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: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> doesn't apply to certain <u>preventive services</u> . Maternity care may include tests & services described elsewhere in the SBC (i.e., ultrasound). <u>Pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Out-of-network maximum: 75% of in-network cost up to \$52/visit for Physical Therapy, including outpatient hospital services. <u>Pre-authorization</u> required for out-of-network care.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 days/calendar year in-network & 60 days/stay out-of-network. <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)	
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% <u>coinsurance</u>	40% <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	20% <u>coinsurance</u>	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.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - Limited to disease, injury & chronic pain. Out-of-network maximum: 75% of in-network cost up to \$60/visit.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year. Out-of-network maximum: 75% of in-network cost up to \$35/visit.
- Hearing aids - 1 hearing aid to \$2,500 maximum per ear/60 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- 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.
 - 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 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.
- 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 <u>plan's</u> overall <u>deductible</u>	\$4,100
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$4,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,160

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$4,100
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$4,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$300
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$4,420

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$4,100
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

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

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 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.

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).

Language Assistance:

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար գանգահարեք 1-800-370-4526 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.
Bengali-Bangala -	সেবাগুলি নিম্নলিখিত ভাষায় উপলব্ধ: বাংলা, হিন্দি, উর্দু, মালয়ালম, তামিল, কন্নড়, অসমীয়া, গুজরাতি, মারাঠি, নেপালি, পশতু, সিন্ধি, সংস্কৃত, ফার্সি, ইংরেজি। 1-800-370-4526 ☎
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.
Burmese -	သင့်အနေဖြင့် အခမဲ့စကားပြော ဖုန်းရပ် ဘာသာစကားဝန်ဆောင်မှုများ ရရှိလိုလျှင် 1-800-370-4526 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
Cherokee -	□□□□ □□□□□□ □□□□□□ □ □□□ □□□□□□ □□, □□□□□□ 1-800-370-4526.
Chinese -	如欲使用免費語言服務，請致電 1-800-370-4526.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવાઓની પહોંર માટે, કોલ કરો1-800-370-4526.

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