



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 1-866-658-2455. 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 1-866-658-2455 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For each Plan Year, \$0. Out-of-Network: Individual \$250 / Family \$750.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	Yes. Emergency care & prescription drugs; plus in-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services 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>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	In-Network: Individual \$2,000 / Family \$6,000. Out-of-Network: Individual \$3,000 / Family \$9,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-866-658-2455 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the specialist you choose without a referral.



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	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	30% <u>coinsurance</u>	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge	30% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	\$15/prescription (retail) \$30/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	Covers up to a 30-day supply (retail) and 90-day supply (mail order).
	Preferred brand drugs	\$35/prescription (retail) \$70/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
	Non-preferred brand drugs	\$50/prescription (retail) \$100/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	

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>Specialty drugs</u>	Applicable copayment	Applicable copayment, plus charges in excess of the allowed amount	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	No charge No charge	30% <u>coinsurance</u> 30% <u>coinsurance</u>	None None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u> , <u>deductible</u> doesn't apply for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	Non-emergency transport: not covered, except 30% <u>coinsurance</u> if pre-authorized.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	No coverage for non-urgent use.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$100 <u>copay</u> /stay, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> 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: \$40 <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	\$100 <u>copay</u> /stay, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
<b>If you are pregnant</b>	Office visits	No charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	

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)	
	Childbirth/delivery facility services	\$100 <u>copay</u> /stay, <u>deductible</u> doesn't apply; except no charge for newborn hospital expenses	30% <u>coinsurance</u>	services described elsewhere in the SBC (i.e. ultrasound.) Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	40 visits/ <u>plan</u> year. Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	60 visits/ <u>plan</u> year for Physical & Occupational Therapy.
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	Limited to treatment of Autism.
	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	No charge	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>	Penalty of 50% of <u>allowed amount</u> 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- 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.)**

- Chiropractic care - 24 visits/plan year.
- Hearing aids - 1 hearing aid per ear/36 months up to age 19 & 1 hearing aid per ear/5 years thereafter.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. \$100,000/lifetime for artificial insemination & ovulation induction combined. Advanced reproductive technology: 3 cycles/lifetime for in-vitro fertilization.
- Private-duty nursing - 70- 8 hour shifts/plan 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 1-866-658-2455.
- 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](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 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 1-866-658-2455.
- 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](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.**

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 \$40
- Hospital (facility) copayment \$100
- 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>\$12,800</b>
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**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
<b>The total Peg would pay is</b>	<b>\$300</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 \$40
- Hospital (facility) copayment \$100
- 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>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,000
<b>The total Joe would pay is</b>	<b>\$6,300</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$100
- 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>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$400</b>

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: 1-866-658-2455.

### Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-658-2455.

### 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](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 subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).**





- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-866-658-2455. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हनिदी में भाषा सहायता के लिए, 1-866-658-2455 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-658-2455.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-866-658-2455 na akwụghị ụgwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-658-2455 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-658-2455.
- Japanese - 日本語で援助をご希望の方は、1-866-658-2455 まで無料でお電話ください。
- Karen - လာဝတ်မစာတတ်ကတိကုန်အင်္ဂါ ကျိန် ကိး 1-866-658-2455 လာတအိန်ဒီးတတ်လာဝ်ဘူဝ်လာဝ်စုဘူဝ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-658-2455 번으로 전화해 주십시오.
- Kru-Bassa - Ɓe m'ké gbo-kpá-kpá dyé pídyi dé Ɓáwó-wuḍuŋ wɛɛ, dǎ 1-866-658-2455
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-866-658-2455 به خورایی یه یومندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-866-658-2455 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-866-658-2455 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-658-2455 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-658-2455 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-866-658-2455 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-658-2455
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-866-658-2455 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tèn kuwoɲy è thok è Thuwoɲjäɲ cɔl 1-866-658-2455 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-866-658-2455 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-658-2455 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefle in Deitsch, ruf: 1-866-658-2455 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-866-658-2455 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-658-2455.

- Portuguese - Para obter assistência linguística em português ligue para o 1-866-658-2455 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-658-2455
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-658-2455.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-658-2455 e aunoa ma se totagi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-658-2455.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-658-2455.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-658-2455. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-658-2455 bila malipo.
- Syriac - ܟܠ ܥܡܪܢ ܟܠ ܗܝ ܡܫܝܝܚܝܢ ܕܗܝܠܟܝܢ ܟܠ ܗܝܠܟܝܢ ܟܠ ܗܝܠܟܝܢ ܟܠ ܗܝܠܟܝܢ ܟܠ ܗܝܠܟܝܢ 1-866-658-2455 ܗܝܠܟܝܢ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-658-2455 nang walang bayad.
- Telugu - భాషలో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-866-658-2455 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-658-2455 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-658-2455 'o 'ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-866-658-2455 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-866-658-2455.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-658-2455.
- Urdu - اگر کسی کو اردو کی زبان کی مدد کی ضرورت ہے تو براہ کرم 1-866-658-2455 پر کال کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-658-2455.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-658-2455 פון אפצאל.
- Yoruba - Fún ìràn጗ọwọ nípa èdè (Yorùbá) pe 1-866-658-2455 láí san owó kankan rárá.